

Managing the drug regimens of immigrants from other cultures

KATIE LAI

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Practice Spotlight features innovations in pharmacy as told by the innovator during an interview with an AJHP news writer. All articles in this section are reviewed by the innovators before publication. Ideas for the section are selected by the editors, whose rationale for showcasing a practice is explained in the opening paragraphs of the article.

Described as a nation founded by immigrants, the United States still serves as a new home to people from other cultures—people who may view medical care differently than mainstream America does. A clinician's lack of knowledge of or appreciation for a patient's culture can hamper efforts to improve that person's health.¹ In 2003, through the adoption of a professional policy statement, ASHP started work to "foster cultural competence among pharmacy students, residents, and practitioners and within health systems" so that patients, regardless of their customs or beliefs, obtain the most from their medical care.²

Harborview Medical Center, located near downtown Seattle, has for about 20 years operated the International Medicine Clinic for adult refugees and immigrants. Here, Seattle residents who do not speak English well or at all can obtain primary care services in a language they readily understand. The patients who frequent the clinic typically emigrated from Southeast Asia or East Africa.

Q: What have been the hardest parts of U.S. medication use to explain to patients at the clinic?

A: Our patients, many of whom are new immigrants, are predominantly from developing countries that lack preventive care services. "Come see the doctor when you have a serious problem" is the usual directive on when to seek health care in those countries. Either the residents cannot afford preventive health care, or their country's health care system does not support it.

When these immigrants come to the United States and we start them on protective aspirin therapy, for example, it's hard to educate them about their need for the medication. A lot of these patients have high

blood pressure, diabetes, or cardiovascular complications. But when a pharmacist counsels them about aspirin therapy, patients often ask, "What's it for?" "It's to protect your heart," we say. "My heart's fine," they answer. Many of them don't understand the concept of preventive care. Their experience with medication is related mostly to acute care.

Another subject that is hard to explain to patients new to this country is the management of chronic diseases, such as high blood pressure. Hypertension is a silent disease, but patients are told to take a lot of medications for the rest of their lives. They do not understand why, if they've been taking their medications, the disease has not gone away. Their homeland's health care system was designed to take care of acute problems, and these patients are unfamiliar with the concept of chronic diseases that are not cured by a single course of medication.

Q: How do you explain preventive medicine to these patients?

A: We try to explain the rationale for preventive medicine, the risk factors for disease, what we see in clinical practice, and what we know of the disease. With diabetes, we explain its

KATIE LAI, PHARM.D., BCPS, CDE, is Clinical Pharmacist Specialist and Clinical Assistant Professor, International Medicine Clinic, Harborview Medical Center, 325 9th Avenue, Box 359895, Seattle, WA 98104 (klai@u.washington.edu).

Dr. Lai was interviewed by Cheryl A. Thompson, M.A., AJHP Senior News Writer. The interview was edited for length and clarity.

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pathophysiology and long-term complications and describe ways to prevent those complications. For example, we tell patients that, to prevent the cardiovascular complications, they should use a cardioprotectant, which is the reason for the aspirin. It's hard for these patients to buy into preventive medicine, though.

Q: So, you have no problem convincing patients to take their antibiotic?

A: Correct, because they have an infection, they have a fever, sometimes they see the infection on their hands and legs. They don't feel good.

We have a lot of difficulties explaining to patients with diabetes the need to control their blood sugar because they may not feel the effects of a blood glucose level of 200 mg/dL. If they don't feel or see it, they don't think it exists.

Q: In explaining the need for tight blood glucose control, do patients tell you that the disease is a problem of white Americans? Or ask, for example, where the proof is that this is a problem in Ethiopians?

A: There is a common belief that you get diabetes by living in America. Patients may have had diabetes in their homeland, but no one screened them for the disease unless they had symptoms. When these patients come to this clinic, we screen them for diabetes and, if their blood glucose level exceeds a certain concentration, tell them they have the condition. They immediately think "Oh, living in America has caused me to have diabetes." Or they don't believe our diagnosis because they feel fine. "I don't have diabetes. No one ever told me I had diabetes in my country."

