
 POPULATIONS AT RISK

Linguistic and Cultural Barriers to Care

Perspectives of Chinese and Vietnamese Immigrants

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CONTEXT: Primarily because of immigration, Asian Americans are one of the fastest growing and most ethnically diverse minority groups in the United States. However, little is known about their perspectives on health care quality.

OBJECTIVE: To examine factors contributing to quality of care from the perspective of Chinese- and Vietnamese-American patients with limited English language skills.

DESIGN: Qualitative study using focus groups and content analysis to determine domains of quality of care.

SETTING: Four community health centers in Massachusetts.

PARTICIPANTS: A total of 122 Chinese- and Vietnamese-American patients were interviewed in focus groups by bilingual interviewers using a standardized, translated moderator guide.

MAIN OUTCOME MEASURES: Domains of quality of care mentioned by patients in verbatim transcripts.

RESULTS: In addition to dimensions of health care quality commonly expressed by Caucasian, English-speaking patients in the United States, Chinese- and Vietnamese-American patients with limited English proficiency wanted to discuss the use of non-Western medical practices with their providers, but encountered significant barriers. They viewed providers' knowledge, inquiry, and nonjudgmental acceptance of traditional Asian medical beliefs and practices as part of quality care. Patients also considered the quality of interpreter services to be very important. They preferred using professional interpreters rather than family members, and preferred gender-concordant translators. Furthermore, they expressed the need for help in navigating health care systems and obtaining support services.

CONCLUSIONS: Cultural and linguistically appropriate health care services may lead to improved health care quality for

Asian-American patients who have limited English language skills. Important aspects of quality include providers' respect for traditional health beliefs and practices, access to professional interpreters, and assistance in obtaining social services.

KEY WORDS: Asian Americans; Chinese; Vietnamese; immigrants; quality; health care access; interpreters; language barriers; indigent care; community health centers. *J GEN INTERN MED* 2003;18:44-52.

Little research has examined how people from different cultures assess the quality of their experiences with Western medicine. What do people from non-Western medical traditions think about their experience when they seek or need care from Western providers unfamiliar with their beliefs and practices? This question becomes more important with rising populations of immigrants from non-Western societies. Over the past 30 years, the migration of Asians and Pacific Islanders (API) to the United States has risen by more than 400%.¹ API Americans are one of the fastest growing minority groups in the country. Many Asian medical beliefs and practices differ significantly from standard Western approaches. Most Western-trained clinicians know little about such beliefs and practices. For example, some Chinese- and Vietnamese-Americans believe that health and illness reflect the internal balance of "yin and yang," hot and cold forces within the body. Others believe that certain illnesses are caused by spirits or ghosts. Some patients use acupuncture or herbal medicine to supplement Western therapies. Others practice "coining" or "cupping," medical practices that leave bruises on the skin.² Western clinicians may mistake these bruises for indications of abuse or signs of hematological diseases. Providers may need to be able to talk about these deeply held, health-related beliefs and practices to effectively care for their patients.

Previous research showed that Asian Americans reported worse health care experiences than white, African-American, or Latino patients,^{3,4} that they were more likely to be dissatisfied with care, and that they rated primary care performance lower than did other racial/ethnic groups.⁵⁻⁷ We sought to understand more about how Asian-American patients perceive the quality of their health care, especially as it intersects with their culture. Although substantial

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patient-centered research on quality has been done, patients who speak little or no English have often been excluded.⁸ Asian-American immigrants who speak limited or no English may encounter more barriers to quality care than other Asian-American immigrants. Our study aimed to measure patients' perceptions of health care experiences by examining the views of Chinese and Vietnamese immigrants who have no or limited English language proficiency. We chose to study these 2 groups because they are the largest subgroups of Asian Americans in Boston and also because they have high percentages of recent immigrants with limited English proficiency.⁹ Large numbers of new Chinese immigrants came to Boston in the 1970s, '80s, and '90s after the 1965 Immigration and Nationality Act amendments lifted restrictions on immigration.⁹ Vietnamese immigrants came to Boston in multiple waves after the end of the Vietnam War in 1975. They were more likely than the Chinese immigrants to have suffered premigration trauma, which occurred during the Vietnam War and afterward in refugee camps or Communist "re-education" camps.^{10,11} The most recent Vietnamese immigrants are primarily Amerasians (children of American soldiers and Vietnamese mothers born during the Vietnam War) and political detainees (former South Vietnamese army officers sent to Communist labor camps for collaborating with the United States during the war).¹² We examined the perspectives of these recent immigrants with limited English language proficiency who may be more vulnerable to poor quality care.

