Hmong Studies Journal v2n2 Spring 1998

The Hmong and Health Care in Merced, California

Miriam E. Warner
Marilyn Mochel

Abstract

This article discusses the linguistic and cultural barriers the Hmong encounter when they attempt to access the health care delivery system in Merced County, California. The theoretical portion of the article discusses the concepts of culture, culture change, and some psychological issues that result from culture contact. Western biomedicine is viewed as a cultural system. Following this theoretical section, the cultural and linguistic barriers confronted by the Hmong when they attempt the access health care in Merced are discussed as well as some successful programs in the development of culturally sensitive health care. These include the Southeast Asian Surgical Coordination Team and the Culture Broker Team. The last part of the article covers, in some detail, a multidisciplinary program in cross-cultural health which is being implemented by health workers in Merced County.

Introduction

[1]

The United States is becoming an increasingly culturally diverse society. Immigrants and refugees from many countries have settled in the United States for various reasons such as economic advancement, education and flight from religious and political persecution. During the last two decades many of these groups have chosen to retain their cultural identity, including their language and cultural practices. These factors have led to an increase in bilingualism and biculturalism which, in turn, has increased the need for successful intercultural communication.

[2]

The refugees from Laos started coming to the United States in the late 1970's. Over 100,000 Hmong have settled in the United States. The states that have the highest populations of Hmong are California, Minnesota, Wisconsin and Michigan. In California the cities that have the largest concentrations of Hmong are Fresno, Merced and the Sacramento area.

[3]

This article will discuss the access to culturally sensitive health care for the Hmong in Merced, California. Prior to this, there is a brief theoretical discussion of culture, culture change, and contact between people of two cultures. We will take a brief look at Western biomedicine as a culture. Following this, the cultural and linguistic barriers facing the Hmong in trying to access the health care delivery system in Merced County, California are discussed and Merced's plan for developing and implementing culturally sensitive medical care will conclude the article.

The Concept of Culture

[4]

Culture may be defined as an integrated system of unconsciously learned behavior patterns that are characteristic of a group of people and that are not the result of biological inheritance. The most important ideas in this definition are: culture is learned, not inherited; culture is shared by members in a common group; and culture is transmitted to children by their parents and other adults, not by formal teaching, but by children observing the actions of their parents. Culture sets guidelines for appropriate behavior, styles of thinking and appropriate ways to express emotions. Culture shapes the way we see the world. It shapes our relationships with our nuclear family, kin groups, neighbors and friends. It shapes our economic, political and religious institutions. Above all, culture shapes our beliefs about illness and health, including reasons for the causation of disease, the methods of diagnosis and the appropriate treatment plans.

[5]

Each culture has a set of values. Values are widely held beliefs about what is worthwhile, desirable or important for well being. Some values define appropriate ways of answering the basic needs of people, such as food and shelter. People in all societies have these needs but each culture defines the ways the needs are satisfied. For example, obtaining food is accomplished by hunting and gathering, gardening, hunting, or shopping in grocery stores. The need for shelter is satisfied by tents as used by the nomadic people of the Middle East, mudbrick huts in Africa, bamboo shelters in parts of Asia and large apartment buildings in cities around the world.

[6]

Cultures have different time orientations: past, present and future. Past oriented cultures are those that know the history of the group, and trace their ancestral ties. Many groups have a myth of origin. The constant retelling of myths and history reinforces the values of the group and gives a rationale for the present structure of the group. The past serves as a prologue for the present. American society is future oriented. The present is just a road to a better future. Generally speaking, most Americans are not satisfied with the current state of affairs. The new is valued while the history of the group is unimportant. Many Americans "know" that a new car, new house, or more money will bring happiness. When happiness is not forthcoming, the push for more new things continues. American advertising, in all forms, reinforces these sentiments. In American society, the present is mainly a fast track to the future. A comparison between past- and future-oriented societies often shows that people see change in different ways. The future-oriented society highly values change, while past-oriented societies often resist certain types of changes.

[7]

What most people do not realize is that cultures are always changing, never static. Many changes within a society are not counted as such, for a change may only be a better tool, a better way to construct housing or a new kind of food to eat. Such internal changes are not threatening because they do not threaten social relationships or the structure of society.

For example, horticultural societies may begin using a new kind of tool or a new method of planting gardens; pastoral people, who are often nomadic, may use a new type of container while milking their herds. Industrialized societies may invent new objects such as computers or faster modems.

[8]

The main reason technological and economic changes may be accepted readily is because they are not directly linked with deep values that define the culture and give a sense of identity to the people living in that society. Non-material parts of culture, such as religion, usually change much slower. Religion gives people meaning in their lives, and it validates the culture and lifestyle of people in a society. Religion serves as an explanatory system for what occurs to members in a society such as illness, death, and unfortunate accidents. Religion gives validation for the present state of society by linking the present with the past experiences of the group. Religion reinforces peoples' goals in life. Religion also validates peoples' beliefs about health and illness. This includes validation for beliefs about the causation, diagnosis, and treatment of disease

[9]

The fact that religion is so integral to identity and lifestyles of a society means that its presence is absolutely essential in times of rapid social and cultural change. In fact, in times of disruptive change, religion, as an explanatory system, may be relied on to a greater extent. In situations of rapid change, people in most societies cling to the old value system because this gives an anchor of stability and connection with past experiences of the group. Rapid social and cultural change brings about much insecurity, trauma, and the sense of a lack of direction.

