

Healing the Hmong

A study of cross cultural issues in healthcare delivery

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Rebekah Barlow
University of California at San Diego
Urban Studies and Planning Program
USP 186 Section # 451143

Email: rbstardust@cox.net

Abstract

Obtaining quality healthcare is challenging for immigrant populations. Profound communication barriers exist, a product of the cultural gap between native and adopted homelands. A prime example visible in California is the Hmong community. Current research on the Hmong suggests that language and cultural barriers have impacted the quality of healthcare received. This leads to a lack of trust in Western medicine and lost opportunities for disease prevention and treatment. In extreme cases it has even lead to death. In pursuit of solutions it is important to examine first what the Western medical model entails, i.e. what its basic assumptions are. In like fashion, the worldview of the Hmong must also be examined. This raises multiple questions. First, what is the nature of the miscommunications both from the point of view of the practitioner and of the patient? Conversely, since some immigrants report positive experiences with their healthcare providers, what is the nature of positive interactions in which the cultural gap is bridged? Finally, given the divergence of the two ideologies, how can healthcare workers adapt their behavior to facilitate communication and make the medical encounter less threatening? To approach these questions in-depth interviews will be conducted with healthcare providers, members of the Hmong community, and scholars from various fields. The Hmong community interviews will draw principally from the Americanized children of the immigrants who straddle both cultures and therefore are often drafted as interpreters for medical encounters. Prior research, Hmong and American films relevant to the practice of medicine including documentaries and practitioner training videos, census data, and government studies and publications will be tapped. The literature is sparse on the Hmong experience with the American medical community. Analysis of the gaps between these two cultures worldviews is yet more limited. The objective of this research then, is to contribute to the literature on medical anthropology, public health, and ethnic studies by addressing the issues of this overlooked group. The results will be shared with healthcare providers in the hope that findings will facilitate better communication between practitioners and patients, resulting in improved health outcomes.

Introduction: The Invisible Immigrants

The history of the Hmong in the U.S. begins in the mid-1970s. Although some immigrant Hmong are from China, most are from Laos. During the Vietnam War the Hmong in Laos fought for the United States against the communists. After the war they were targeted for genocide by the victors. They fled Laos to refugee camps in Thailand, and from there many immigrated to the U.S. (Dibble et al, 1996: 155).

The Hmong are unique among immigrants in the U.S. in that they did not come in pursuit of greater opportunity, nor did they come only to save their lives. They came in an attempt to resist assimilation and to preserve their ethnic identity (Fadiman, 1997: 183). The combination of this desire to maintain their traditions and familiar ways of life, and the drastically different and technological advanced country in which they now reside has led to a culture clash. Hmong newcomers are known to have “poured water on electric stoves to extinguish them . . . washed rice in their toilets . . . ate cat food . . . and hunted pigeons with crossbows in the streets of Philadelphia (Fadiman, 1997: 187-188).” Adjusting to their new homeland has not been easy for the Hmong. This is apparent in their interactions with the American medical system as well.

Asian populations have tended to be ignored in health literature. The Hmong are perhaps the most understudied of this already infrequently examined group. What literature that exists points to profound cultural differences between Hmong patients and their Western physicians that have not been bridged, and which lead to compromised healthcare delivery and suboptimal treatment. This study will examine the gap for this understudied and small (yet still numerically significant in California) group of immigrants. The differing worldviews of American healthcare practitioners and Hmong refugees and the interactions between these two groups in the medical

context will be explored in a sequence of interviews, with the goal of finding ways to bridge the cultural gap and facilitate better communication.

Literature Review

In anthropology, it is well known that one's worldview and perception of the causation of illness and disease is determined by culture. Every culture has a medical model, an assemblage of understandings and beliefs regarding sickness and health. Differences in belief between various cultures has led to a rising awareness that healthcare delivery needs to be culturally competent, meaning that practitioners need to be able to "provide services that are perceived by clients as relevant to their problems and are helpful for intervention outcomes (Dana, 1993: 220)."

To date, research regarding cross cultural competency in the delivery of healthcare services has centered mainly on Latinos and African Americans and has given little notice to Asian populations. Studying this population deserves increased priority: there has been and continues to be enormous growth in the U.S. Asian-Pacific population in the last several decades. The majority of these immigrants are coming from Taiwan, China, Korea, the Philippines, and various Southeast Asian countries such as Cambodia and Laos (Okazaki: 1998, 57). Although there is empirical evidence that a lack of assertiveness in presenting concerns during the medical interview is common among all immigrant Asian groups because of their collectivist culture (patient participation theory), the cultural variations between these nationalities is large, and it is important for health care providers to be aware of these differences in order to communicate more effectively with them (Klingler & Young: 1996, 45-46).