METHODS

Study Design

We used a structured focus group interviewing technique to allow patients to describe the details of their personal experiences when obtaining medical care.¹³ This interview format lets patients identify quality domains that

they consider important, using their own narratives. The group format enables one member's response to stimulate another member's, until all salient points are covered.¹⁴

Data Collection

Development of a Focus Group Moderator Guide. We developed a Focus Group Moderator Guide based on a review of the literature and review of 2 surveys. The first was the Picker Institute Ambulatory Care Recent Visit Adult Questionnaire, adapted from the Picker-Commonwealth Survey of Hospital Care.¹⁵⁻¹⁷ This survey was designed to obtain reports on the quality of care received during a specific outpatient visit. The second was the Consumer Assessment of Health Plans Adult Survey (CAHPS 2.0),¹⁸ which focused on evaluation of services received from a health plan over 12 months. We also reviewed a focus group guide developed by Wiedmer et al. at RAND for use among Spanish-speaking health plan members.^{19,20} We then developed a structured guide to help moderators lead the discussion from beginning to end with a series of questions that progressed from general to specific. Open-ended questions were developed to elicit patients' views of the following topics: 1) patients' positive and negative experiences with medical care in the United States; 2) patient and provider communication; 3) the use of interpreters; 4) the role of the family in patients' care; and 5) patients' use of non-Western medical practices. Table 1 gives examples of some scripted probes. Focus group moderators used the probes to promote discussion, to refocus the participants on issues relevant to quality of care, and to encourage all participants to share their views while discouraging anyone from monopolizing the discussion. To facilitate coverage of all topics in all groups, the guide suggested an amount of time to be spent on each topic, allowing time at the end for the participants to rank order the quality domains most important to them.

Table 1. Examples of Questions from Focus Group Moderator Guide

Domains	Sample Questions
1. Perceptions of health care providers	"Have you ever had a good or bad experience with a doctor or nurse?" "What made it a good or bad experience?" "What do doctors and nurses you like do differently from the ones you do not like?"
2. Patient and provider communication	"How well do you think your doctor understands you and your health care needs?" "What kinds of things does your doctor do or say to show you that he understands your problem or concerns?" "What kinds of things does your doctor do or say that make you think he does not understand you?"
3. The use of interpreter services	"What has been your experience when a family member helps you interpret?" "What has been your experience using interpreters provided by the health center?"
4. The role of the family	"When you are sick, how do you want your family member to participate in your care?"
5. The use of non-Western medicine	"Do you use alternative therapies or non-Western medicine?" "If yes, please describe some of the therapies." "Do you tell your doctor or nurse that you are using such therapies?" "What is their reaction to your using such therapies?"

The Guide was translated into Chinese and Vietnamese, and back-translated independently into English. Any discrepancy in translations was resolved by consensus between the translators and one of the investigators (QN-M). Moderator guides are available from the authors upon request.

Recruitment of Bilingual Focus Group Moderators. Trained, professional focus group facilitators who were fluent in both English and Mandarin or Cantonese Chinese or Vietnamese were not available to work on this project. We relied on referrals from the local Asian-American community to identify potential moderators. We sought individuals who were fluent in either language and in English, had experience leading small groups, and expressed an interest in improving the quality of health care for their communities. Qualified individuals participated in two 2-hour training sessions that involved leading a mock focus group made up of Asian-American project and health center staff. The research team used the information generated from the mock focus group to revise the content and wording of the guide.