Psychological Impacts of Culture Contact

[10]

The impact of rapid social and cultural change can be seen most vividly in situations where people are forced to leave their native country, relocate and settle in a society very different from their own. The forced relocation of refugees

occurs around the world but the examples best known to people in the United States are refugees from countries in Central and South America, refugees from Africa, from the former Soviet Union, and refugees from Asia and Southeast Asia. People who have lived in one culture most of their life cannot fathom the changes that face refugees in this country. Everything -- the physical environment, the customs of social life, the realities of economic life -- are all so very foreign to refugees who settle here. The psychological implications of such drastic relocation, including posttraumatic stress syndrome, depression, loss of purpose in life, loss of individual and cultural identity, loss of friends and families, new styles of houses, the everyday battle to use a grocery store, and above all, the bureaucratic nightmare of all forms of government, leave refugees in a state of culture shock, and profound disorientation. Exacerbating these psychological discomforts are the traumas that refugees suffered before they arrived in the United States.

[11]

Such dislocation and trauma and the psychological effects of this trauma can be seen most clearly and dramatically in the Hmong refugees from Laos who settled in the United States during the last two decades. Many people have documented the horrors the Hmong suffered. The Hmong were an agrarian society, living with kinsmen in small villages. The recruitment by the CIA, as recorded in books by Jane Hamilton-Merritt (1993), Chan (1994) and many other authors, started change in the Hmong communities. The change was exacerbated in the refugee camps and continued with the Hmong arrival to the United States.

[12]

When such radical situations of cultural change occur, people use their native cultural frame of reference to try to make sense of and understand the new culture. This is impossible to do unless there is active participation on the part of the receiving culture. Such help was not present for the Hmong. Everything in American culture was foreign to the Hmong. This included the styles of houses and apartments, electrical appliances and all the other outward manifestations of

American culture. The new patterns of social behavior, communication, religion, economic life, political life -- all of these were completely new and there was usually no one to help the Hmong make sense of their new surroundings. The only guidelines they possessed were those of Hmong culture and these were not always appropriate in their new surroundings.

[13]

In such situations, the psychological principle called "selective permeability" is operative. This principle is discussed by anthropologist / psychologist George De Vos (1978). Selective permeability is the process whereby our cognitive and emotional screen only lets those new cultural elements and ideas into our consciousness that do not conflict with the values of our native culture. When the new cultural elements are contradictory with our native culture, the new material will not become part of our cognitive system. To do so, would create overwhelming feelings of cognitive and affective dissonance. The principle of selective permeability protects us, our cultural identity and our values by admitted only those things that are not contradictory to our sense of identity and self. Selective permeability operates on an unconscious level because to do otherwise would create too much conflict within us. We will use this concept when we discuss the contact the Hmong have with the American health care delivery system.

The Culture of American Health Care

[14]

The field of Western biomedicine has a distinct culture. Medical students, nurses and other health care professionals are socialized into this culture while they are in training for their professions. As Arthur Kleinman and others have noted, "the biomedical view of clinical reality . . . assumes that biologic concerns are more basic, real, clinically significant, and interesting that psychological and sociocultural issues. . . .This biomedical viewpoint is . . .based upon particular Western explanatory models and value orientations, which in turn, provide a very special paradigm for how patients are regarded and treated (Kleinman, 1978:255) He explores these ideas in his book, *Patients and*

Healers in the Context of Culture (1980).

[15]

This biomedical viewpoint, as Specter (1994) points out, believes "there are no alternative forms of healing; there are no other healers. The belief is that Western biomedicine is far superior to other medical systems in the world and, because of this fact, other beliefs about the causation, diagnosis and treatment of disease are disregarded and/or denigrated. This highly ethnocentric viewpoint is rigid and highly judgmental especially when treating patients from other cultures.

[16]

In the clinical setting, the applications of this theory include the ideas of promptness, patient compliance with the provider's treatment plan, subordination of health care workers to medical doctors, and the close following of patients to doctors' instructions. If these applications are not followed, the doctor may feel personally and medically threatened and lash out at patients and health care workers.

[17]

Kleinman (1980) differentiates between the concepts of "disease" and "illness." Western biomedicine is focused on disease as a "pathology, abnormality or deviation from clinical norms." According to Kleinman, "illness is the way in which an individual interprets his or her experience with the use of cultural categories and the influence of social relations." American health care providers, by focusing on disease rather than illness, concentrate only on the sick individual, and not on the individual as part of a much wider social setting. Western physicians don't understand the decision making process the Hmong use, they dismiss the Hmong beliefs about the causation, diagnosis and treatment of disease.

[18]

All cultures have beliefs about the causation, diagnosis and treatment of disease. Biomedicine is focused on the germ theory of disease. Diagnosis is done with the use of blood

tests and other diagnostic procedures. Most Non- Western cultures do not rely on the germ model of disease but instead believe that illness is caused by object intrusion, spirit possession, soul loss or breach of taboo. Diagnosis is made by a healer and the appropriate treatment is prescribed.

The Hmong in California

[19]

The Central Valley in California is a vast agricultural area and many people have settled here because agricultural jobs are available. There are a large number of Southeast Asian refugees in the Central Valley from the countries of Cambodia, Laos and Vietnam. The majority of refugees in Merced and Fresno counties of California are Hmong and Iu Mien.

[20]

For hundreds of years the Hmong and Iu Mien lived in the mountains of northern Laos and southwestern China and fought to maintain their independence. During the Vietnam War, the CIA recruited them to fight the "secret war" in Laos. Though no document exists to corroborate the story, it is said the United States promised the Hmong, Mien and several smaller societies that the United States government would take care of them after the way was over. This promise was not kept. Following the withdrawal of American troops from Vietnam in 1975, the Communist Vietnamese flooded into Laos. Many people in Laos, including the Hmong, fled communist oppression by going to Thailand. Large refugee camps were built to house the refugees (Chan, 1991). After living in these camps for varying periods of time, thousands of Hmong settled in the United States.

