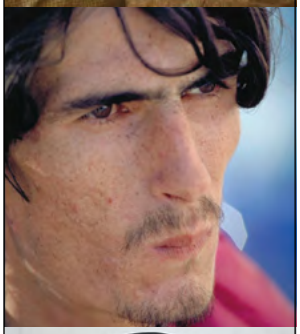

TB & CULTURAL COMPETENCY

Notes from the Field

New Jersey Medical School Global Tuberculosis Institute Issue #17, Spring 2013

Working Through Communication Challenges

This case comes a nurse in Indiana, and involved a complex contact investigation. This article focuses on the cultural issues involved.

Tina

As the designated TB nurse for the county Health Department, I was informed about Tina, a TB case suspect, in mid-January. Tina had gone to the emergency room the previous month for a persistent cough. While she was in the ER, Tina had a chest X-ray and CT scan. She was diagnosed with a lung mass and pneumonia and sent home with Zithromax and cough medicine. Despite the medications, her cough continued, so she went to her physician and had a bronchcoscopy. The lab results revealed she had active tuberculosis (TB), was smear positive for acid fast bacilli (AFB) and was likely infectious. This is when the health department and I were notified. My first contact with Tina was by telephone at her place of business, a nail salon located in a strip mall. I advised her to go home immediately as per Indiana infection guidelines and told her that I would meet her there to discuss her condition.

Tina and her husband were originally from Vietnam. They had been in the United States for about 15 years and had previously lived in New York and California. The Asian community in our town isn't large; I think there may be a perception that there isn't work available for Asian immigrants and that they aren't welcome or safe here. Tina had taken on an American name, but I called her by her Vietnamese name, Tien. Her husband went by his Vietnamese name, Hao.

Translation Necessary

The couple spoke some limited English, and Hao spoke better English than Tina did. Due to the complexity of TB treatment, I realized I was going to need help translating medical information and health education materials to their native language. The Health Department is fortunate to have an employee who could help me with the translation since

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she was born and grew up in Vietnam. She speaks several languages including Vietnamese, Cambodian and Chinese and has translated for us several times in the past. She is very active in the Vietnamese community in Indianapolis. She knows it is important to hear what people are actually saying, especially when in an unfamiliar situation.

My colleague and I ended up educating each other while we drove to the patient interview. For example, she suggested I remove my shoes before we entered Tina and Hao's home as a sign of respect. She also counseled me to speak to Hao rather than directly addressing Tina, and to avoid any casual touch. She also told me not to be insulted if Hao interrupted me or asked the same question several times. I appreciated this insight because this did end up happening several times and I was able to not take it personally but attributed this to cultural differences. On the other hand, my translator colleague was hesitant to come into the house because she had grown up in Vietnam where TB is endemic, and was afraid of becoming infected. She was able to gain knowledge about TB and how it was spread, as well as use of appropriate infection control measures. I reassured her we would not get TB during the interview.

I was also advised that Tina and Hao might have a different communication style than what I typically encounter in a patient interview. She said they might answer only direct specific, direct questions. Usually when I do an interview, I try to put people at ease, since I think they are more likely to answer questions if they feel comfortable. I aim to keep the interview as an informal "conversation", and communicate with open-ended questions. I try to let the conversation flow naturally, while ensuring that important TB medical and general information is discussed. The style my colleague recommended that I use would be quite different for me.

The Interview

The translator and I removed our shoes before entering Tina and Hao's home and began the interview shortly after our arrival. Through my colleague, I was able to provide TB education to Tina and Hao and to learn more about their history. I described latent TB infection (LTBI) versus active TB, signs and symptoms, modes of transmission, treatment options and the need for isolation and why it was necessary to wear

a mask. I also explained Directly Observed Therapy (DOT) as a standard of care as well as the difference between sputum smear and sputum culture. My colleague's translation skills were invaluable. I was able to communicate information in small bursts instead of a lengthy monologue, which made it easier for the translator to explain the information to them. Tina and Hao asked many questions, and we were also able to hear more about their health and social background.