Recruitment of Patients. We received approval from the Committee on Clinical Investigations at Beth Israel Deaconess Medical Center and recruited patients from 4 community health centers in Massachusetts. One center cares for Asian-American patients primarily (99%), while the other 3 have them as 8% to 25% of their patient volume. Bilingual site coordinators who were staff members of the health centers recruited patients by following a standardized recruitment script. Inclusion criteria were: 1) Chinese or Vietnamese in origin and speaks Mandarin or Cantonese Chinese or Vietnamese as the primary language; 2) identified the health center as the patient's usual place of care; and 3) was seen by a provider at the center at least twice in the last 12 months. Patients with diabetes or hypertension were invited to participate in groups that were disease specific. Site coordinators invited patients whose age ranged from 18 to 80 years. Patients who were hearing impaired were excluded because of their inability to easily participate in a group discussion with nonimpaired patients. Each patient received a \$50 stipend for attending a 2-hour session.

Focus Group Sessions. Between November 1999 and January 2000, we conducted 12 focus groups consisting of 6 to 12 patients in each group. Two of the 12 groups consisted only of patients with diabetes or hypertension. Six groups were conducted in Vietnamese and 6 in Chinese (4 in Cantonese, 2 in Mandarin). Each group was segregated by gender and was led by a gender-concordant moderator, following cultural norms to ensure maximum participation. We conducted 6 groups of all-male and 6 groups of all-female patients. Focus groups were held at patients' own health centers to maximize their comfort and convenience. However, to ensure patient confidentiality, no staff members of the health centers

were present during the discussions. After receiving informed consent from each participant, research staff video-recorded each session. The videotapes were translated and transcribed verbatim into English by independent professional bilingual transcribers.

Data Analysis

Review of Focus Group Transcripts. Each moderator reviewed the videotape of his/her own focus group and made edits to improve the accuracy of the transcripts. The investigators used an inductive approach to coding, using procedures informed by grounded theory methods.^{21,22} We identified passages in the transcripts that represented topics, and categorized the content of discussions that suggested distinct domains of quality. Each investigator reviewed and coded each transcript independently, then met in groups of 3-member teams to reach consensus on the major content areas represented in that particular transcript. Each 3-member team consisted of 1 sociologist, 1 health services researcher, and 1 physician. We then met as a larger group and identified quality domains represented by the transcripts of all 12 focus groups.

RESULTS

Patient Characteristics

The characteristics of the participants are shown in Table 2. All patients were foreign born. Vietnamese patients had lived in the United States for 7 years, on average, and Chinese patients for 11 years. Most patients identified themselves as limited English-proficient (LEP) and reported incomes below the poverty line. Employment status data were intentionally not collected because of concerns regarding reliability of reporting. Patients could have been uncomfortable revealing employment status because of unreported income or undocumented immigration status.

Quality Domains

The focus group discussions of the Asian-American patients included frequent mention of 3 dimensions of quality care that are not usually encountered in research among white U.S. patients: 1) respect for patients' health beliefs and practices; 2) quality of interpreter services; and 3) availability of social support services. In addition,

Table 2. Characteristics of Participants

	Chinese (N = 66)	Vietnamese (N = 56)
Born in the United States, %	0	0
Female, %	52	50
Mean age, y	57	51
Mean y in United States	11	7
Limited English-proficient, %	88	98
Completed high school, %	42	71
Annual income ≤\$20,000, %	92	82

patients identified other dimensions that have been previously well-described and embodied in the current Picker¹⁵⁻¹⁷ and CAHPS 2.0¹⁸ instruments: 1) access; 2) information and education; 3) respect for patient preferences and showing emotional support; and 4) continuity and transition. Table 3 lists these expressed needs and indicates whether the Picker or the CAHPS 2.0 survey¹⁵⁻¹⁸ asks about these concerns. Below, for each domain, we present the patients' views of quality of care in their own words.

Respect for Patients' Health Beliefs and Practices. Patients reported using practices such as "coining" and "cupping" to treat symptoms of minor illnesses, such as respiratory infections. "Coining" involves rubbing the spine and sternum with oil and a coin to release the "wind" or "cold"

element. "Cupping" involves heating air in a cup with a flame, placing the cup onto the skin, and "pulling out the cold air."² Patients stated that they often used traditional treatments before seeking Western medical care. A Vietnamese woman explained: "My husband hates going to the doctor. If he has a cold, he prefers these treatments first; if he does not get better, then he would go to the doctor."