[21]

The initial settlements of Hmong in the United States were scattered throughout the country. Actually the United States government came up with this idea with no knowledge of Hmong social structure or culture. As can be expected, these plans were disastrous. The initial settlements of the Hmong were scattered throughout the Northeast, South, Midwest and Western United States. After the initial settlement, there

was a large secondary migration of Hmong to the Central Valley of California. The reasons for this migration included the reunification of kinship groups and economic opportunities. The central valley cities of Fresno and Merced were favorite destinations because these cities already had Hmong settlements. Fresno is the largest settlement site of Hmong in the United States (Finck, 1986:185). As of 1996, Fresno County is home to approximately 32,000 Hmong and Merced County has a population of 14,000.

[22]

Adaptation and adjustment to Western culture, especially Western medical culture, have been difficult for Hmong refugees. They have great difficulty accessing the health care delivery system because of linguistic and cultural barriers. Some of the linguistic barriers include: lack of proficiency in English, lack of trained medical interpreters, and lack of medical terminology in their native language. The cultural barriers include: lack of knowledge about the Western health care delivery system, suspicions about Western medicine, and lack of respect by health care providers for their culture including their beliefs about health and illness. Most refugees had minimal exposure to Western medicine in their homeland. They used the services of traditional healers who successfully practiced healing rituals for centuries. Many Hmong and Iu Mien seek the help of traditional healers before they turn to Western medicine. This is only natural because their traditional healing rituals have served them well for thousands of years. They trust and have confidence in these rituals while they are suspicious of the medical procedures, diagnostic tools and treatment plans of Western biomedicine.

[23]

Researchers and health care advocates have written numerous articles on the barriers that face immigrants and refugees when they attempt to access health care services in the United States (Buchwald, et. al 1992; Brotzman and Butler 1991; Galanti 1991; Gilman, et. al. 1992; Muecke 1983; Pachter 1994; Thao 1986; and Uba 1992). Dissertations on health care and the Hmong in California include those by Elizabeth Kirton (1985) titled *The Locked Medicine Cabinet:*

Hmong Health Care in America; Pao Lee's *Health Care Systems Utilized by the Hmong in California: A Case Study in Stanislaus County* (1991) and John Ensign's *Traditional Healing in the Hmong Refugee Community in the California Central Valley* (1994). Hard copies of these dissertations can be obtained from UMI in Ann Arbor, Michigan. A book by Anne Fadiman (1997) entitled *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* in bookstores. [Editor's Note: see the review of *The Spirit Catches You and You Fall Down* in this issue]. Also, it should be noted that there are numerous discussions in the literature on cross-cultural health care for immigrants and refugees through focusing initial cross-cultural awareness and training in medical schools. Two of these articles are: Berlin and Fowkes, "A Teaching Framework for Cross-Cultural Health Care" (1983) and Like's "Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care" (1996). The full citations for these articles are in the bibliography of this article.

The Hmong and the Health Care Delivery System in Merced

[24]

Southeast Asian refugees face language and cultural barriers when they attempt to access the health care delivery system in California. A large number of Southeast Asian refugees are limited English proficient. Physicians do not know Southeast Asian languages such as Hmong. Friends, family and *ad hoc* interpreters are often used by physicians. As Woloshin has pointed out (Woloshin et al, 1995) the use of such interpreters pose many problems. Woloshin states,

> They may lack sufficiently good language skills and frequently commit stereotypical errors, including omissions, addition, substitutions, or other editing, which may result in serious semantic distortions and negatively affect care. . . .Other reasons use of *ad hoc* interpreters may not be appropriate include the possibility that they may not be fully committed to providing quality interpretation because it may be viewed as an unwelcome, unpaid burden. Requesting the assistance of *ad hoc* interpreters, particularly family

> and friends, also may undermine patient confidentiality. Using children to interpret may potentially expose them to sensitive information and invert family dynamics. (Woloshin 1995:724).

[25]

Southeast Asian patients complain about the difficulty understanding what physicians are doing during physical examinations, diagnostic tests and treatment procedures. Provider and facility insensitivity to the linguistic needs of the Southeast Asian patients sends a loud negative message about accessing health care to the ethnic communities in Merced County.

[26]

Health care providers were, and still are, unaware of the traumatic experiences their Southeast Asian patients have experienced such as family separations, torture, life in refugee camps and death of family members. Health care providers are unaware of the feelings of isolation and fear that Southeast Asians experience when they are unable to communicate in their primary language. This inability to share their beliefs about the illnesses and treatment expectations contributes to frustration, poor adherence to treatment plans, failure to keep follow-up visits and delays in seeking health care services. This frustration increases substantially when physicians disparage their culture, including their beliefs about the causation of disease and treatment plans that are rooted in non-Western cultures.

[27]

Many Health care providers have no knowledge of Hmong beliefs about health and illness. The ideas of soul loss, spirit possession and object intrusion are completely foreign to Western health care providers. Treatments using herbs, soul-calling ceremonies and other Hmong health care practices are strange to health care providers. Instead of trying to learn the importance of these ideas to Hmong patients, most health care providers ignore them and even tell their patients that such ideas are foolish. They may seem foolish to culturally ignorant health care providers, but to the Hmong they are an

essential part of their beliefs governing illness and health. Health care providers think the patient himself should make his own health care decisions so the importance of the family and clan in the decision making process are ignored or dismissed.

