

Curbside Consultation

Challenges and Opportunities in the Care of Asian American Patients

Commentary by GIANG T. NGUYEN, MD, MPH, MSCE, FAAFP, *University of Pennsylvania, Philadelphia, Pennsylvania*

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Please send scenarios to Caroline Wellbery, MD, at afpjourn@aafp.org. Materials are edited to retain confidentiality.

A collection of Curbside Consultations published in *AFP* is available at <http://www.aafp.org/afp/curbside>.

Case Scenario

A 48-year-old Chinese immigrant presented to my office for a sick visit. At the time, I ordered hepatitis B screening because he had never received preventive care. The hepatitis B surface antigen came back positive, so I ordered follow-up tests to decide if treatment was needed. Luckily, his tests were reassuring, and he needs only monitoring for now. With similar patients in the past, I have had difficulty with poor follow-up after I tell them that they do not need immediate treatment. How should I approach the situation with this patient to encourage long-term monitoring and prevent future morbidity?

Commentary

In cases such as this, patients are often told, "You don't need treatment now," but they only hear, "You are fine." Subsequent failure to follow up may result from a combination of issues related to health literacy, educational attainment, linguistic barriers, and cultural differences.

Numbering 14.7 million in the 2010 census, Asian Americans are the fastest growing racial group in the United States.¹ Most Asian Americans are immigrants; as of 2011, there were 11.6 million foreign-born persons from Asia in the United States.² For nonimmigrant patients with chronic conditions, it is often enough to simply advise follow-up examinations and testing within a specified time frame. However, for patients from immigrant families, physicians should not assume the same health literacy as American-born patients.³ Also, despite the common perception that all Asians are well-educated, many Asian immigrants have low educational attainment and poor medical knowledge; for example, 30% of Vietnamese

Americans 25 years or older have completed less than a high school education (compared with 11% in non-Hispanic whites).⁴ Consequently, greater effort must be taken to educate patients and families about the long-term implications of chronic conditions and the potential for patients to change outcomes through close clinical follow-up.

A high percentage of Asian Americans have limited English proficiency, with 77% speaking a language other than English at home.⁴ Even when patients and family members appear to have good command of conversational English, their linguistic skills may not be adequate for clinical discussions. When interpreters are used, physicians must remember to speak in short phrases, pausing for interpretation, and to avoid the use of jargon, idioms, and colloquialisms that are difficult to translate.

Culturally, Asian families may adhere to a collectivistic approach.⁵ Major health care decisions are often made as a family, and the adult children of immigrant patients can be helpful allies in ensuring mutual understanding and promoting adherence to care plans.

Physicians should ask explicitly about use of supplements and herbals, because patients often do not think to mention this during medication review.⁶ Asian ethnic newspapers may include more nutritional supplement advertisements than actual health articles,⁷ and patients may believe that the use of such products can supplant the need for medical care and follow-up testing.

Finally, the previous health care experiences of immigrants from low- and middle-income countries are different from what physicians are accustomed to seeing in the United States.⁸ These patients typically seek physicians only when they feel symptoms, ►