Patients reported sometimes using both Western medicine prescribed by their doctors and Asian medicine at the same time. A Vietnamese patient reported that her herbal medicine doctor told her to take herbs "one hour after I take regular [Western] medicine." Patients viewed Western medicine as being more potent than Asian medicine to treat acute pain or infection. They viewed

Table 3. Comparisons of Patient's Expressed Needs and Domains Covered by the Picker and CAHPS Instruments

Quality Domains	Needs Expressed by LEP Asian-American Patients	Picker Questions	CAHPS Questions
Respect for patient's health beliefs and practices	• Providers know about and respect non-Western health beliefs and practices	No	No
	• Providers discuss patient's health beliefs and practices in nonjudgmental manner	No	No
Quality of interpreter services	• Access to professional, culturally appropriate interpreters	No	No
	• Adequate time spent with interpreter	No	No
	• Gender-concordant interpreters for sensitive issues	No	No
	• Complete and accurate translations	No	No
	• Being treated with respect by interpreters	No	No
	• Interpreter access for nonscheduled visits and for after-hour phone calls	No	No
Availability of social support services	• Staff help patient understand and navigate the medical system (i.e., knowledgeable about benefits, claims, etc.)	No	Yes
	• Staff provide assistance in other areas (housing, welfare, immigration, etc.)	No	No
	• Providers help patient obtain health-related assistance and support services	No	Yes
Access	• Appointments as soon as you wanted	Yes	Yes
	• Short waiting time during office visit	Yes	Yes
	• Providers spend enough time with you	Yes	Yes
	• Urgent care without needing scheduled appointments	No	No
	• Medical care that is within walking distance or accessible to public transportation	No	No
Information and education	• Written medication labels in patient's native language	No	No
	• Effective communication of health-related information	Yes	Yes
	• Education regarding life-style behaviors and preventive care	No	No
	• Prompt communication about test results	Yes	No
Respect for patient preferences and showing emotional support	• Providers and staff show respect and dignity	Yes	Yes
	• Providers listen to what patient had to say	Yes	Yes
	• Providers and staff display empathy and support in nonverbal ways	No	No
	• Providers ask about how your family or living situation may affect your health	Yes	No
Continuity and transition	• Staff arrange follow-up appointments, tests, and referrals for the patient	Yes	Yes
	• Interpreter services available at the time of referrals	No	No
	• Assistance with transportation	No	No
	• Providers coordinate care for evaluation and treatment	Yes	Yes
	• Providers communicate with others who may be involved in the patient's care	Yes	Yes

Asian herbal medicine as being less potent, but its “minimum side-effects . . . [make] it very appealing.”

Patients reported that they often encountered negative reactions from Western clinicians and therefore were reluctant to tell their providers about their use of Asian medicine.

I told the doctor, ‘I am taking some angelica and ginseng. Do you think it is OK?’ The doctor said, ‘I don’t know Chinese medicine. . . . You should be responsible for the results if you take them!’ After that I did not dare mention Chinese medicine again.—Chinese woman

Patients reported that their providers often did not understand traditional practices such as coining or cupping, and often mistook the bruises for hematological diseases or signs of abuse. Many patients wanted their providers to know more about non-Western medical practices because they believed that they might be “the right treatment for a disease.” A Chinese woman offered a summary comment:

I think how they treat Chinese medicine here [in this clinic] is a very big issue, as is the quality of medical services. To accept Chinese medicine or not, to combine it with Western medicine or to reject it, really means a lot to us. To let these two cultures of medicine learn from each other and benefit from each other. . . . Even if the doctors here reject Chinese medicine, the patients will still value it in their heart, though many of them would not tell the doctors because they could not. The patients still believe in Chinese medicine.

Quality of Interpreter Services. Patients preferred trained interpreters to using their own family members. When Asian-American immigrants must rely on their children to interpret, this alters the power dynamics in the family and creates discomfort for them. They reported that respect for elders is an important Asian cultural value. A Vietnamese man stated: “When you go see the doctor, and your children go with you as your translators, this changes. . . [the relationship] in your family.” Patients declared that family members were not adequately trained in medical terminology, and were not always available to accompany them to the visit.