[28]

In summary, when the Hmong refugees attempt to access the Western health care delivery system, they are faced with almost insurmountable barriers. Cultural barriers, including their beliefs about health and illness, are diametrically opposed to those of the Western health care professional. Most physicians believe the Western biomedical model of disease is the only rational approach to illness. They dismiss the alternative views of their patients

MATCH: A Multidisciplinary Approach to Cross-Cultural Health

[29]

To address these cultural and linguistic barriers, the Merced Department of Public Health developed several programs which have been successful. One of these is MATCH which stands for A Multidisciplinary Approach to Cross-Cultural Health. But first some background information on Merced County.

[30]

Merced County is located in the Central Valley of California. The population of the county is 34% Latino, 9.2% Asian and 4% African American. The City of Merced is 20% Southeast Asian. This is the largest per capita resettlement of Southeast Asian refugees in California. Of these refugees, approximately 9,500 are Hmong and 2,000 are Iu Mien. There are smaller numbers of Lahu, Vietnamese etc.

[31]

In the past two years there have been three community needs assessments completed. These assessments were *The Health Profile of Merced County* (1995), *Hurting in the Heartland: Access to Health Care in the San Joaquin Valley* (1996), and *The California Initiative* (1996). These assessments identified health needs of immigrants and refugees. The

Merced County Department of Public Health, with input from Southeast Asians, Latinos, and health care providers, developed and piloted several projects: 1) health education courses in Spanish, Hmong and Mien; 2) medical interpreter training; 3) a Southeast Asian surgical coordination team; 4) biweekly health presentations for Hmong television; 5) an R.N. Cultural Broker/Patient Advocate team; and, 6) cultural competency training for health care providers and administrators. These programs demonstrated that better communication and satisfaction are possible between ethnic patients and health care providers. Although the surgical coordinator team involved only a small number of patients, the positive health outcomes demonstrated cost savings with decreased length of hospitalization and fewer complications. All of the pilot programs listed above were successful. The Merced County Department of Public Health received the 1996 Award for Excellence in Multicultural Health from the National Association of County and City Health Officers in Seattle in June 1996. Two of the above programs: the Southeast Asian Surgical Coordination Team and the Culture Broker team, are discussed in more detail in the following sections.

Southeast Asian Surgical Coordination Team

[32]

The Southeast Asian Surgical Coordinator Team was developed by the Merced County Department of Public Health as a three month pilot project. The goal of the program was to determine whether an RN working in the capacity of a cultural broker with a medically trained interpreter could overcome language and cultural barriers in obtaining informed surgical consent.

[33]

During the time period of the project twenty-three Southeast Asian patients and their families were seen by the team. Twenty patients were Hmong, two were Mien and one was Lahu who spoke Mien. Sixteen requests came from the Merced Community Medical Center and six requests from Mercy Hospital. Both of these hospitals are in the city of Merced. Most of the requests were received during regular working hours Monday through Friday. Two requests were made between

1:00 and 4:00 a.m. Four interventions extended past 5:00 p.m, and three occurred on weekends. The most common procedure requiring assistance was appendectomies. During the entire project, an R.N. and a medical interpreter were on call twenty four hours a day, seven days a week.

[34]

Southeast Asian patients consistently verbalized their appreciation for the respect that was given to their group decision making process. They highly valued the anatomical pictures and the detailed descriptions of the medical procedures recommended. The appropriate and profound questions that were asked reflected their genuine desire to understand the procedures. They had high expectations and their questions needed to be adequately addressed before consent would be given.

[35]

The Southeast Asian patients and family members expressed more concern about the semantics of statements made by Western physicians. Most Americans today accept a physician's statement about uncertainty of causes of medical problems with trust in the physician's judgment. Because of the limited prior experiences with physicians, Southeast Asian patients and families tended to perceive this uncertainly as an opportunity for Western doctors to experiment with surgery. They wanted to hear that surgery was clearly needed to identity and resolve the medical problems. They appreciated the way the statements were restructured with percentages of probability on suspected causes of the problem when surgery was recommended. The concepts of percentages was understood. Some family decision makers appreciated the accessibility of pathology reports and the availability of consultation with a pathologist. This helped decrease the fear of experimentation associated with surgery. The Southeast Asian family members also appreciated the explanations that were provided about Western biomedical culture. In addition, the explanation about provider expectations helped families to better understand the behavior of providers. They were then more accepting of physicians' limited time and their brief explanations of procedures or surgeries.

The Culture Broker Team

[36]

A culture broker serves as a link / bridge between people of two cultures. A culture broker must have respect for other cultures, cross-cultural awareness and sensitivity, good cross-cultural communication skills and a broad knowledge and understanding of more than one culture. A culture broker is especially useful in the field of health care. The functions of a culture broker in the American health care delivery system include: serving as a cultural interpreter and advocate for refugee patients, helping health care providers develop their knowledge and respect for people from other cultures and helping to negotiate a treatment plan that is acceptable to both provider and patient.

[37]

The Merced Family Practice Residency clinic serves patients from a variety of ethnic groups, including the Hmong who live in and around Merced. There have been numerous conflicts between health care providers and Hmong patients. We would like to mention several cases where a culture broker was not used and then contrast these cases with several in which a culture broker team was used.

Case One:

[38]

After consulting with a Hmong traditional healer, Hmong parents reluctantly brought their listless eighteen-month-old child to a Western physician. He was eventually able to convince the parents and elders to consent to a lumbar puncture. From the parents' perspective, this procedure did not help their child's condition. They refused to hospitalize their child for treatment of meningitis. When the physician called upon the Child Protective Services to pressure the parents to hospitalize the child, they eloped to another state with their child.