As we started the interview, I quickly realized my colleague was right about the need to adjust my usual approach to communication. For example, asking, "What do you do on the weekend?" didn't generate valuable information. I realized that the most effective strategy would be to ask very specific, pointed questions rather than to ask general, open-ended questions as I usually would. So instead of asking what Tina and Hao did on the weekend, I would ask if they attended religious services, or if they visited anyone. This method interrupted the flow of conversation but resulted in obtaining useful information. From the interview I learned that they worked a lot and didn't have a close circle of friends or family. Tina and Hao indicated that they did not have children.

We explained what a contact investigation was and

why we would be doing one. We learned that Tina and Hao owned the nail salon where Tina worked. In fact, Tina and Hao were also the only employees and her absence would have a significant impact upon the business. Tina seemed to enjoy working at the salon, and while both of them did manicures and pedicures for clients, it was mostly Tina who provided services. She frequently wore a mask at work due to the dust and fumes from the chemicals she used, but she didn't wear one all the time. The nail salon was a cash-only business, so they did not have a list of clients. The majority of customers were US born, and the clients knew Tina by her American name. The salon was open from Monday to Saturday, and had long hours. The couple told us they worked in the salon and then just went home. Sometimes on Sundays they would drive to Indianapolis to go to an Asian grocery store or beauty supply wholesale store to pick up materials for the salon. The TB diagnosis appeared to be a source of embarrassment for them. Their main focus was completing the treatment and putting this episode behind them so that Tina could return to work as soon as possible.

The physician had immediately started Tina on the standard four drug TB treatment regimen. We did a skin test on Hao, and he was positive. Since his tuberculin skin test (TST) was positive, Hao was started on LTBI therapy not too long after Tina started TB treatment. They were very eager to follow the instructions I provided. I gave them my office and personal numbers in case they became concerned about any aspect of the treatment. I received calls on weekends or evenings, and it was always Hao who called. He often would ask questions regarding items that we had already covered, and kept asking when Tina could go back to work. Each time we spoke, I explained that I didn't know because Tina's return to work was dependent upon on when her sputum culture sample converted to negative. I think he kept asking because he was hoping I'd give a different answer and say she could go back to work. Even though Hao spoke better English than Tina, I believe he probably would've dominated my conversations with the couple even if language wasn't an issue since he assumed an overall leadership role in their relationship. Additionally, Hao was very afraid the salon would go out of business and that they would be forced to move and start again.

Complicating the case was that the media picked up the story, which caused stress and anxiety to the couple. Business at the salon dropped to zero for several weeks. Hao continued to ask me for a specific date when Tina could return to work, but I could not give him one. He thought if Tina could return to work, business would resume to its normal level. I think Tina felt pressure from Hao to get better so she could resume her duties at the nail salon. She was pale and had a productive cough, but would deny that she had a cough, and would try to suppress it.

Contact Investigation

The contact investigation was fairly complex since there were no client records to establish contact information. It became even more interesting when I was testing one of the contacts and he asked if we were also looking at the couple's laundromat as a source of exposure. I was stunned. I quickly learned Tina and Hao also ran a cash-only laundromat along with the nail salon; in fact, the two businesses were next door to each other in the same shopping plaza. The laundromat didn't have much business in the first place, and Tina was rarely there which reduced potential exposures. I realized that during the interview, the question that I had asked was whether Tina and Hao worked in a nail salon, and they had answered "yes." Since I didn't specifically ask about a second business, they did not volunteer the information.

I had jumped to the conclusion that they were hiding something, but that wasn't it at all.

After I found out about the laundromat, I went back to talk the couple to see if there was other information they hadn't disclosed. During the initial interview, I asked if they had children and they told me no. I asked again if they had children, and this time they told me they had a 16-year old son. Based on this, I was prepared to have an uncomfortable discussion regarding their dishonesty during the initial interview. I then learned their son lives in California with his grandparents, and that Tina and Hao hadn't seen him in 3 years. They did not volunteer any more information about him. I had jumped to the conclusion that they were hiding something, but that wasn't it at all, since I don't think they were secretive about him out of shame or embarrassment. To Tina, her son wasn't involved because he wasn't present, so she

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did not mention him. I realized this might have been due to our different communication styles. She did not disclose the full response to the direct question I had asked. She did have a child but he wasn't there at that that time. Even though the son didn't end up being relevant to the contact investigation in this case, it did get me wondering what other ways I could have phrased the question to get a fuller response. This might be relevant in future contact investigations, especially those involving more complex family structures.