The translators are trained to translate, therefore they translate medical terms better than our relatives. Our relatives have to take time to go with us. Sometimes the kids do not want to go.—Vietnamese man

Patients worried that their symptoms were not being completely or accurately translated, and wanted interpreters to translate word-for-word. A Vietnamese man explained: “I did not know if the translator translated my whole story to the doctor or not.” A Chinese patient with diabetes added: “The doctor speaks so much, but the translator says only a few words.” Patients valued having same-sex interpreters when dealing with sensitive issues, and wanted interpreters to treat them with respect and spend enough time with them.

That [translator] just yelled at me and he did not care. . . . He treated me as if I am stupid because I cannot speak English. He said, ‘I am busy, but you talk a lot.’—Vietnamese man

Availability of Social Support Services. Patients viewed the medical clinic as a source of advocacy to help them navigate the complex medical and social service systems in the United States. They were pleased with health centers that provided social services, and appreciated medical providers who showed a concern for patients’ total needs. A Vietnamese female patient praised her health center saying: “This center pays attention not only to the health of my family, but also my personal problems. They helped me with social work and to apply for welfare benefits.”

In addition to the 3 new quality domains described above, patients mentioned other domains that have been described in English-speaking populations.

Access. Patients expressed confusion over how to obtain urgent care in the U.S. medical system. They had problems communicating with health center staff and were unable to obtain urgent care when needed. They were accustomed to a “walk-in” system in their native country, but had difficulty in the United States accessing their providers by phone because of the language barrier. Patients also spoke of long wait times to schedule routine appointments.

It takes me at least 3 months for an appointment. I asked why and was told that they did not have room for me. Therefore, sometime I want to make an appointment and do not feel like doing so because it takes too long. . . .—Vietnamese man

Many patients spoke of the long wait time during the appointment. Patients did not wish to wait more than 45 minutes in the waiting room when they arrived on time for their appointment. However, many patients reported 1 to 2 hours waiting time as routine. Patients also had problems accessing the health centers or hospitals because of lack of transportation. Since the majority of the patients do not drive, they valued having medical care that is accessible by public transportation.

Information and Education. Patients expressed a need for prompt communication about test results, and stated that they often worried when they did not hear back from their providers. They also valued written health education materials and written instructions about prescribed medications in their native languages. They valued detailed explanations about how to participate in their care. A Vietnamese woman explained that it was important that “[doctors] teach us what to do to reduce the sickness . . . [how] to exercise, [what] to eat.”

Respect for Patient Preferences and Showing Emotional Support. Patients valued being treated with respect and dignity by providers and staff. They defined “being treated with respect and dignity” as being treated “as an equal.” They wanted providers and staff to respect their needs and individuality, and to extend respect to family members as people who can provide additional information and improve patient-provider communication. Patients defined “showing courtesy” as displaying “a warm and welcoming

manner." Patients stated that because of the language barrier, they especially valued providers and staff who expressed nonverbal emotional support. They valued clinicians with whom they were able to establish a trusting relationship.

We feel like they [good doctors] are truly the good mothers [who] give good care to their children... If we have someone who just does not care [for] us a lot, maybe we would not have good treatment and maybe we would die.—Vietnamese woman

Continuity and Transition. Patients stated that because of language difficulties, they needed clinic staff to arrange referrals and to coordinate transportation and interpreter services for specialty care or further testing at another facility. When asked to describe what she liked about her health center, a Chinese patient said:

We were told how to do this, how to handle that, what to be aware of when you go to the hospital... They'll arrange for interpreters at the hospital. They'll tell you which bus to take, what time the bus leaves, how to get there.

DISCUSSION

Our focus group results show that Chinese and Vietnamese immigrants with limited English proficiency have some concerns that their providers and health care systems must address. Some needs are unique to their cultures; other needs are similar to those of other new immigrants with limited English skills; while other needs are shared with all patients. Newly described aspects of quality include providers' respect for patients' traditional beliefs and practices, access to trained interpreters, and the availability of social services.

