Cross-Cultural Caring

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Cross-Cultural Caring
A Handbook for Health Professionals

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Cross-Cultural Caring

INTRODUCTION
The Need for Culturally Sensitive Health Care

Nancy Waxler-Morrison and Joan M. Anderson

Mrs. L., a social worker at the public health department in a small town in western Canada, received a call from Dr. N., a local physician, who said, "I've just examined a two-year-old child from one of those Vietnamese families living out north of town. He's got bruises all over his back and I think you had better make a home visit because it looks like a case of child abuse to me. We'll probably have to report it." Mrs. L. discovered that the family lived in a trailer park full of Vietnamese refugees. The mother worked as a cleaner in the local hospital; the father was unemployed and stayed at home with their four young children. The two-year-old had had a severe cold and trouble breathing, which led the parents to take him to the doctor. When Mrs. L. looked at the child she saw the bruise marks down his back. The child's mother looked somewhat embarrassed as she explained that they were short of money so they hadn't taken him to the doctor right away but instead tried a treatment everyone used in Vietnam – "spooning." A silver spoon was pressed firmly up and down the child's back as a way to remove the illness. That's where the bruises had come from. They had done this for about five days, but when it didn't seem to work they finally took the child to the doctor.

Purpose of This Book

The potential "problem" in the Vietnamese family described above arises not simply from the use of a traditional healing practice that many Western practitioners would think useless or even harmful because it delays good treatment. It arises also from the Western practitioner's assumptions that parents may harm children and that the government may or should intervene. Thus both Vietnamese parents and Western-trained family doctors have different ways of understanding and treating illness that derive from their own cultures. These "cultures of medicine" are often incongruent and

in conflict. It is to avert this "clash of cultures" and the resulting dissatisfaction and poor health care that we have written this book. We hope to inform health professionals about the social background, beliefs, and practices of particular cultural groups in order to ease patient management. We hope also to provide guidelines to members of various immigrant groups in Canada which will ensure that their expectations, needs, and interests are attended to when they require health care.

How are ethnic and cultural factors associated with health and health care? First, some diseases are associated with ethnic group membership. These diseases may be genetically linked to the group, or prevalent in the home country because it is poorly served by preventive medicine, or linked to diet or other cultural practices. Because these culturally linked diseases are often unusual and not a central part of Western medical training, learning about them is obviously useful to professionals dealing with patients from that culture. Second, ethnic membership often means that family structure, religion, medical beliefs, and practices are incongruent with Western society or its health beliefs, thus leading to unfulfilled expectations and dissatisfied health professionals and patients. Third, these incongruencies often result in ineffective health care, to patient non-compliance from the point of view of the practitioner, and to continued illness, alienation, and feelings of being discriminated against from the point of view of the immigrant patient.

This handbook provides the health practitioner with basic information on medically relevant cultural practices in some immigrant groups in Canada. The contents of this second edition have been brought up to date to represent the situations of these immigrants at the beginning of the new millennium. Close attention is paid to the social contexts in which these patients live: why they came to Canada, where and how they may live, what sorts of family situations are common, who provides support, who makes decisions, what medical practices and beliefs they may have brought from their home countries, and what problems they may experience in obtaining health care in Canada. The focus is on information that may aid professionals in providing more culturally sensitive health care.

Perspective

A distinctive "culture of health" is not found only among recent immigrants to Canada. Immigrants do indeed bring with them beliefs about what causes symptoms – from the "evil eye" to "too much bile gone to the head" to "germs" – and about suitable treatments, ranging from talismans to aspirin to coriander tea. But Western-trained health professionals equally have a distinctive culture of health, often taken for granted and thus unrecog-

nized. For example, Western-educated health professionals tend to attribute disease to individual behaviour, such as exposing oneself to germs or eating improperly and not exercising, and to regard the individual as thus largely responsible for getting well. Moreover, to a Western doctor getting well usually means cooperation with technical procedures applied to the body, such as medicines and surgery.

Health care is a social process to which each party – the professional and the patient – brings a set of beliefs, expectations, and practices. Their common task is to negotiate an understanding of the problem, or diagnosis, and decide what to do about it. Health practitioners usually do not think of their day-to-day work in terms of cultural transactions. Instead, they use phrases like "taking the history," "physical examination," or "management" to describe medical work as a technical task to which they apply their expertise and training. It is easy to think in technical terms when the health practitioner and the patient share very basic assumptions about illness and treatment. If both are members of the Canadian cultural majority, it is likely that they both believe, for example, that bacteria and viruses cause disease, that the patient should provide concise and relevant information about symptoms, and that the technical recommendations of the health professional should be followed if the illness is to be cured. Negotiations between a health professional and a patient who share the medical culture can be smooth and satisfying to both parties.