Case Two:

[39]

An eight-year-old Hmong boy was hospitalized with a ruptured appendix. After surgery, the child complained of postoperative pain. The child's father requested an X-ray. An untrained interpreter communicated this request to the physician. The physician declined to order an X-ray by conveying his rationale in a way the family perceived as disrespectful to the patient's father. The untrained interpreter became so emotionally involved that he and the physician exchanged angry words "eye to eye." The Hmong informal network quickly communicated this throughout the community in Merced County. Blame was placed on the hospital and Hmong individuals passed along the message that this hospital was a bad place to go when a Hmong gets sick.

[40]

After Cases One and Two, the Merced Department of Public Health, in response to requests from the Southeast Asian community and health care providers, established a "culture broker" team. The team consisted of a registered nurse who acted as the culture broker along with a team of trained medical interpreters who were bilingual and bicultural.

[41]

The culture broker selected was highly qualified for this role. She was objective, maintained self control and mobilized the strengths of both sides to reduce conflicts between the physician and patient in the medical setting. The culture broker knew the basics of Hmong culture. She was respectful of both cultures -- the biomedical culture of the Western trained physicians and the Hmong culture of the patients. The culture broker operated at the margin of both Western medical culture and Hmong culture. She dealt with both physician and patient positively and facilitated communication by translating messages between the two sides.

[42]

The medical interpreters on the team were bilingual and bicultural. They had completed a course in medical interpreting. They knew medical terminology and how to communicate effectively with both physician and patient. Following is an example of how the culture broker team was

able to resolve conflicts and negotiate treatment plans successfully in ways that were satisfactory to both the Western physician and the Hmong patient.

[43]

Mr. M. is the respected leader of a large Hmong clan and a successful community businessman. He has lived in the United States for about twenty years and is fluent in English. He had been healthy for all of his fifty-five years. A family practice physician hospitalized Mr. M. with abdominal pain. The consent for surgery was difficult to obtain because diagnostic tests were not conclusive. The delay in surgical treatment of the acute vascular insufficiency of the intestine contributed to septicemia and multiple postoperative complications.

[44]

About seventy visitors came to the hospital to show their respect to Mr. M. Some visitors were from out of state and others came from Europe and Asia. This is customary in Hmong culture when a prominent leader is ill because the patient's clan is obligated to provide vigilant support until the illness is resolved. The hospital staff was legitimately concerned about the congestion in the halls and the patient's room. They called hospital security to monitor the visitors. Language and cultural barriers caused immediate misunderstandings. Mr. M.'s family requested the culture broker team.

[45]

The culture broker, with the help of a trained medical interpreter, assessed the needs of the Hmong family and the hospital staff. The broker negotiated designation of a room near Mr. M's for the patient's family and clan members. This room was available to the family twenty-four hours a day. The family was pleased with the solution to the problem. Although this solution alleviated hallway congestion, the hospital staff was still distressed about many cultural practices of the Hmong. The staff did not know Hmong culture. The culture broker facilitated many discussions to help the staff understand Hmong beliefs regarding hospital care and the

importance of the presence of family and clan members. The hospital staff was encouraged to ask questions and the culture broker team answered these questions.

[46]

When the hospital implemented the negotiated plan, Mr. M. was in such critical condition the physicians did not expect him to live through the night. Twenty-eight secondary diagnoses were made that included respiratory failure, acute renal failure, septicemia, acidosis and frequent seizures. He required ventilation with a respirator, hemodialysis and two additional surgeries.

[47]

The culture broker team was on twenty-four-hour call to facilitate continued negotiations between Mr. M.'s family, clan members, physicians, administrators and hospital staff. The Hmong interpreters helped the culture broker explain procedures and diagnoses to the family and clan. They simplified medical terms and used anatomical pictures to explain things to the family and clan. The family practice residents and attending physicians met with the family and the culture broker team on a regular basis to discuss the patient's progress. The family felt free to ask questions of the physicians. This would not have been possible without the presence of the culture broker and the trained medical interpreter.

[48]

Mr. M.'s family and clan wanted to conduct traditional healing ceremonies for his recovery. This negotiation was very difficult and challenging for the culture broker team. Doctors and nurses were concerned about the unknown nature of the ceremonies. The Hmong traditional healers, using the services of the medical interpreter, described the details of the ceremonies. They agreed to modifications for patient safety such as the use of sterile water and gloves. After intense discussions with all sides -- administrators, physicians, traditional healers, the family and the clan -- the physicians allowed the traditional ceremonies to be held under nursing supervision. Throughout the hospitalization,

medical staff did not expect Mr. M. to recover, or if he did, to have a good quality of life. He did, however, experience full recovery and returned to work within several months of his discharge from the hospital. An ICU nurse with sixteen years experience described Mr. M.'s recovery as the most remarkable she had ever seen.

[49]

The culture broker team was credited for the success of the negotiation process. Many times, during Mr. M.'s hospitalization, negotiations broke down and the culture broker had to reassess the situation and offer alternatives based on these reassessments. Many times the negotiation process had to begin all over again. Interestingly enough, Mr.M.'s family, clan, and the Hmong traditional healers were more willing to compromise than the Western physicians, administrators and nursing staff.

[50]

The culture broker team, as noted above, was on call twenty four hours a day. They answered all questions raised by the family and clan and they patiently explained complex medical procedures to the family. They continually explained Hmong cultural practices and beliefs about illness and health to the physicians, nursing staff and administrators. Negotiations broke down, but the culture broker team never gave up. They persisted until negotiations were back on track. It should be reemphasized that the success of the culture broker team was the professional yet empathic approach used by both the culture broker and the medical interpreter. On the role of the culture broker, Royce (1982: 135) notes: "Culture brokers . . . almost always have some personal qualities that allow them to live between two cultural worlds and use these qualities to help others bridge the [cultural] gap. Culture brokers take a personal interest in the individual(s) who are trying to understand the cultural world different from their own." The medical interpreters who were an integral part of the team had all taken a course in medical interpreting. These Hmong professionals had worked as interpreters before this and they had worked with the culture broker for several years prior to Mr. M.'s hospitalization.

