

Hepatitis B Clinical Specialists:  
responding to cultural diversity.

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# Background

- Hepatitis B = cultural diversity
  - 56% of people with hepatitis B in Australia are born overseas
  - Huge diversity within specialist clinics
- Clinical monitoring reduces liver disease
  - Hepatitis B related liver cancer increasing
- Systematic deficits in information provision
  - Inadequate testing/diagnostic processes
  - Poor knowledge among health care workers
- Challenging condition
  - Asymptomatic
  - Populations affected
    - Understandings of health

# Background

National Hepatitis B Needs Assessment:

*They are sitting there nodding saying 'yes, yes, yes, thank you very much', but they don't understand, they won't say 'what's that mean?'*

*They're easy to deal with but it doesn't mean that they're doing what they say they are doing.*

*You're much more likely to get people who want to be treated and stick to their therapy if they understand what they're doing and they think it's good for them.*

# Methods

- Thirteen specialists: Hepatologists/ID physicians/ CNCs
- Semi-structured interviews based on vignette

Theme	Questions
Critical information about hep B	<ul style="list-style-type: none"><li>• What are the key issues that Patient X needs to know about having hepatitis B?</li><li>• How do you communicate these issues to Patient X?</li></ul>
Impact of cultural background on knowledge transfer	<ul style="list-style-type: none"><li>• Does the fact that Patient X was born in Vietnam change what they need to know?</li></ul>
Utilising supports	<ul style="list-style-type: none"><li>• How do you provide this information?</li></ul>
Sharing cultural competency knowledge	<ul style="list-style-type: none"><li>• Have you spoken to colleagues/other specialists about communicating to culturally diverse patients?</li></ul>
Barriers	<ul style="list-style-type: none"><li>• What are the barriers for you in communicating about hepatitis B with people from CALD backgrounds?</li></ul>

- **How do specialist clinicians in Australia negotiate cultural diversity?**
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# Vignette

*Patient X is a Vietnamese born person diagnosed with chronic hepatitis B who has been referred to you by their local GP. They are in the immune control phase and their English is good enough to not require an interpreter. You become aware that they have little understanding of the natural history of hepatitis B, its treatment options, or possible outcomes and you are concerned that they may not return for continued monitoring. The patient tells you they have not told their family that they have chronic hepatitis B.*

# Findings: Information on hepatitis B

- Hepatitis B is a chronic asymptomatic infection that is not curable, and requires lifelong monitoring, with an option for treatment
- The natural history of the infection including the progression to liver disease and cancer, and the silent or asymptomatic nature of this progression
- Transmission routes for hepatitis B, with two clinicians stating that they specifically provided information on how hepatitis B was not transmitted given misunderstandings about this within the communities most at risk
- Hepatitis B can be prevented through vaccination

# Findings: Educational approaches

*It would be good if you got them back over a few times... each time you got them back, it would give you an opportunity to go over what has already been said.*

*If somebody doesn't speak English, and has had no education, what I'm saying to them is going to be very different to what I am saying to a Vietnamese gentleman who is trained and articulate, and educated. (Spec 4)*

# Findings: Normalising hepatitis B

*You know 5 to 10% of people your age have hepatitis B (in Vietnam), but a lot of people don't know about it. It's actually important that we talk about it, and that you go home and are able to talk about it to others because then they can get tested as well.*

*If they come from an area where hep B is endemic, they think that hep B is normal ... To engage them in the management and treatment and compliance can be a challenge.*



# Findings: Information across languages

*We have found that some words in the English language, there is no word to match certain words we have here .... It means that at times interpreters have said "I can't interpret that word", and have to think of another way to put that.*

*(Their English is) fine for getting buses and getting shopping and doing all your other stuff but when you come to discuss a medical condition, I may well be still asking for an interpreter in, or seeing if he would be happy for me to get an interpreter to help with things.*

# Findings: Cultural competency

*The resources ... are mainly written by translating a document meant for a European, Caucasian, English speaking background ... we translate into a language which doesn't necessarily make it culturally appropriate.*

*The other issue is trying to understand how each different CALD population will have different perception on hepatitis, different concepts on whether there is stigma, also different perceptions towards health care ... and whether there may even be some mistrust of Western health care.*

# Conclusion

- Patient centred approach to informational issues
- Different level levels of information provided to different patients
  - Need to ensure this is not limited by assumptions
- No systematic response to cultural diversity
- Interpreters:
  - Translate both English + biomedical
  - New model of natural history description
  - Translation of resources inadequate
- Clinical information focus
- Hepatitis B is complex.

# Thank you

Investigators:

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