Traditional treatments such as coining (*cao gio*) and cupping (*giac ho*) and the use of herbal medicine are part of the cultural practices of many Chinese- and Vietnamese-American patients. We found that patients used traditional remedies and herbs either before seeing a Western provider or concurrently. This finding is consistent with other studies on the use of folk remedies among Puerto Rican and Mexican immigrants in the United States.^{2,23} Previous research has documented the use of folk remedies among Vietnamese immigrants.²⁴ However, to our knowledge, our study is the first to find that these patients wanted to discuss their beliefs and practices, but were reluctant because of previous negative responses from their providers. They viewed providers' knowledge, inquiry, and non-judgmental acceptance of their beliefs and practices as being a part of effective patient-provider communication.

The quality of interpreter services was another key concern of the patients in our study. They preferred using professional interpreters rather than their own family members or ad hoc bilingual personnel, which could result in inaccurate translations.²⁵ Furthermore, patients were acutely aware that much of what they say to providers,

and much of what is said to them, may be censored by the interpreter. Although quality measures such as the Health Plan Employers Data and Information Set (HEDIS 3.0) now include an indicator for the availability of interpretation services, the quality of the services is not considered. Patients also preferred gender-concordant interpreters, especially when discussing sensitive issues. This finding is consistent with studies of LEP Latino patients that found similar concerns and preferences.^{26,27} However, the study conducted by Kuo and Fagan showed that some Spanish-speaking patients may prefer using family and friends to translate rather than using an unfamiliar interpreter.²⁷

The availability of social support services was a new quality dimension found to be important to LEP Chinese and Vietnamese patients. This dimension may reflect a need or expectation that is similar to that of other vulnerable patients who may have problems navigating complex medical and social service institutions. Previous research conducted among patients who are not Asian Americans found that patients at an urban, inner-city clinic may require more social support than do more affluent patients who obtain care at a suburban health center.²⁸ In our study, the participants did not read or speak English well and relied on providers and clinic staff to assist them in other areas of life, such as housing or immigration. In addition to having limited English proficiency, our study participants had low levels of education and low income. The need for more social services may have been primarily related to their low socioeconomic status. Because of the qualitative nature of our study, we could not differentiate whether patients' perceived needs for social services were related primarily to cultural, linguistic, or socioeconomic factors. Additional research using quantitative methods may be able to clarify how low socioeconomic status interacts with culture and language to shape patients' health care needs.

Limited English-proficient Chinese- and Vietnamese-American patients identified some quality domains that are similarly important to all patients. These domains are measured by existing surveys such as the Picker and CAHPS instruments.¹⁵⁻¹⁸ However, the Picker instrument does not contain questions about cultural issues or interpreter services. It has been tested primarily among white, English-speaking populations. CAHPS 2.0 is currently being tested among Spanish-speaking patients.²⁰ Its supplemental item set contains questions about the availability of interpreters, but does not ask about interpreter quality.¹⁸ Using information obtained from our focus groups, we are currently developing and validating a structured survey to assess quality of care among Chinese- and Vietnamese-American patients with limited English proficiency.²⁹

Our study has 2 types of limitations: the first group of limitations is inherent in qualitative research; the second group of limitations is related to the lack of generalizability to other Asian-American populations. First, although focus

group research is an effective method for identifying and exploring health-related perceptions and needs, results can be biased and may not represent all patients' experiences. Patients who do not regularly visit a health center are unlikely to be asked to participate, and the views of more articulate members are more likely to be represented. We also may not have elicited all quality domains important to patients, although we used open-ended questions to lead the discussions.

Second, our study population was limited to patients of Chinese and Vietnamese origin, whose views may not generalize to other Asian-American populations. As noted previously, the Chinese and Vietnamese have different migration patterns and may differ in other ways.⁹ However, because of the qualitative nature of our study, we could not quantify any significant differences between the results obtained from the Chinese focus groups as compared to the Vietnamese focus groups. Third, the respondents in our study were primarily recent immigrants, had limited English proficiency, and had lower socioeconomic status. Therefore, their views cannot be generalized to more-educated Chinese and Vietnamese immigrants or to immigrants who have resided in the United States for longer periods of time and who may be more fluent in English and have higher socioeconomic status. Furthermore, the respondents were all first-generation immigrants, and their views cannot be generalized to second- or third-generation Chinese- and Vietnamese-Americans who may be more acculturated. Fourth, we did not measure the acculturation levels of our study participants. Degrees of acculturation to Western culture may affect how patients view non-Western medicine and how they perceive their health care in the United States. Finally, the focus groups were all held in Massachusetts in community-based health centers with relatively large proportions of Asian-American patients. These patients' experiences may not generalize to Asian-American patients who obtain care in other settings.

