

Finding the Words: Literacy and Traditional Vietnamese Medicine

By Emily King

Introduction

When I began studying at Oregon Health Sciences University, I hoped to eventually practice medicine in underserved areas around the world. In my first weeks of medical school, a professor challenged my classmates and me to consider that, although less glamorous than traveling to exotic places, there are many “international” Americans who are underserved. With this challenge in mind, I applied my enthusiasm for diverse populations and traditional means of health care toward an assignment to interview a patient with the goal of learning how she and her family utilize health care in this country. I am honored to have interviewed an immigrant from Vietnam, Vicky, who has given me an opportunity to appreciate some of the challenges the US health care system presents to recent immigrants.

Ethnographic Interview

Vicky gave me permission to share her story. She was born in Vietnam in 1975. That year, her father, who had helped the US military during the Vietnam conflict, left Vietnam in a small boat to escape Communist persecution. The boat drifted toward Hong Kong, where he lived for five years before immigrating to Portland, Oregon. Three years later, he was able to sponsor his family’s immigration. Vicky, the

youngest of six siblings, lives with her father, mother, two older brothers, a nephew, a niece, and her niece’s cat. Vicky’s four older sisters live with their husbands’ families. One of Vicky’s brothers-in-law is training to be a physician. Vicky is the youngest of her six siblings. She graduated from Portland State University with a degree in computer information systems and works part time for the City of Portland.

When I asked Vicky how she maintains her health, she revealed that she and most of her family members and friends of her family use allopathic medicine but supplement it with use of herbs and some Traditional Vietnamese Medicine (TVM). For example, Vicky’s mother uses allopathic and traditional methods to manage her diabetes, and her parent’s friends used allopathic medicine and acupuncture when recovering from strokes. Both of Vicky’s parents see allopathic physicians on a regular basis. Vicky sees an allopathic physician and feels comfortable having blood drawn and general tests performed at this physician’s office. She uses over-the-counter medications as well as green tea provided by her mother’s friends when she feels she is catching a cold. She also specifically mentioned using garlic and ham when she first notices cold symptoms to stop them from getting any worse.

Traditional Vietnamese Medicine

The traditional methods that Vicky’s family uses are based in TVM. Researching further, it was interesting to learn that historians believe that TVM, which is now very similar to Traditional Chinese Medicine (TCM), started independently of TCM and may have predated the Chinese conquest of northern Vietnam in the fourth century BCE. Over the next 1000 years of Chinese occupation, TVM and TCM are believed to have undergone mutual exchange in that TVM incorporated the theories of TCM and TCM incorporated many of the local Vietnamese medicines. In the 17th century, the term *Dong Y* began to be used to encompass all of the Eastern medical traditions and to distinguish them from the medical traditions of the Western colonizers. Currently, the practice of *Dong Y* depends on the observation of *Qi*, roughly “energy” that comes in numerous forms. *Qi* functions to provide movement, defend the body from pathologic factors, and support and promote growth and development. Levels of *Qi* can go up and down on the basis of lifestyle, diet, and work choices.¹

Although Vicky and her family do not completely rely on TVM or TCM, elements from these systems are preserved in the manner that they care for themselves. A major



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theory underlying *Dong Y* is yin and yang. This theory describes the existence of and the importance for balance between opposite states. A manifestation of this theory, which is practiced by Vicky's family, is that medicines prescribed by Western physicians that are considered "hot" will be balanced by taking "cool" herbs or foods.

Overall, it does not appear that Vicky or her family has difficulty accessing and using the medical system in the United States. This may be in part due to having a functional knowledge of English, health insurance through their employers, and a family member who is training to be a physician. It is not difficult to anticipate, however, what problems they might have if they had no health insurance or what problems immigrants may have who may be less proficient in English.

Minority Health Literacy

Proficiency in English is crucial for a patient to be health literate in the United States. The 2003 National Assessment of Adult Literacy demonstrated that 14% of the study population had below basic skills in prose (eg, brochures and instructional materials) and document (eg, forms, drug labels, and schedules) literacy. Twenty-two percent of the study population had below basic skills in quantitative (eg, balancing a checkbook and figuring a tip) literacy.² Literacy in these areas are essential for patients to successfully navigate and utilize the US

health care system. As defined in Healthy People 2010, health literacy is: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to

make appropriate health decisions ... It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations."³ Difficulty with language impacts the patient's ability to give important historical information; the physician's ability to understand and assimilate the information the patient is giving; and the nature of the patient-physician relationship.⁴ Ferguson and Candib found that minority patients, especially those not proficient in English, are "... less likely to engender empathic responses from physicians, less likely to establish rapport with physicians, less likely to receive sufficient information, and less likely to be encouraged to participate in medical decision making."⁵

Interpretation

Interpreters seem to be the obvious solution for the language barriers between physician and patient. Historically there have been debates as to who is ethically or legally responsible to provide interpreters: the physician or the patient and his/her family? The legal conflict has its origins in the Civil Rights Act of 1964 which states that "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."⁶ The Department of Health and Human Services views inadequate interpretation services as a form of discrimination. However, few hospitals, whether or not they receive federal funding, have the resources to provide adequate interpretation for all languages necessary, and only a few states such as California, Illinois, Massachusetts,

and Washington have established state regulations about interpreters.⁵ For financial and logistic reasons, many hospitals and clinics rely on interpretation provided via telephone. The alternatives to interpreters are 1) to conduct the visit with the patient's limited proficiency, 2) to have a family member or friend act as interpreter, or 3) to have a bilingual employee of the hospital (ie, an aide, nurse, custodian, or, if possible, another physician) act as interpreter. These are difficult options both for maintaining patient confidentiality and, if the interpreter is a family member or friend, working within the social and cultural rules of decision making and respect.