We ultimately found 11 people with LTBI, and 5 initiated treatment and 3 completed treatment. We were so fortunate to have so many great partners during this case, such as the director and health officer of our local health department. The Emergency Management Agency (EMA) staff was also wonderful, and helped us in so many ways. They helped us find a location to do testing and transported our supplies.

Back to Business

As a result of Tina's experience with TB, the nail salon was in bad financial shape. I was considerably impressed when the local Chamber of Commerce got involved. A representative from the Chamber of Commerce met with Tina and Hao and had lots of different ideas for helping the salon, including relatively simple, low-cost ideas such as repainting the walls, reorganizing the furniture, placing new advertisements and having a grand re-opening. The couple didn't have funds to make all the changes, but they managed some of them. In fact, some of us at the health department helped them repaint the salon. Eventually, business bounced back and they had more business than ever. I personally felt very rewarded they were able to resume business and have even more customers.

Tina and Hao were on treatment for nine months. Tina started treatment about a week and and half before Hao, and her regimen was determined by standard treatment guidelines which are driven by sputum conversion to negative status, so she took medication twice a week during the continuation phase. However, Hao had to take medication every day for his LTBI treatment, and he had trouble understanding why he had to take more medicine than she did, when she was the one who was sick. I used a calendar as a visual aid during my discussions with them to say when the end goal for treatment would be, but Hao kept asking when they would both be done. I continually reassured them they were on the appropriate regimens and used the calendar as a guide. Tina finished treatment about a week and half before Hao, which I don't think he was pleased about. It didn't seem to matter that she had started treatment earlier than him; he felt he wasn't contagious, and should be done as well. Though I don't think Hao ever felt fully comfortable with this, in the end both Tina and Hao did successfully complete treatment!

I encouraged them to call the health department if they had any future issues. When Tina finished treatment, I gave her a certificate of completion, which is now framed on their wall at home. It's hard not to form a bond after all that time. At the end of treatment, they expressed their appreciation and I felt able to hug them and joke around.

For me, this case was a real learning experience and I hope my experience will be useful for others.

Physical versus Psychological TB

Some Vietnamese may believe in two different forms of TB-both a psychological and a physical form. Psychological TB is characterized by symptoms of fatigue, loss of appetite and lethargy, and is believed to be caused by depression and worry. Psychological TB is not considered infectious, and can be treated by reducing worry and stress. It's believed psychological TB takes a toll on the person, and can eventually lead to physical TB. Physical TB is more similar to biomedical TB, and is characterized by chills, cold sweats, and a productive cough. It is believed physical TB is contagious, and can be treated with antibiotics. Ask questions to understand the patient's beliefs and ideas about TB symptoms, transmission and prevention, so that you can tailor educational information appropriately.

Adapted from Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam by the Centers for Disease Control and Prevention

Houston, HR, Harada, N and Makinodan, T. (2002). Development of a Culturally Sensitive Educational Intervention Program to Reduce the High Incidence of Tuberculosis Among Foreign-Born Vietnamese. *Ethnicity and Health*, 7(4): 255-265.

Using Open-Ended Questions

To elicit a patient's understanding of diagnosis or treatment, avoid asking close-ended or "yes or no" questions. Close-ended questions are best used to obtain specific pieces of information, and are generally best used during initial interviews for obtaining identifying information. Instead ask open-ended questions that call for more than a one word reply. To confirm understanding, have patients repeat information in their own words.