The MATCH Proposal

[51]

The Merced County Department of Public Health developed The Multidisciplnary Approach to Cross-Cultural Health (MATCH) program which, which will begin as soon as funding is obtained. The aim of this proposal is to increase culturally sensitive health care access for underserved ethnic populations of Merced County. It is the goal of the MATCH Proposal to improve health outcomes by decreasing the linguistic and cultural barriers to quality health care service. The programs of the MATCH Proposal are for health care professionals and the ethnic populations of Merced County. As stated in the original MATCH Proposal: "It (MATCH) will increase provider sensitivity to different cultures and their beliefs about health and illness. This program will give accurate information about the health care delivery system, medical programs, diagnostic procedures, medical treatment and illness prevention to members of the ethnic populations of Merced County."

[52]

The five components of the MATCH Proposal are as follows:

- Cultural competence training for resident physicians, nurses, ancillary health professionals, health care providers and administrators,
- A certification program in health care for traditional healers,
- Health education for ethnic communities in Merced County,
- A medical resource center for the ethnic groups in the county, and
- Cultural education for the population of Merced County at large.

Cultural Competence Training for Health Care Professionals

[53]

Most physicians in Merced County have been trained in Western medical schools and have been socialized according to the Western biomedical model of disease. The proposed program in

cultural competence training will include cultural self-awareness training to help them recognize how their own cultural background influences their professional and everyday lives. The curriculum is designed to increase the practical knowledge and skills in the areas of cross-cultural health care, interpreted medical encounters, and commonly encountered cultures that the medical residents can immediately begin to utilize. This program will enhance their ability to elicit and work with the health beliefs of patients from different cultures. It will give providers some techniques for continually improving his or her ability to work with ethnically diverse patients. The physicians, for the most part, are not receptive to other modes of thought such as those held by Southeast Asian refugees and Latino immigrants. The cultural competence training for resident physicians, practicing physicians, nursing programs, ancillary health training programs and training for administrative personnel includes the following components:

- Knowledge and awareness of the physician's own culture and Western biomedical culture,
- Basic knowledge about other cultures,
- Knowledge about verbal and nonverbal communication,
- Knowledge about the role of the traditional healer in ethnic communities,
- Use of trained medical interpreters in their practice,
- Development of skills by health care professionals to deliver culturally sensitive health care to the immigrants and refugees of Merced County.

Health Certification Program for Traditional Healers

[54]

Health education will be provided to Southeast Asian traditional healers because individuals in the Southeast Asian community seek health treatments from their own community healers whom they trust. These healers play an important role in many Southeast Asian families. The groundwork has already been laid for this training. Good rapport exists between public health staff and the traditional healers. A few exploratory sessions with healers were well-attended and healers are eagerly looking forward to

this training. The certification program will involve completion of basic health education classes and training about the delivery of Western health care. Tours of hospital and clinic facilities, as well as direct experiences with health care providers, are planned. It is hoped these visits will encourage communication and improved understanding between physicians and healers. Accurate health information will allow traditional healers to assist members of their ethnic communities to seek and access medical care. This certification will enable healers to have hospital visitation privileges similar to those afforded to Western clergy. The piloted advocacy project fostered an interest between some health care providers and Southeast Asian traditional healers. Emergency room physicians are interested in working with traditional healers and several healers have verbalized an interest in sharing their beliefs with health care providers. There will be an opportunity to ask questions about medical procedures that run counter to their traditional beliefs about illness and health. There are approximately fifty traditional healers ready to enroll in such a course as soon as it is offered. That will begin when funding is obtained for the course.

Training for Medical Interpreters

[55]

A survey conducted by the California Department of Health Services discovered that Merced County is the only county with large numbers of refugees to offer special training for medical interpreters. The Merced County Department of Public Health has already piloted a medical interpreter training course which was highly successful. The medical interpreter training under the MATCH Proposal is taught by a multidisciplinary team. The staff will adapt and enhance the medical interpreter program, "Bridging the Gap" which was developed initially by the Cross Cultural Health Program of the Pacific Medical Center in Seattle. Adaptation is needed because the group in Seattle did not create their program for the Laotian languages -- Hmong, Mien and Lao. These languages are tonal, have simple sentence structure and have small vocabularies. Common English words and many medical terms do not exist in these languages.

[56]

The medical interpreter training will teach essential skills necessary for accurate interpretation. New skills will be taught to improve the development of therapeutic relationships between health care providers and patients. This training of medical interpreters will be a cost effective component in the health care delivery system of Merced County.

[57]

Approximately every two months, there is a class for medical interpreters. The length of the class is five full days. The lead instructor is Marilyn Mochel along with a multidisciplinary team for the course. During the course, videos are presented, medical and anatomical terminology is learned, and there is role playing which helps the participants learn the appropriate role of the medical interpreter. The code of ethics for medical interpreters is explained and discussed. Hmong and Mien medical interpreters who have already taken the course speak to the class. All questions asked are answered and the previously trained interpreters serve as a valuable resource for participants. So far approximately eighty medical interpreters have been trained. Of this number, approximately thirty are Hmong.