A lot of our educational efforts seek to explain that health care professionals in the United States do a lot of disease screenings. We show them their test results. In this clinic, the pharmacists have more time for

education. That's the role that we serve—patient education.

Q: How do the prescription bottle labels and patient information sheets for your patients differ from what English-speaking adults commonly receive at pharmacies?

A: They're very similar in terms of directions, but there is some information we choose not to include.

We can print the directions in Vietnamese or Spanish. For example, the directions state in English, "Take one tablet every day," and then the same phrase follows in Vietnamese or Spanish.

Traditionally, mental illness has been viewed by some Southeast Asians as a black-and-white issue: You're either crazy or not. There's no such thing as depression, which most Americans view as an acceptable diagnosis. Some Southeast Asians' opinions of mental illnesses resemble Americans' view of schizophrenia. To say to a person that he or she has a mental illness, which encompasses depression, is not acceptable in some Southeast Asian communities.

When we start a Southeast Asian patient on paroxetine, sertraline, or any of the selective serotonin-reuptake inhibitors for depression, we don't include "for depression" on the prescription label. And when we counsel the patient, we say, "This medicine will help you with your mood. It takes a while to work. Take it every day."

Some Somalis associate tuberculosis with a negative stereotype and tend to ostracize tuberculosis patients. They treat tuberculosis like Americans used to treat HIV infection in the 1970s and 1980s. Somalis with tuberculosis do not want to tell anyone that they have it. So we don't write "for latent tuberculosis" on their isoniazid bottle, especially since prescriptions are often retrieved by family members. We counsel these patients in a private setting.

Q: What percentage of your patients speak Spanish or Vietnamese?

A: About 30% of our clinic patients speak Vietnamese, and of those, about half can read Vietnamese. That does not mean that they are from Vietnam. Vietnam is close to Laos, Cambodia, and Thailand, so emigrants from those countries may read and speak Vietnamese.

Most Spanish-speaking immigrants go to SeaMar Clinic, which is about a 30-minute drive from Seattle. About two thirds of the providers at that clinic speak Spanish. Other immigrants go to Harborview's Adult Medicine Clinic, because a few providers there speak Spanish in addition to English. So the International Medicine Clinic itself serves relatively few Spanish-speaking patients.

I would estimate the clinic's ethnic mix as 70% Southeast Asian and 30% African.

Q: How do you convince your patients to take their medications exactly as directed?

A: Keep in mind two things. First, our patients view Western medicine as "stronger" than their own culture's. Second, in America, pharmacists counsel patients about their medications and disclose a lot of information about possible side effects. A lot of our patients who come to pick up their medication are already very worried about the side effects of Western medicine. When they hear all the disclosures, it compounds their concerns.

Herbals are considered by many people, including Americans, to have no side effects, because the products include natural ingredients. On top of that, there's no counseling when consumers obtain these products, so people may not realize that the side effects they're feeling may be due to the herbal product.

Because our patients' health care is funded by insurance and Medicaid, most medications are

covered. If patients spend their own money to buy herbal products, we conclude they are having a side effect from the Western medicines. Therefore, we aggressively seek information about side effects and why the patients may not like their medications. For example, they may not like the color. In developing countries, nearly all medications are generic and white. People from those countries may vaguely associate side effects with their medication having a color. Or they may not like the size. "It's too big." Many of the patients who take herbs are accustomed to drinking herbal liquids that are boiled.

The method we use to convince patients to take medicine as directed is basically the same as with everything else: We take longer with education. That is why the International Medicine Clinic has its own pharmacy—to provide the longer counseling sessions that cannot be given at the main outpatient pharmacy that serves all the other clinics.

Q: Are your follow-up counseling sessions about as long as the initial session?

A: No. Often patients just drop in, and we have one of the interpreters act as the go-between for a few questions. Many of our staff members are multilingual. We just pull aside a staff member and ask for help in understanding the patient's questions.

Sometimes the issue is, "She doesn't like this because it causes upset stomach." We tell the patient to try taking the medication with food. We try to work with the patient.

Q: To what extent does your clinic use interpreters and translators?