However, when the same health professional treats a patient with a different culture of medicine, the negotiations are often ineffective and unsatisfactory to both. The professional may regard medical care as largely a technical task requiring the individual cooperation of the patient. The patient may not see it that way. For example, in some non-Western cultures the patient is expected to wait passively for the doctor's diagnosis since "the doctor should know" what the problem is. Western-style taking of histories is not part of the patient's experience. Or, in some cultures, whether or not a prescribed medicine is taken is not the sick person's decision but the prerogative of the family head, who is often the grandfather or grandmother. Instructions or recommendations by health professional to patient, stemming from a Western assumption of individual responsibility, are thus ineffective.

The culture of medicine of most Canadian health professionals and the differing culture of an immigrant or minority patient are both legitimate perspectives. In the eyes of the latter, the Western medical system does not have a monopoly on wisdom about how a sick person should behave, the kinds of recommendations a health professional should make, or even the causes and proper description of disease. It is unrealistic and unhelpful to ignore cultural differences and expect that Western medical practices will work smoothly and immigrant patients will simply adapt to them. Instead, the professional who is alert to cultural differences will more easily find a

mutually satisfactory way to achieve "compliance" or effective treatment with a patient who is more likely to recover and feel satisfied.

Cross-Cultural Caring provides a basic introduction to the social background and culture of a number of immigrant groups in Canada. Comprehensive knowledge about every ethnic group is impossible and unnecessary, and we have not attempted to furnish it. Moreover, people differ individually even though they share a culture. What we have done is to alert health practitioners and other professionals to some of the important cultural and social characteristics that have been described to us by members of these groups as possibly affecting health care. These can be explored in more detail with an individual patient or family. In the last chapter, we suggest culturally sensitive ways of obtaining important information from patients and their families, of negotiating common understandings, and of agreeing upon care plans that are consistent with the cultures of both health practitioner and patient.

Problems Common to Ethnic and Cultural Minorities in Canada

Although each cultural minority group has a distinct history, social situation, and set of beliefs, they have some experiences and problems in common. These are often reflected in their use of health services, their experiences with health professionals, and their common illnesses. Some of these problems appear repeatedly in the chapters that follow.

Many of the cultural minorities described are relatively recent migrants to Canada. The disruption of life associated with migration affects many people from different cultures in similar ways. Much has been lost: family ties, familiar language, community support, and the comfort that comes from the general predictability of life. Some migrants, too, have not lost the familiar life by choice; though some have come to Canada to better their lives, others have come as refugees who have been forced against their will to leave their home countries. Recent migrants have lost a great deal and need strength to reintegrate and begin again.

Migration also requires adaptation to a new society. Many migrants must learn a new language, find new supports, and change how they eat, live, and relate to their own children. They must also learn new jobs, and create new visions of the future. Dealing with adaptation, like dealing with loss, takes time and energy.

Three problems are felt by almost all cultural groups, most strongly soon after arriving in Canada. The first is lack of English or French. Many are eager to learn and do so quickly, but lack of a Canadian language makes health service encounters frustrating and unrewarding for everyone, and the help available for this problem in no way meets the need. The second

problem is lack of money. Some immigrants have or can bring funds to cover living expenses; others rely on relatives in Canada. The majority live at a basic subsistence level and find it difficult, for example, to buy medicine or pay for bus fares to the hospital. A third problem for many is posed by the health, social service, and immigration bureaucracies, which they find difficult to understand and utilize. Many newcomers spend scarce time and money going from one office to another to obtain clarification of status and medical insurance. Immigrants may not be familiar with social workers, for example, and may be understandably reluctant to discuss family problems with a stranger.

Other issues affect immigrants as family members. Crucial for many immigrant women is learning to balance housework and a paid job without the support of the family network that they once had at home. Immigrant women who are not employed are often the last to learn the new language, enduring social isolation and deprived of what help is available. Men, too, experience loss of status and self-esteem when jobs for which they were trained in their home countries are closed to them in Canada; doctors may work as hospital orderlies and teachers as store clerks. Family relationships change. Children usually learn English or French sooner and tend to become intermediaries between parents and the outside world; doing so may displace their father from his former role. Moreover, children may adopt Western dress, behaviour, and aspirations that are believed by their parents to be bad, immoral, or disrespectful. The resulting personal and family stresses can lead to physical and mental health problems.

Members of these cultural minority groups frequently experience problems with hospitals and health professionals that represent, in microcosm, the general difficulties they have in the new society. They feel frustrated and insecure because few health professionals can communicate in the family's language and translators are not readily available. Even if someone in the family can speak English or French, the family's lack of understanding of how the Canadian health system works and how it differs from such services in their home country creates difficulties. This problem is often compounded by the health professional's neglect of the need for explanation. Such confusions may waste time and energy which working family members can ill afford. Members of cultural minorities often feel that health professionals do not understand them and simply assume that they feel and think about health just as other Canadians do. Some experience their contact with health professionals as "stereotyping," such as behaving towards them as if "all South Asians are the same." Some immigrants report encounters in hospitals and clinics in terms of discrimination, prejudice, or racism.

