Vietnamese Diabetic Patients And Their Physicians: What Ethnography Can Teach Us

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Introduction

Dorothy Mull, Nghia Nguyen, and J. Dennis Mull's article "Vietnamese Diabetic Patients and Their Physicians: What Ethnography Can Teach Us" examines how Vietnamese immigrants in Southern California understood and managed type 2 diabetes. Published in 2001, the study remains useful because it demonstrates that clinical recommendations are interpreted through language, family experience, food traditions, migration history, economic conditions, and ideas about how the body works. The original review accurately identifies the importance of ethnography but sometimes presents Vietnamese culture as the main reason patients experienced poor outcomes. That conclusion is too narrow. The study describes encounters between patients and a healthcare system, so communication failures, limited education, poverty, access, clinician assumptions, and treatment burden must be analyzed alongside health beliefs. (Mull et al., 2001)

Diabetes care has also changed since the research was conducted. Current American Diabetes Association standards emphasize person-centered decisions, shared goals, social determinants of health, culturally and socially appropriate diabetes self-management education, affordable treatment, and the involvement of interpreters, community health workers, dietitians, pharmacists, and family or other supporters when the patient wishes. The historical article should therefore be read as evidence about a particular community at a particular time, not as a permanent description of Vietnamese Americans. Ethnography is valuable precisely because it resists treating a population as a list of fixed traits. It asks how people explain illness, how they make decisions in daily life, and how clinical institutions can become more responsive. (American Diabetes Association Professional Practice Committee, 2026)

The Research Question and Ethnographic Method

The researchers wanted to understand differences between Vietnamese patients' explanations of diabetes and physicians' biomedical explanations. They interviewed thirty-eight Vietnamese patients, as well as Vietnamese physicians, nurses, and a traditional healer. Conducting interviews in Vietnamese allowed participants to describe concepts that might have been lost in an English-only survey. The study explored perceived causes of diabetes, medication behavior, food, symptoms, herbal remedies, insulin, and the advice patients remembered receiving. (Mull et al., 2001)

The original review calls the patients "randomly chosen," but ethnographic samples are usually

purposive or convenience-based rather than probability samples designed to represent an entire population statistically. The article's contribution lies in detailed patterns and meanings, not a prevalence estimate for all Vietnamese immigrants. Thirty-eight participants from low-income Southern California settings cannot establish that two-thirds or seventy percent of every Vietnamese American community behaves in the same way. The sample may overrepresent people facing barriers, and responses are shaped by memory, interviewer relationships, translation, and the circumstances in which questions were asked. (Mull et al., 2001)

These limitations do not make the study weak. Ethnography answers questions that a laboratory test cannot. A clinician may know that a medication lowers glucose but still not know why a patient takes it only when symptoms appear, fears insulin, or combines it with herbs. Interviews reveal the practical logic behind behavior. They can show whether a patient received advice in an understandable form, whether the plan fit family meals and work schedules, and whether the clinician asked about remedies used at home. (Mull et al., 2001)

Different Models of the Body and Illness

Several participants described health through balance, bodily sensations, and traditional ideas about hot and cold qualities. In a biomedical model, type 2 diabetes is a chronic metabolic disease involving insulin resistance and progressive impairment of insulin production. Glucose can remain elevated without obvious symptoms, so medication and monitoring may be needed even when a person feels well. A patient who understands illness primarily as a temporary imbalance may reasonably stop treatment when the body seems normal. The behavior is dangerous from a biomedical perspective, but it is not evidence of irrationality. It reflects a different model of what medicine is for. (Mull et al., 2001)

Effective communication begins by eliciting the patient's model rather than dismissing it. A clinician might ask, "What do you think caused the diabetes? How do you know when it is better or worse? What treatments do you use at home? What worries you about this prescription?" The answers can then be connected to measurable indicators such as A1C, blood pressure, kidney function, eye examinations, and symptoms of low or high glucose. The goal is not to win an argument about culture. It is to create a shared explanation that allows safe decisions. (American Diabetes Association Professional Practice Committee, 2026)

The phrase "out of balance" can become a bridge. A clinician can acknowledge the patient's language while explaining that glucose may be out of range before the person feels a change. Visual aids, teach-back, and concrete examples can clarify why daily treatment continues. Teach-back does not test the patient's intelligence; it tests whether the explanation was clear by asking the person to describe the plan in their own words.

Medication, Insulin, and Herbal Remedies

The study reports that some patients reduced or stopped prescribed medicine and preferred herbal or traditional treatments. The original review treats this mainly as resistance created by culture. Medication behavior is usually more complicated. Cost, side effects, complex schedules, fear of dependency, limited transportation, inconsistent insurance, mistrust, work demands, and previous experiences with healthcare may all affect adherence. A patient may call a decision “traditional” while also responding to an unaffordable prescription or an explanation that was never translated adequately. (Mull et al., 2001)

Herbal remedies should be discussed without ridicule or automatic approval. Some plants or products may have pharmacologic effects, interact with diabetes medicines, affect the liver or kidneys, or vary in dose and contamination. Others may be harmless as foods or rituals. The clinician needs the actual product, dose, source, and frequency. A blanket demand to stop every traditional practice can drive use underground, while uncritical acceptance can expose the patient to harm. Shared decisions may allow a low-risk practice to continue alongside evidence-based treatment, with monitoring and clear warnings about replacing essential therapy. (American Diabetes Association Professional Practice Committee, 2026)