While Asians in general seem to be underrepresented in the literature, research on specific Asian groups such as the Hmong is particularly sparse. The little Hmong-American literature base focuses largely on education in the U.S. (Walker-Moffet, 1995) and (Timm, 1994), involvement in the Vietnam War (Pfaff, 1995), or the coping process associated with immigration (Chan, 1994). The literature that does exist regarding health and the Hmong is predominately from an anthropological case study basis rather than a public health or medical perspective. Research on the Hmong has addressed the high incidence of sleep paralysis in the community and its folk explanations (Adler, 1995), as well as Hmong beliefs regarding illness causation and specific conditions such as epilepsy (Fadiman, 1997), and measles (Henry, 1999). From this literature one can begin to piece together the worldview of the Hmong and get a general idea of the way that Hmong culture differs from mainstream American culture and therefore what potential misunderstandings could occur in health care situations.

Anne Fadiman's "The Spirit Catches You and You Fall Down," is a particularly valuable albeit narrow exploration of the Hmong belief system and the need for cross cultural competency in healthcare. Focusing on a particular Hmong family living in Merced, California, Fadiman documents the misunderstandings between them and the medical community which culminate in the Lee's epileptic daughter Lia becoming brain dead. In compiling the book she interviewed scholars, as well as members of the medical and Hmong community. She describes Hmong customs, such as the belief that one must bury the placenta of a newborn baby: when it dies it will need it in order to reenter the spirit realm. This belief is significant in the realm of healthcare. The Hmong will request the placenta after giving birth. The need for cultural competency becomes readily apparent: most doctors refuse to give the placenta, mistakenly believing that the Hmong intend to eat it. Fadiman briefly acknowledges, but otherwise ignores

the Western medical model. Tacitly assuming that its implications for cross-cultural care are well known and obvious, she focuses primarily on the Hmong worldview.

In a larger, but still relatively narrow investigation of the Hmong experience with the U.S. healthcare system, Rebecca Henry investigates a 1990 measles epidemic in St. Paul, Minnesota. Hmong comprised 4.2% of the population, disproportionately accounted for 46% of the cases. Henry examined Hmong folk beliefs regarding the causation of illness and how this affects treatment and prevention. In this study she found that Hmong beliefs regarding immunizations had prevented them from immunizing their children, who subsequently were infected during the outbreak. Henry does not address the issue of conflicting medical models at all, entirely satisfied with the validity of western thought. She holds that educational outreach is perhaps the most efficacious approach to addressing the cultural gap.

Explorations of the assumptions and structure of the Western medical model itself abound. In one genre, fringe practitioners necessarily exposit the western model as background for their alternative offerings. A prime example is Andrew Weil's "Eight Weeks to Optimal Health." A second genre takes a more overtly scholarly and philosophical approach. Kassirer's "Learning Clinical Reasoning" describes the acculturation process that medical students undergo in pursuit of their credentials. This includes a Cartesian view of human life in which the body is seen as being separate from the mind and soul. Multiple sociologists (Treacher, 1982) and (Andrews, 1997) have examined medicine and the U.S. health care system as being both social and cultural constructions. However, none of these examine the western medical model in the context of cross-cultural health care delivery.

The Hmong are only small population in the U.S., but there are many such ethnicities in the country that cumulatively constitute a sizable population. Examining how to provide culturally

sensitive care is important. Its lack leads to reduced efficacy of prevention and treatment, and potentially to public health epidemics like that described by Henry. The Hmong are of local interest because of their concentration in California. According to the U.S. Census data for 2000, there are nearly 200,000 Hmong living in the U.S., 75,000 of which reside in California. In San Diego there are 1,441, in the LA-Riverside-Orange County region there are 2,500, and in Fresno 22,456.

The preferred methodology of the reference articles and books seems to be surveys, interviews, and collecting narratives. There also seems to be a trend toward analyzing Hmong beliefs which lead to negative health outcomes without reciprocally analyzing the assumptions and biases of the Western medical model. This complicates culturally sensitive communication in the health care setting. Fadiman touches on the issue by mentioning the Cartesian structure of Western medicine, but does not actually take a hard look at its cultural biases and assumptions. Others, such as Arthur Kleinman in "Patients and Healers in the Context of Culture," do critically examine both the western and certain eastern worldviews regarding healthcare (although not specifically the Hmong's). But his objective is not cross-cultural health care delivery but rather the extraction of a more universal perspective from these competing ideologies. The scholastic literature then is in general agreement on the importance of overcoming cultural barriers. But the issue of cross cultural health care delivery has yet to be solved generally, and at a minimum the issues of the Hmong community specifically have yet to be adequately addressed.