Health Education Programs for Ethnic Communities

[58]

The Match Proposal incorporates health education for the ethnic communities in Merced County. This is essential. The objectives of this program are: 1) to create a safe environment where anyone can ask questions about the health care system; 2) to teach community members about the human body, the focus of Western medicine, and the rationale behind Western beliefs about the causation, diagnosis, and treatment of disease; 3) to discuss medical practices perceived as threatening to traditional cultures such as the drawing of blood for diagnostic tests; and, 4) to serve as cultural brokers between the ethnic populations and the health care delivery system.

Medical Resource Center

[59]

Many times ethnic patients leave the physician's office with instructions, sometimes written, concerning medical treatment. They may, for example, be given a prescription for medication. Most times they leave the physician's office confused, not sure of what the doctor or staff said, not sure how to take their medication and not able to read the prescription, even if they know English well. Many times the medication will be taken home, one dose taken, and the rest put in the back of a kitchen cupboard. The MATCH proposal wants to establish a medical resource center to serve the ethnic communities. This center will be staffed with bilingual, bicultural employees. Questions may be answered and answers received. If the employees have any questions about the encounter with the physician, the culture broker can be contacted and questions cleared up. The resource center will be open six days a week.

Cultural Education for the County Population

[60]

The population of Merced County needs accurate information on the immigrant and refugee communities in the county. Negative information about the ethnic communities is prevalent. The media, at the national, state and local levels, promote this negative information. "Immigrant bashing" is rampant without people learning the true history of Southeast Asian refugees. It is more convenient for people to disparage the Southeast Asian refugees than to learn to know them better. For example, the average media consumer does not know the extent Southeast Asians helped the United States military in Vietnam and Laos, the promises the military gave them, the horrors of the refugee camps and the treacherous journey to California. Most do not know that many disabilities among the Hmong while fighting for the United States military. Many people in Merced Count suffer from "compassion fatigue." They become detached because problems seem insurmountable.

[61]

In light of the negative media so far, the MATCH Proposal seeks to promote the positive aspects of cultural diversity

by giving accurate cultural information through the media and community presentations. Reaching health care staff at all levels of health care delivery is a difficult task. The media will offer one more opportunity to inform staff as part of the general community about other cultures with factual information.

Submission of the MATCH Proposal to Foundations

[62]

The MATCH Proposal was submitted to five national foundations which stated interest in developing programs to increase health care access in the United States. Funding was not available and only a few of the foundations seemed interested in the proposal. This was discouraging, to say the least, to all the personnel involved in researching and presenting the proposals. The strong commitment to culturally sensitive health care continued and has grown stronger. Parts of the MATCH Proposal have been implemented even though funding for the larger projects is not available at this time.

The MATCH Coalition

[63]

At the same time Merced County had the opportunity to develop a coalition for improvement of health care that was funded by the California Wellness Foundation. The foundation funded two collaboratives in the Central Valley of California, of which the MATCH Coalition was one. During this process, it was clearly evident that foundations are more eager to fund broad-based coalitions that establish collaborative partnerships between organizations to address health care needs than to continue funding for smaller projects.

[64]

It was agreed the coalition approach is able to develop broader commitment among a wider range of Merced County agencies, all of which are working to improve the health status of all county residents The MATCH Coalition has eighty individuals as members, including government and private organizations. The Coalition meets twice a month. One of these meetings is a group meeting of all members. The second

meeting is for coalition work groups to meet. Each work group has a special problem for focus. Members volunteered for these work groups.

[65]

The mission statement of the MATCH Coalition is to increase access to culturally sensitive health care for underserved and uninsured ethnic populations of Merced County and to improve population health. The goals of the MATCH Coalition are as follows: building an infrastructure to address health needs of all Merced County residents, bringing together health needs assessment already completed by all agencies in the county, strategic planning and formulation of both long term and short term goals and finally, training for team development.

[66]

The programs of the original MATCH proposal have not been forgotten. There is still a search for funding. In the meantime, specific portions of the proposal are going forward. A class for medical interpreters is given every two months. There are weekly presentations to the medical residents at the Sutter Merced Medical Center on different cultures represented in Merced County. In addition, the residents have required reading in cross-cultural health care and discussions on the linguistic and cultural barriers to health care for immigrants and refugees in Merced County. The culture broker team is continuing to work and be successful. Several videos have been produced for the Hmong and Iu Mien on parenting and child safety issues. The health presentations on Hmong television are ongoing. Funding for the original MATCH Proposal is still being pursued diligently. The success of the MATCH Coalition will be a positive step in obtaining funding for the development of more programs to increase culturally sensitive health care for the Hmong who live in Merced County.

Bibliography

Berlin, E.A. and Fowkes, W.C. 1983. A teaching Framework for cross-Cultural health care. *Western Journal of Medicine* 139:

934-938.

Buchwald, Dedra; Panwala, Sanjiv; Hooten, Thomas M. 1992. "Use of traditional health practices by Southeast Asian refugees in a primary health clinic." *The Western Journal of Medicine* 156(5):507.

Brotzman, Gregory L.; Butler, Dennis J. 1991. "Cross-Cultural issues in the disclosure of a terminal diagnosis: a case report." *Journal of Family Practice* 12(4):426.

Chan, Sucheng 1994. *Hmong Means Free: Life in Laos and America.* Philadelphia: Temple University Press.

Center for Cross-Cultural Health 1997 *Caring Across Cultures: The Provider's Guide to Cross-Cultural Health Care.* Minneapolis, MI: The Center for Cross-Cultural Health.

De Vos, George A. 1978. "Selective permeability and reference group sanctioning: psychocultural continuities in role degradation." IN J.M. Yinger and S.J. Cutler, (eds.) *Major Social Issues: A Multi-disciplinary Approach*. New York: Free Press.