Table 1. Preventive Services to Consider for Asian American Patients

Screening and other preventive services	Comments
Anemia screening	Thalassemia is common in Asian populations ⁹
Cancer screening	Asians are the only racial group in the United States for whom cancer is the top cause of death, yet cancer screening is low Breast, colorectal, and cervical cancer screening should be promoted Other cancers that do not require screening but should be considered in symptomatic patients include liver, lung, nasopharyngeal, stomach, and thyroid ^{10,11}
Diabetes mellitus screening	Metabolic risk may be high at a BMI as low as 26 kg per m ² (rather than 30 kg per m ²) The World Health Organization considers a BMI of 27.5 kg per m ² as a potential action point for Asians ¹² Diabetes counseling should reflect awareness of the typical rice-based diet
Glaucoma screening	Older Asians are at increased risk of glaucoma Narrow angle and normal tension glaucoma is considerably more common in Asians than other races ¹³
Hepatitis B screening and immunization	Hepatitis B (endemic in Asia) can lead to cirrhosis and liver cancer American-born Asians may still be at risk through vertical transmission from an infected mother Hepatitis B surface antigen testing is advised, and vaccine should be offered if the patient is not infected but nonimmune ¹⁴
Hepatitis C screening	Prevalence is 2% or greater in Pakistan, Taiwan, Thailand, and Vietnam ¹⁵ Hepatitis C can be transmitted through infected medical or dental instruments and blood products, in addition to illicit drug use ¹⁵
HIV screening	Absolute numbers of HIV cases are low for Asian Americans, but the trajectory of the increase in HIV infection suggests the need for vigilance, especially for men who have sex with men ¹⁶
Intestinal parasite screening	Consider testing for recent immigrants and refugees ¹⁷
Mental health assessment	Depression and posttraumatic stress disorder are common in refugee populations ¹⁷ Physicians should ask about experiences associated with migration Referral should be made to therapists who speak the patient's language if possible
Osteoporosis screening	Older Asian women are at risk, partly because the typical diet is low in calcium ¹⁸
Tobacco counseling	Smoking rates are lower for Asians than other groups, but Asian immigrant men are more likely to smoke than other Asian subgroups ¹⁹
Tuberculosis screening	Asians are the most at-risk racial group in the United States ²⁰ Purified protein derivative may be falsely positive because of bacillus Calmette-Guérin vaccination, so consider interferon-gamma release assay to confirm the diagnosis

BMI = body mass index; HIV = human immunodeficiency virus.

Information from references 9 through 20.

and perhaps only when symptoms are severe. Even when patients are aware of chronic conditions, they may self-manage through nonallopathic approaches rather than through formal medical care. Therefore, as in this scenario, physicians should emphasize screening and prevention during sick visits in addition to well visits, because many Asian American patients will not schedule health maintenance visits. *Table 1* lists some preventive care considerations relevant to Asian Americans.⁹⁻²⁰

Many items on the list can be accomplished with a simple blood draw and can be addressed without adding too much time to the office visit.

By using nonpreventive visits for preventive care, and by proactively addressing the health literacy, linguistic needs, and cultural nuances relevant to Asian American patients, primary care physicians can take full advantage of every opportunity to promote the care of a population that has often been underserved. ▶

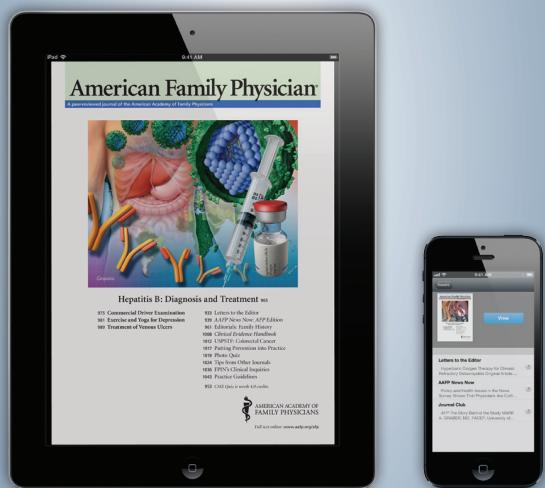
GO MOBILE

with *American Family Physician*

Now you can access all of AFP's vital peer-reviewed clinical content on your iPhone®, iPad®, or other smartphones and tablets.

Make the most of the new apps:

- Download for offline reading.
- Share articles instantly with colleagues.
- Bookmark content.
- Enjoy the more mobile-friendly formats.
- Receive real-time news and content feeds from the AAFP and *AFP*.



Search for “*AFP Journal*”



Also available:

Family Practice Management app



Curbside Consultation

Address correspondence to Giang T. Nguyen, MD, at Giang.Nguyen@uphs.upenn.edu. Reprints are not available from the author.

Author disclosure: No relevant financial affiliations.