Communicating with a Physician

If a patient with limited English proficiency has difficulty communicating with their physician and does not feel they are receiving adequate care, it seems logical that the patient might rely more heavily on other culturally traditional forms of medicine to meet their health care needs. Ngo-Metzger, et al found that, literacy issues aside, when interviewing Asian Americans and Caucasians via random-digit dialing telephone interviews, Asian Americans were more likely to report that their physicians did not talk to them about lifestyle or mental health issues and that their physicians did not listen or involve them in decision-making processes as much as they would have liked. Although Asian Americans were significantly less likely to be very satisfied with their care, they were likely to trust their physicians and were significantly less likely to change physicians.⁷ Because these patients are less satisfied with their care, one might predict that they

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would supplement or change the treatments they are given to accord with what they believe to be appropriate or more beneficial while continuing to use the American health care system which is not meeting their needs.

Clinicians in any health care system may find it difficult to accept patients supplementing or changing treatments, especially if the patient is not likely to disclose the additions or changes. Nondisclosure may be because the patient does not think disclosure is necessary, because their language skills prevent them from disclosing, or because the clinician-patient relationship does not encourage full disclosure from the patient. Johnson et al, again using random-digit dialing telephone interviews, found that African Americans, Latinos, and Asian Americans were all significantly more likely to feel they would have received better care if they were a different race/ethnic group and that they were judged and treated unfairly or in a disrespectful manner by medical staff because of their race/ethnicity.⁸ Perhaps compounding the situation, patients may fear that if they tell an allopathic physician about their use of traditional practices, they may be told to stop using the traditional practices that they may believe are relieving their symptoms.⁹ Even Complementary and Alternative Medicine (CAM), what could be considered the “traditional” medicine in the US, is used for reasons that may be similar to those of recent immigrants and their families using the traditional medicine of their own cultures: to fill perceived gaps in health care. In a review of CAM research among patients with cancer, one study found that 73% of patients using CAM did so to feel hopeful, 77% used CAM to improve their quality of life, 44% used CAM

for relief of symptoms, and 44% used CAM to achieve greater control in their medical care decisions.¹⁰

Health literacy, traditional or CAM techniques, and difficulties in communication are issues encountered daily by most health practitioners in the US. As the population becomes more diverse, these issues will continue to grow. I think part of the difficulty in caring for minority groups in this country is that we have yet to figure out how to provide adequate health care for the “average” American. I do not believe we will be able to successfully care for patients with unique cultural and language needs until we can care for the majority of patients in this country in a respectful, economically feasible, sustainable manner.

My Future Role

With population growth, inflation of medical cost, and the impending catastrophe of the retirement of the baby-boomers, we cannot expect our current health care system to meet our needs without extreme political and social change. Considering the large scale of the issues such as national health care and health insurance coverage, health literacy, and cultural/ethnic specific health practices, I question how I see myself making a positive contribution. I see myself able to positively affect patients’ noneconomic needs in my own practice in the future. Specifically, I plan to do this by tailoring my practice to have access to interpretive services, to train or hire culturally competent office staff, and to make it a priority to openly discuss with all of my patients how they are complementing the health care they receive from me or any other allopathic physician and what else I or my staff can do to meet their health care needs. In my preceptor’s practice, I do not

see many non-Caucasian patients. I don’t have a lot of practice using interpreters to ask questions in a sensitive and respectful manner. My self-initiated discussions with Hmong students at my undergraduate institution and my interview with Vicky are experiences that have shaped how I relate to people of different racial, ethnic, social, religious, and economic backgrounds. I anticipate that improvements will always be necessary, but I hope to continue

to have opportunities to improve my skills and ultimately to provide better care for my future patients. I also hope to use these interactions and forthcoming research to understand how patient’s interactions with office staff can be conducted in a more respectful manner and how we can act preemptively to reduce the likelihood that patients will feel bias or at a disadvantage.

I also feel physicians should accept the responsibility of apologizing to patients for the current state of medical care in the United States because physicians are the interface between patients and a system that is spiraling out of control. We need to apologize to our patients for failing to be better advocates for their interests in matters of state and federal legislation. It is my hope that with an apology from those representing the medical system will come eventual forgiveness from patients and ultimately a forging of a new system that will better meet the needs of all patients that seek care.

My interview with Vicky has made me more aware of and better able to appreciate and understand some of the health-related issues facing

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recent immigrants as well as many average Americans. I appreciate the opportunity to explore these issues and discuss new ideas. I look forward to participating in ongoing conversations about health literacy, traditional medicine practices, CAM, and reinventing the US health care system, and hope that these movements continue to gather momentum and ultimately generate positive change. ❖

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Good Communication

The basic building block of good communication is the feeling that every human being is unique and of value.

— Anonymous