Research Design and Methods: Getting to Know the Hmong

The expected timetable for this research will be from November 2002 to early March 2003. During this time I will be attending biweekly meetings of the Hmong Student Association of San

Diego, helping organize social and cultural events for the club, and participating in fundraisers. Through this endeavor I will be establishing valuable relationships with Hmong students who will then be interviewed in-depth beginning in January 2003. The students will be asked questions regarding their families experiences with the U.S. medical system, whether these experiences have been positive or negative, how their families cultural beliefs or traditions have impacted the medical encounter, and what they feel health care providers could do to improve the quality of care. (For a list of proposed questions please see Appendix A). Since the Hmong constitute only a small portion of the population, this study will employ a purposive sampling technique focusing on Hmong college students. This population will be utilized both because it is the most accessible (since these students all speak English and live in San Diego during the school year) and also because of their unique position of straddling both mainstream American culture and Hmong culture. They are likely to be able to provide a fresh perspective regarding problems facing the Hmong community that has not been explored in other studies.

Health care practitioners from Mid-City and Linda Vista area will also be interviewed. The majority of Hmong in San Diego reside in these areas. They will be interviewed in-depth and will be asked questions regarding their experiences with Hmong patients, and for suggestions for other practitioners attempting to provide culturally competent care. (For a list of proposed questions please see Appendix B).

Scholars from various disciplines will also be interviewed and the questions for each will vary in regards to their area of expertise. From UCSD, professors of Anthropology, Ethnic Studies, Medicine, and Sociology will be contacted. The questions here will center on the exploration and importance of worldviews, the experience of Southeast Asians in the U.S., the need for cultural competency in the healthcare setting, and issues of communication between ethnic groups.

In addition to interviews, documentaries, health practitioner training videos, census data, and government publications will also be utilized.

Time, resources and geography of necessity place constraints on the scope of the work. The limited sample size may not be entirely representative of Hmong living in California or the healthcare providers who work with them. The majority of Hmong in California live in Sacramento, Merced, or Fresno, whereas the majority of the Hmong interviewed for this study will be students from the Hmong Student Association in San Diego. As previously noted, healthcare practitioners interviewed for this study will be drawn from two targeted areas in San Diego – Linda Vista and Mid-City. Since neither group consists of a random sampling there is the likelihood of imperfect representation of both the Hmong community and of the healthcare workers. However, although the Hmong interviewed are mostly college students in San Diego, many are originally from other areas of California such as Irvine, Riverside, Merced, and Fresno. This should help to make the results more generalizable. At any rate, the study will provide a snapshot of the importance of cultural competence in healthcare delivery, and an in-depth look at both western ideology and the worldview of the Hmong.

Expenses of the Study

This study will require the purchase of a tape recorder, tapes, and batteries. I will also be providing incentives for the students who are interviewed. Each student who participates will receive a ten dollar gift certificate to Edwards Cinemas. I estimate the total costs to be anywhere from a minimum of one-hundred and fifty dollars to two-hundred dollars depending on the number of students interviewed.

Conclusion: Healing the Hmong

The raw data from this study will be a collection of the experiences, both positive and negative, of interactions of Hmong immigrants and refugees with the U.S. medical system. A priori, it may be supposed that the negative interactions will range from simple language barrier issues to quite complex communication difficulties stemming from worldview and disease model differences in the two cultures. Important to this study is the often neglected look at the positive: what is already working, and why. In the real world, it is often more practical and effective to expand upon that which is working than trying to reverse that which is broken. This study will cover both bases.

The data will then be sorted, categorized in pursuit of common themes, and then compared and contrasted to existing literature on the Hmong as well as that of other ethnic minorities' interactions with western medicine. The analysis will also attempt to put the findings in context by probing the tacit and often unconsciously held religious and worldviews of the participants on both sides. In addition to these findings, suggestions to enhance cultural competency offered by other scholars based on studies of different ethnic groups such as Latinos and African Americans will be assessed for generalization to the Hmong.

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Appendix A: Questions for the Hmong Students

1. How has your family experienced the U.S. health care system? Has it generally been a positive experience or a negative one?
2. How have the beliefs/values of your culture or cultural traditions influenced the experience?
3. Since you straddle both the mainstream culture and Hmong culture, what do you think could improve the health care experience for Hmong patients?
4. Have cultural barriers prevented anyone from seeking healthcare? Has it lead to anyone ignoring a physician's recommendations?
5. Have you ever been an interpreter at a hospital/clinic for a relative/friend?
6. Tell me about a time you or a family member were ill and had to go to the hospital. What was your view of what had happened to you or your family member? What was your parents view?

Appendix B: Questions for Practitioners:

1. What experiences have you had with Hmong patients?
2. In what ways do they differ from other patients?
3. In your experience what have you learned about working with the Hmong that could help other health care providers to provide culturally competent care?
4. Tell me about a time where you did not see eye to eye with a Hmong patient about an illness. What was your point of view of what was happening to them? What do you think their point of view was?