It's important to remember each individual has personal beliefs. One method to determine how an individual thinks about their own health is to use a series of questions developed by the anthropologist Arthur Kleinman. The questions can help the healthcare worker understand how the patient understands TB. The questions can also be used to address a patient's fears and the impacts of TB on the patient and their family and friends. The questions can be incorporated into an existing health assessment or an ongoing assessment of the patient's needs. Questions can be reworded and tailored to suit the patient. Samples of Kleinman's Questions for TB are as follows:

- What do you call your illness?
- What do you think causes TB?
- Why do you think you got sick when you did?
- What do you think TB does to your body?
- How severe is your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the main problems TB has caused?
- What do you fear most about TB?
- How do your family members or close friends feel about you having TB?

Adapted from *Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam* by the Centers for Disease Control and Prevention

Communication Styles

Communication is complex, and involves much more than words. It involves the exchange of information and the creation of meanings. The success of TB control activities is directly related to the health care professional's ability to develop and sustain positive relationships with TB patients. Communication is the foundation of that relationship.

You will need sharp written and verbal communication skills to carry out basic functions of TB control. However, you will also need effective cross-cultural communication skills. These skills involve awareness and sensitivity to non-verbal cues, body language and gender roles.

Different communication styles can pose communication challenges for both the health care professional and the patient. There are two communications styles; direct and indirect. Someone with a direct communication styles says what they mean and means what they say. In this style, the truth is more important than sparing someone's feelings. However, someone with an indirect communication style does not always say what they mean. The listener may have to read between the lines of what is being said. Someone with an indirect communication style may temper the truth so it does not hurt the listener. If a health care professional and patient have different communication styles, more time may be needed to build rapport. Observe the patient's body language and nonverbal cues. Misunderstandings about nonverbal cues can also create complications.

Be aware of your own communication style. If you communicate directly, it will be easier to communicate with others who have a similar style. However, if you encounter someone with a different style, you may need to adapt your approach and be observant of nonverbal cues to best understand what is really being said.

Adapted from: *Cultural Competency and Tuberculosis Care: A Guide for Self-study and Self-Assessment* by the NJMS Global Tuberculosis Institute, and *Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam* by the Centers for Disease Control and Prevention.

Cultural Issues

In 2003, the CDC conducted a study to better understand the TB-related experiences, perceptions and attitudes of the Vietnamese. In the study, many Vietnamese described TB as a stigmatizing and socially isolating disease. Many participants in the study said they would not disclosure their TB status because they feared being ostracized. In Vietnam, TB is a social humiliation that isolates the person diagnosed with disease as well as their family. In some Asian countries, gender inequality may be more prominent, with women having a lower status. In traditional Vietnamese families, the eldest male serves as the decision maker and spokesperson. Some health care decisions may be made on a collective basis and under the guidance of the eldest male. There are many studies that highlight how deferring to authority and fear of losing face are important factors that affect health outcomes among Asians.

Treat each patient as an individual and avoid making assumptions about them based on their country of origin. Some general guidelines are:

- Ask the patient what they like to be called, and for the correct pronunciation of their preferred name
- Vietnamese names consist of a family name, middle name, and a given name. Upon moving to the US, some individuals may adopt a more Western name.
- Avoid medical jargon, and use simple terms and phrases instead.
- To avoid showing disrespect, especially to persons of higher status, Vietnamese may not express disagreement. Instead, they may not answer a question directly or they may remain silent.
- Nodding or saying yes may indicate respect for the person talking, and not actually indicate agreement with what is being said.
- Some Vietnamese consider TB to be a highly stigmatizing disease that would result in rejection and ostracism. To allay fears, emphasize the need for only short-term isolation during active TB treatment
- When possible, provide TB information in an oral or written format that is appropriate to the age, literacy level and preferences of the patient.

To effectively control TB in the US, the care and treatment of all patients should be appropriate and effective, regardless of country of origin, language or cultural factors.

Adapted from *Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam* by the Centers for Disease Control and Prevention.

Salant, Y and Lauderdale, D. (2003). Measuring Culture: a critical review of acculturation and health in Asian immigrant populations. *Social Science & Medicine*, 57, 71-90.

Yu, M and Nguyen, TD. (2012). Clinical Challenges in Working with Asian Immigrant Women and Their Families. *Asian Social Science*, 8(7), 11-19.

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