A: Extensively. Interpreters, by definition, are used when you talk with the patient, and translators work with written materials. We can have an interpreter with us at the patient visit or during a telephone conversa-

tion (a three-way call). A phone interpreter is very helpful for less commonly used languages.

The hospital tries to accommodate more than 80 languages. Thirty to 40 interpreters are employed full-time by the hospital. Many interpreters speak three or more languages.

The clinic's interpreter service employs eight case-manager cultural mediators, one per language. They inform us of community events, teach the clinicians about the culture, and work as a liaison between the patients and the medical center.

Q: How many patients do you usually assist each day or week?

A: I'm scheduled to see 80 to 140 patients a month. This works out to 4 to 8 patients a day, starting at 9 in the morning.

Some days I'm overbooked, which means I'm scheduled to see patients every 15 minutes instead of every 30 minutes. On half-days, my last appointment is supposed to be at 11:30 a.m. But by the time I'm finished with everyone, it can easily be 1 p.m.

We have a show rate of 80% to 90%, meaning I may see 120 to 130 patients a month. About 10% of the patients I actually see are drop-ins—they don't have an appointment. And 5% to 10% are "tag-ons"—the physician has pulled me aside and needs assistance with drug management or monitoring.

My job is to perform disease management for diabetes, hypertension, and hyperlipidemia and to help patients manage their medications. I am also involved in encouraging smoking cessation and managing patients' anticoagulation regimens. With a new case of diabetes, for example, the physician informs the patient of the diagnosis, schedules a follow-up visit at two months, and tells the patient to see a pharmacist and a nutritionist the next week.

Q: There are other pharmacists in the clinic, right?

A: Yes. I'm the full-time pharmacist here. Another pharmacist covers my day off. I'm off every Friday because I work long days on Tuesday and Thursday, when the clinic is open into the evening. Another pharmacist works with me on Tuesdays and Thursdays. Both of these other pharmacists also cover the clinic when I'm on vacation. The rest of the time, they work in the Women's and Children's Clinic.

Q: What do you do in afternoons when no patients are scheduled?

A: Mostly I complete patient charts. Since I see patients back-to-back, I have to go back later to complete their charts. A lot of my time is spent on training. I always have a pharmacy resident, a Pharm.D. student, or a pharmacy intern with me.

I schedule all my meetings for the afternoon. That's when I try to handle all the matters related to the International Medicine Clinic pharmacy.

I also lead the non-English diabetes education team.

Q: What is the non-English diabetes education team?

A: There are about nine people on the team: four pharmacists (including myself), two dietitians, one physician, one nurse practitioner, and our librarian, who manages EthnoMed (a Web site with translated materials)³ and acts as our recorder. We meet monthly.

This project started four or five years ago with a pilot program at the International Medicine Clinic. We realized that there are patients who are best served in a big group. At the time, the hospital offered diabetes education classes in English only. The small pilot program grew into a huge hospitalwide—now communitywide—program in which we offer diabetes classes to six lan-

guage groups. All of Seattle is invited. For each language, we planned for three to six months before launching the class. We had the material translated and then field-tested in patients' homes. We asked 5–10 patients to give us feedback on the translated materials. From there, we fixed the translation and now use the material in the class.

Each class is culturally appropriate. We sit down with the case-manager cultural mediator for three to six months and learn about the culture and its health beliefs.

We split the Somali diabetes class in two—one for women and one for men—because that is appropriate for the culture.

We also helped develop the material in six languages for EthnoMed: Spanish, two Ethiopian languages (Amharic and Tigrinya), Vietnamese, Cambodian, and Somali.

If you go to the EthnoMed Web site (www.ethnomed.org), you'll find lots of translated material and links to the classes.

Q: You learned about cultural differences in medication use from the case-manager cultural mediators?

A: For the most part, yes.

Q: Your diabetes patients don't have a problem with the group approach?

A: That's why we had to split the Somalis into men and women. The women won't talk in front of the men. And we split the Amharics and the Eritreans, because they refuse to speak one or the other language when they're together.

The reason for the group approach is that patients who come to this country arrive with ideas they won't share during clinic visits. They think that, during clinic visits, we won't understand their ideas. In a class setting, patients share their

ideas, and that's how we all learn from each other.