REFERENCES

1. Humes KR, Jones NA, Ramirez RR; U.S. Census Bureau. Overview of race and Hispanic origin: 2010. U.S. Dept. of Commerce; 2011. C2010BR-02. <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>. Accessed July 15, 2014.
2. Gryn T, Gambino C; U.S. Census Bureau. The foreign born from Asia: 2011. U.S. Dept. of Commerce; 2012. ACSBR/11-06. <http://www.census.gov/prod/2012pubs/acsbr11-06.pdf>. Accessed July 15, 2014.
3. Nguyen GT, Bowman MA. Culture, language, and health literacy: communicating about health with Asians and Pacific Islanders. *Fam Med*. 2007;39(3):208-210.
4. U.S. Census Bureau. The American community—Asians: 2004. U.S. Dept. of Commerce; 2007. ACS-05. <http://www.census.gov/prod/2007pubs/acs-05.pdf>. Accessed July 15, 2014.
5. Theisen C. In different cultures, cancer screening presents challenges. *J Natl Cancer Inst*. 2004;96(1):10-12.
6. Wu AP, Burke A, LeBaron S. Use of traditional medicine by immigrant Chinese patients. *Fam Med*. 2007;39(3):195-200.
7. Nguyen GT, Ashfaq H, Pham TV. Health information in Vietnamese-American print media: results of a content analysis. *Am J Health Promot*. 2010;25(2):122-125.
8. Wagner AK, Graves AJ, Reiss SK, LeCates R, Zhang F, Ross-Degnan D. Access to care and medicines, burden of health care expenditures, and risk protection: results from the World Health Survey. *Health Policy*. 2011;100(2-3):151-158.
9. Lorey F. Asian immigration and public health in California: thalassemia in newborns in California. *J Pediatr Hematol Oncol*. 2000;22(6):564-566.
10. Miller BA, Chu KC, Hankey BF, Ries LA. Cancer incidence and mortality patterns among specific Asian and Pacific Islander populations in the U.S. [published correction appears in *Cancer Causes Control*. 2008;19(3):257-258]. *Cancer Causes Control*. 2008;19(3):227-256.
11. McCracken M, Olsen M, Chen MS Jr, et al. Cancer incidence, mortality, and associated risk factors among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese ethnicities [published correction appears in *CA Cancer J Clin*. 2007;57(6):380]. *CA Cancer J Clin*. 2007;57(4):190-205.
12. WHO Expert Consultation. Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies [published correction appears in *Lancet*. 2004;363(9412):902]. *Lancet*. 2004;363(9403):157-163.
13. Stein JD, Kim DS, Niziol LM, et al. Differences in rates of glaucoma among Asian Americans and other racial groups, and among various Asian ethnic groups. *Ophthalmology*. 2011;118(6):1031-1037.
14. Weinbaum CM, Williams I, Mast EE, et al.; Centers for Disease Control and Prevention (CDC). Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. *MMWR Recomm Rep*. 2008;57(RR-8):1-20.
15. Holtzman D. Hepatitis C. In: 2014 Yellow Book. <http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-3-infectious-diseases-related-to-travel/hepatitis-c>. Accessed February 28, 2014.
16. Centers for Disease Control and Prevention (CDC). Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001-2006. *MMWR Morb Mortal Wkly Rep*. 2008;57(25):681-686.
17. Eckstein B. Primary care for refugees. *Am Fam Physician*. 2011; 83(4):429-436.
18. Thomas PA. Racial and ethnic differences in osteoporosis. *J Am Acad Orthop Surg*. 2007;15(suppl 1):S26-S30.
19. Baluja KF, Park J, Myers D. Inclusion of immigrant status in smoking prevalence statistics. *Am J Public Health*. 2003;93(4):642-646.
20. Centers for Disease Control and Prevention. Reported tuberculosis in the United States, 2012. Atlanta, Ga.: U.S. Department of Health and Human Services, CDC; 2013. <http://www.cdc.gov/tb/statistics/reports/2012/default.htm>. Accessed July 15, 2014. ■