Despite these limitations, our study provides new knowledge about the health care needs of populations that have historically been under-studied. The patients who participated in this study may be more vulnerable to poor quality care because of cultural, linguistic, and socioeconomic barriers. Addressing these barriers, at both the provider and system levels, can lead to improved care for these patients and their families.

In our study, patients wanted providers to respect their culturally based health beliefs and practices. Clinicians should be aware of potential differences between the biomedical model of disease and a patient's belief systems. Providers should ask patients directly about their health beliefs and their use of non-Western therapies. The best source of information regarding their beliefs and practices are the patients themselves. Asking the patient directly would prevent any assumptions or stereotyping. Our study found that patients welcome provider initiatives in opening the lines of communication around these issues. Providers

should also ask patients about social factors that are most pertinent to the medical encounter. Previous research has shown the inextricable link between social factors and patients' health status.³⁰⁻³³ Defining the patient's social context may include questions about education, employment, migration history, social networks, and literacy (in English and in the patient's native language).³⁴ These questions allow providers to assess patients' needs that may affect their ability to participate in the treatment plan (financial ability to obtain medication, ability to read medication labels, etc). Taking a comprehensive social history would enable clinicians to provide appropriate health education materials and appropriate referrals to social services, aspects of care important to patients.

Limited English-proficient Chinese and Vietnamese patients voiced the need for help in accessing social services and navigating complex medical and social service institutions. Bilingual, bicultural social workers and health care advocates may play key roles in improving patient care. These community health workers may work as members of the health care team to facilitate patient and community access to the health care systems, educate providers about cultural concerns, and improve the continuity and coordination of care.³⁵ If a health care facility does not have adequate resources to provide such programs, it is crucial that referrals be made to other agencies that may be helpful to patients.

Health care systems must also recruit bilingual, bicultural personnel and professional interpreters. If individual medical facilities lack the resources to have on-site professional interpreter services, multiple institutions can combine resources to support community-sponsored interpreter banks.³⁶ Although using professional interpreters is the highest quality standard of care, institutions that use ad hoc bilingual staff to interpret must design ways to formally assess and advance the skills of their bilingual employees utilized as interpreters.³⁶ The quality of interpreter services should be continually monitored by obtaining structured feedback and evaluations from the patients and their providers. Monolingual providers must also receive training in how to most effectively use interpreters and how to assess problems that may arise in the provider-interpreter-patient interaction. This training is especially important given previous research showing that less communication is taking place between patient and clinician during encounters requiring interpreters.³⁷ For many health care facilities with limited budgets, finding ways to financially support quality interpreter services may be difficult. States with large numbers of LEP patients should follow the example of Washington state, where Medicaid reimburses for outpatient interpreter services, and hospitals are required to provide trained interpreters.³⁸ A recent report released by the Commonwealth Fund profiles 14 programs around the country that provide interpretation services, and also identifies public and private funding sources for interpretation services in the health care setting.³⁹

On a system level, it is important to train clinicians and other staff to increase their understanding about the history, culture, and health beliefs and practices of Chinese and Vietnamese immigrants. However, rather than simply learning the stereotypical cultural traits of specific ethnic groups, clinician training should focus on how to ask appropriate questions to obtain information on each individual patient's cultural and social factors. Clinicians must be taught how to handle conflicts that may arise when provider and patient disagree on the role of traditional practices. Cross-cultural medical education curricula have been developed to address these issues.^{34,40} Further research is needed to evaluate the effectiveness of these curricula, and to evaluate how culturally sensitive medical care affects patient satisfaction and outcome.

More research is needed to better understand how cultural and linguistic concerns can guide quality improvement efforts. Providing quality care to culturally diverse patients who have limited English skills is a challenge. Finding ways to overcome cultural, linguistic, and other social barriers may lead to improved care and a more satisfying encounter for patients and their providers.

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