When you teach a patient one-on-one about insulin, he or she says, "No, I don't want insulin." Well, nobody wants insulin. But *why* the person doesn't want insulin is never really considered.

In the class setting, when you place someone who does not use insulin next to someone who does and you talk about insulin, the nonuser will say, "I don't want insulin." Then the insulin user will say, "Well, at first I was afraid too."

The myth some cultures harbor about insulin is that it kills you. In a patient's home country, people who used insulin often had a serious disease. They were not routinely monitored, so there were many deaths associated with the drug. Recent immigrants may believe that insulin equals death or approaching death. Patients in our class learn from each other, and we learn from them.

We've held four or five classes for Vietnamese, one for Spanish speakers, two or three for Somalis, and four or five for Ethiopians over the years.

Q: What do you estimate as your success rate with patients?

A: We don't have specific numbers. We've had a lot of successes, though. Once patients have their medications and disease under control, we sign off. We don't see them forever.

Q: Do you adjust medication dosages?

A: Yes, I have prescribing authority. When patients see me, I will initiate therapy, adjust the dosage, or discontinue the medication and order blood tests if I need to.

Q: Do you also fill the prescriptions?

A: No, there's a pharmacy in the clinic where four pharmacists fill prescriptions.

Q: Since you've already talked with the patients, do they just pick up their medications at that pharmacy and leave?

A: No, those pharmacists counsel the patients. It's a double-check system. I see the patient, just as a physician does, and I write the prescription. The patient takes the prescription to the pharmacy, the pharmacy fills the prescription, and the pharmacist counsels the patient. The dispensing pharmacists don't assume that patients know how to take their medication.

Q: Is that the pharmacy where patients receive their information sheets?

A: We don't hand out many patient information sheets, for two reasons. A lot of my patients come from developing countries and are illiterate. Even for those who can read, we may not have an information sheet in their language. We have patient information sheets for only our most common languages.

One thing we worry about is patient information sheets obtained from a Web site. Those information sheets are direct translations and may not be culturally appropriate. Translations need to be field-tested. Often, the online information sheets do not indicate that anyone field-tested them. You'd be amazed how much we learn from using the material in our classes for patients who do not speak English.

In the Somali diabetes class, for example, we were trying to teach about carbohydrates. Somalis eat a lot of spaghetti, so we had a picture of spaghetti with meatballs and a fork. They had no idea what the picture was. They don't eat meatballs, and they use their hands to eat. Fieldtesting the material allowed us to identify this problem. Often the best information sheet consists only of pictures, such as drawings of the moon and the sun

to tell the patient to take the medication twice a day.

Field-testing information sheets is very expensive. When we developed the material for the diabetes classes, we had a grant from Group Health Community Foundation.

Q: Do the clinic's pharmacists specialize in any cultures?

A: No. One of the things we worry about is being fair with all languages. The dispensing pharmacy has one pharmacist who speaks Vietnamese and English and one who speaks an Ethiopian language and English; the rest speak English only.

The International Medicine Clinic is very sensitive to the appearance of bias toward any particular group. We don't have a Christmas party; we have an end-of-the-year thank-you party. We don't celebrate New Year. Cambodian New Year is in April, American New Year is in January,

Vietnamese New Year is in February, Ethiopian New Year is in October—the list could go on.

Because we see so many more Southeast Asians and Africans, we just happen to know more about them.

Q: How many patients does the International Medicine Clinic serve a year?

A: There are 10,000–12,000 visits a year, mostly Medicaid and Medicare patients. About 15% of our patients are low income without insurance, and another 5% have commercial insurance. The hospital's mission is to serve the underserved.

Q: Because your patients receive Medicaid, do you have to work with a formulary or preferred-drug list?

A: Washington State Medicaid does have a formulary and a limit of five brand-name products per patient. About 20% of the clinic's patients

have health insurance with Molina Healthcare, a managed care company that has policies for low-income persons. Molina has a very restrictive formulary, and we have to change many medication orders to meet its requirements.

Q: At the end of the day, do you believe that you've overcome the cultural barriers?

A: Yes. It requires a lot more education, knowledge of the cultures, and an understanding of patients' expectations.

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