Diringer, Joel; Ziolkowski, Cynthia; Paramo, Noe 1996. *Hurting in the Heartland: Access to Health Care in the San Joaquin Valley: A Report and Recommendations*. Sacramento, CA: California Rural Assistance Foundation.

Donnelly, Nancy D. 1994. *Changing Lives of Refugee Hmong Women*. Seattle, WA: University of Washington Press.

Dunnigan, Timothy 1986 "Processes of Identity Maintenance in Hmong Society," IN *The Hmong in Transition*, pp. 41. New York: Center for Migration Studies. pp. 41-54.

Engebretsom, Joan 1994. "Folk Medicine and Biomedicine: Culture Clash or Complimentary Approach?" *Journal of Holistic Nursing* 12(3)240-250.

Ensign, John Stewart 1994. *Traditional Healing in the Hmong Refugee Community of the California Central Valley*. Ph.D. Dissertation, California School of Professional Psychology, Fresno, CA. Ann Arbor, MI: University Microfilms.

Fadiman, Anne 1997. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus and Giroux.

Finck, John 1986. "Secondary Migration to California's Central Valley," IN *The Hmong in Transition*. New York: Center for Migration Studies. pp. 184-186.

Galanti, Geri-Ann 1991. *Caring for Patients from Different Cultures: Case Studies from American Hospitals*. Philadelphia: University of Pennsylvania Press.

Gilman, Stuart C.; Justice, Judith; Saepham, Kaota; Charles, Gerald 1992. "Use of traditional and modern health services by Laotian refugees." *The Western Journal of Medicine* 157 (3):310.

Gross, Catherine Stoumpos 1986. "The Hmong in Isla Vista: Obstacles and Enhancements to Adjustment," IN *The Hmong in Transition* New York: Center for Migration Studies.

Hamilton-Merritt, Jane 1993. *Tragic Mountains: The Hmong, the Americans, and the Secret Wars for Laos, 1942- 1992*. Bloomington, IN: Indiana University Press.

Kirton, Elizabeth Stewart 1985. *The Locked Medicine Cabinet: Hmong Health Care in America*. Ph.D. Dissertation, University of California, Santa Barbara. Ann Arbor, MI: University Microfilms.

Kleinman, Arthur; Eisenberg, Leon; Good, Bryon 1978. "Culture, illness and care: clinical lessons from anthropologic and cross-cultural research." *Annals of Internal Medicine* 88(2):251-258.

Kleinman, Arthur 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderline between Anthropology, Medicine, and Psychiatry*. Berkeley, CA: University of California Press.

Kraut, Alan M. 1990. "Healers and strangers: immigrant attitudes toward the physician in America: a relationship in historical perspective." *JAMA The Journal of the American Medical Association* 263(13):1807.

Lee, Pao 1991. *Health Care Systems Utilized by the Hmong of California: A Cast Study in Stanislaus County*. M.A. Thesis, California State University, Stanislaus. Ann Arbor, MI: University Microfilms.

Like, R.C.; Steiner, R. Prasaad; Rubel, Arthur J. 1996. "Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care." *Family Medicine* 28: 291-297.

Minnesota Immigrant Task Force 1996. *Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees*. Minneapolis: Refugee Health Program, Minnesota Department of Health.

Muecke, M.A. 1983. "In search of healers: Southeast Asian refugees in the American health care system." *The Western Journal of Medicine* 129: 835-840.

Pachter, L.M. 1994. "Culture and Clinical Care: Folk Illness Beliefs and behaviors and their implications for health care delivery." *JAMA The Journal of the American Medical Association* 271: 690-694.

Royce, Anya 1982. *Ethnic Identity: Strategies of Diversity*. Bloomington, IN: Indiana University Press.

Specter, Rachel E. 1996. *Cultural Diversity in Health and Illness*. Stamford, CT: Appleton & Lange.

Thao, Xoua 1986. "Hmong Perception of Illness and Traditional Ways of Healing," IN *The Hmong in Transition* p. 365. New York: Center for Migration Studies.

Uba, Laura 1992. "Cultural Barriers to Health Care for Southeast Asian refugees." *Public Health Reports* 107(5):544.

Return to top of page

Profiles of Authors

Miriam E. Warner, Ph.D., (mwarner@ccnet.com) is a cultural

anthropologist with a strong interest in psychological anthropology. Her doctorate in anthropology is from the University of California, Berkeley. Miriam spent her childhood and adolescence in East Africa as the daughter of a medical doctor. She has twenty-three years experience teaching anthropology at the college and graduate school levels. Miriam has worked with Marilyn Mochel since 1996 and she is a member of the MATCH Coalition in Merced County. Miriam is the founder of Cross-Cultural Consulting, a consulting business in the field of cross-cultural health. She develops and presents training sessions in cultural competence to health care professionals, gives presentations to community and professional organizations, and continues to do extensive research in the field of cross-cultural health care.

Marilyn Mochel, R.N., CDE, (jimmy@elite.net) is a registered nurse in Merced County. who has worked in Merced County since 1980. For three years she served as the Refugee Coordinator for the Merced County Department of Public Health. Currently she is the clinical nurse educator at the Sutter Merced Medical Center. Marilyn has been responsible for starting most of the cross-cultural programs in health care for Merced County. These include: the Southeast Asian Surgical Coordination Team, the Culture Broker program, and the course in medical interpreting and the MATCH Coalition. She also gives presentations in cross- cultural health to the medical residents at Sutter Merced Medical Center, to community and health care groups. She is a frequent presenter at conferences on cross-cultural health care. Marilyn is a member of the MATCH Coalition and the Refugee Forum in Merced.

Hmong Studies Journal v2n2 Spring 1998

5/1/98