Insulin deserves particular attention. Fear may involve needles, pain, stigma, hypoglycemia, perceived disease severity, inconvenience, or the belief that starting insulin means personal failure. Modern care should explain that type 2 diabetes can progress despite effort and that insulin is one treatment option, not punishment. Demonstration, smaller needles, glucose-monitoring support, affordable access, and involvement of a diabetes educator can reduce fear. The appropriate regimen depends on the individual; the ethnographic lesson is that a prescription alone does not complete treatment. (American Diabetes Association Professional Practice Committee, 2026; Mull et al., 2001)

Food, Family, and Daily Life

Nutrition advice often fails when it is delivered as a generic list that ignores customary meals. Vietnamese diets vary by region, migration history, religion, income, and generation. Rice, noodles, soups, vegetables, fish, meat, fruit, sauces, and shared dishes can be prepared in many ways. Telling someone simply to stop eating rice may be culturally alienating, nutritionally simplistic, and difficult in a household where meals are communal. A dietitian can instead discuss portion, meal timing, fiber, protein, cooking method, sweetened drinks, and how glucose responds to the person’s usual foods. (American Diabetes Association Professional Practice Committee, 2026)

Family involvement can be helpful because shopping, cooking, medication reminders, and decisions may be shared. It can also become controlling if clinicians assume that relatives should speak for the patient. The person with diabetes should decide who participates. Interpreting should be provided by a qualified interpreter rather than relying routinely on a child or family member, especially for

sensitive information or complex consent. Bilingual community health workers can help patients navigate appointments and explain concepts, but they complement rather than replace clinical expertise. (American Diabetes Association Professional Practice Committee, 2026)

Work and migration experiences matter as well. Long shifts, multiple jobs, food insecurity, unstable housing, and transportation barriers can make an idealized plan impossible. The 2026 ADA standards recommend assessing social and structural barriers and adapting care accordingly. A plan that ignores affordability or schedule is not person-centered merely because it is scientifically correct. (American Diabetes Association Professional Practice Committee, 2026)

What the Study Teaches Physicians

The article challenges the assumption that clinicians communicate effectively simply because instructions were given. Some patients reported limited guidance about self-management. Physicians may have believed that they discussed diet or medication, while patients may have heard technical language without a practical plan. Time pressure and fragmented care can reduce education to brief commands. Ethnography shows what remains after the visit: the patient's interpretation, family discussion, symptoms, costs, and comparison with trusted community knowledge. (Mull et al., 2001)

Cultural humility is more useful than memorizing a checklist about Vietnamese beliefs. Cultural competence can imply that a professional can master another group's culture. Humility emphasizes ongoing inquiry, awareness of power, and willingness to correct assumptions. Not every Vietnamese patient uses traditional medicine, fears insulin, or prefers family involvement. Generational status, education, English proficiency, war and refugee experiences, religion, and socioeconomic position create diversity within the community. (Mull et al., 2001)

Clinicians should also avoid treating race or ethnicity as a biological shortcut. Asian populations can develop type 2 diabetes at lower body-mass-index levels than some other groups, but individual risk still depends on age, family history, body composition, diet, activity, medication, sleep, and social conditions. Screening and treatment should follow evidence while remaining attentive to the person rather than a stereotype. (American Diabetes Association Professional Practice Committee, 2026)

Strengths and Limits of the Original Research

The study's strongest feature is its comparison of patient and professional perspectives in a shared linguistic and cultural setting. Interviewing nurses and a healer broadened the analysis beyond physicians. The work also documented the limits of symptom-based treatment and the importance of discussing traditional remedies directly. These findings helped shift the question from "Why are patients noncompliant?" to "How do patients understand the plan, and how does the clinical relationship shape their choices?" (Mull et al., 2001)

Its age and setting limit application. Diabetes medications, monitoring technologies, insurance arrangements, immigration patterns, and community resources have changed since 2001. The study did not measure whether a culturally adapted intervention improved A1C or complications. It also risks being read as though Vietnamese culture itself caused poor management. A contemporary follow-up should include a larger and more diverse sample, patient partners, measures of access and treatment cost, and longitudinal outcomes. It could compare language-concordant care, trained interpreters, culturally tailored education, and community-health-worker support. (American Diabetes Association Professional Practice Committee, 2026; Mull et al., 2001)

Researchers should preserve complexity in reporting. A death associated with abandoning treatment is clinically important, but one case cannot demonstrate that all traditional medicine is fatal. Likewise, a percentage from a small sample should not be presented with false precision. Qualitative evidence is strongest when it explains mechanisms and generates testable interventions.

Conclusion

“Vietnamese Diabetic Patients and Their Physicians” demonstrates why diabetes cannot be managed through prescriptions alone. Patients interpret chronic disease through bodily experience, family practices, language, trust, cost, and cultural knowledge. When biomedical advice does not connect with those realities, people may stop medication, use it only when symptoms occur, or rely on remedies that feel more understandable and accessible. The appropriate response is not blame. It is better communication, shared decision-making, safe discussion of traditional treatments, and practical support. (Mull et al., 2001)

The article should not be used to stereotype Vietnamese Americans as resistant to science. Its enduring lesson is methodological: listen before designing the intervention. Current diabetes standards reinforce that lesson by emphasizing culturally and socially appropriate education, individual values, social determinants, and team-based care. Ethnography makes invisible reasoning visible. When clinicians take that reasoning seriously, they can explain risk more clearly, negotiate safer plans, and build the trust required for long-term treatment. (American Diabetes Association Professional Practice Committee, 2026)

References

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