Health professionals in turn report problems in working with cultural minority groups. Patients may not follow instructions with medications, or medicines are given to another family member with a different disease.

Families may not abide by hospital policies and instead visit in large numbers, bringing small children and forbidden food. Parents may not dress their small children "properly" or provide nutritious food or may send sick children to school. Appointments may be missed, advice not followed. Health professionals often see real problems in completing the provision of good care to immigrant and minority group patients.

Some of these "problems," as seen by minority group members or by health professionals, are linked to differences in cultures of health. The parties often have distinctly different understandings of illness, beliefs about appropriate behaviour for doctors and sick people, and ideas about proper treatment. But the cultural differences are accentuated by the fact that health professionals, mostly members of the majority culture, also seem very powerful to their patients. Professionals have, or seem to have, the expertise that the patient lacks, and they regard their expertise as the reason the patient seeks professional care in the first place. When the professional also belongs to the majority culture, it is extremely difficult for the immigrant patient or family to ask questions, seek a second opinion, or disagree with the proposed treatment. Relative differences in power between professional and patient compound the cultural differences hindering collaboration between ethnic minority members and health professionals.

Immigrant Groups Described

We have not tried to describe all immigrant groups in Canada, nor do we focus on the largest groups or the most recent arrivals. Instead, we have selected the people who report that they have problems in obtaining satisfactory health care and those cultural groups believed by health professionals to be difficult to work with. In short, we describe people who have "problems" with health care.

Reported problems with health care can certainly be found in every segment of the Canadian population. Our selection, necessarily somewhat arbitrary and subjective, does not imply that all is well in health care with other cultural groups, including the cultural majority. For example, Aboriginal peoples sometimes express dissatisfaction with mainstream health care, but they are not discussed in this book because they are not immigrants. Also not covered are the predominant Anglo- and French-Canadian groups, which have their own "culture of health." Other groups like these deserve attention in further publications. The immigrant groups we have chosen to discuss are those that provide useful insights into the variety of cross-cultural problems in health care and possible solutions to them.

The immigrant groups we describe represent minority cultures in Canada: Central Americans, Chinese, Cambodians and Laotians, Iranians, Japanese,

South Asians, and Vietnamese. We describe them in terms of their country or area of origin. Many members of these groups in Canada are Canadian citizens or will become so. In the chapter on refugees we also mention other recent migrants, such as those from Afghanistan and Somalia.

A "cultural minority" is a distinctive and identifiable subgroup in the Canadian population that sees itself as having origins, beliefs, and values that contrast with the culture of the homogeneous, most-dominant, subgroup of the Canadian population, the white, largely European, culture. Underlying this contrast is an imbalance in economic and political power that favours the dominant group. Therefore, "minority" cultures often imply both distinctive cultural beliefs and less powerful social and economic positions – at least within Canada. Both characteristics are reflected in the problems facing subgroups and health professionals in devising mutually satisfactory health care.

When describing a cultural group, there is always the danger of stereotyping, of implying that all group members are the same. Yet if one takes the opposite position – that the group is only a collection of unique individuals – one would deny the reality of the common culture by which the group expresses and maintains its distinctiveness. In practice, we know that people of South Asian descent widely believe that imbalance in the body humours can cause illness and that a diet of hot and cool foods may relieve the symptoms. Yet we also know that some South Asians who come to Canada have adopted Western concepts of illness and no longer believe in this traditional concept of bodily imbalance. Immigrant cultures are filled with change and adaptation. Thus, to recognize diversity and avoid stereotyping, we attempt to point out important variations within each cultural minority group.

One must also beware of generalizing about cultural minorities across different countries. Each country receiving immigrants has unique policies and services that can profoundly affect the experiences of new residents. In Canada, for example, all immigrants and asylum seekers receive government-funded health care and so have fewer worries about the cost of basic health services. Moreover, the bureaucratic procedures for confirming refugee status in Canada cause most asylum seekers high anxiety at certain points in the screening procedures. Historical and political events usually mean that a country receives immigrants representing specific subgroups of persons from other countries. For example, the Hmong people, a tribal group from Laos, were taken in mainly by the United States, while Laotians who came to Canada were often professionals and government servants from urban areas.

For such reasons, professionals must be very cautious about generalizing from situations in other countries. The policies and social contexts of their own country and the characteristics of specific cultural minorities will

determine how to work successfully with immigrants and refugees. And in any case, it will always be up to the health professional to investigate carefully each patient's particular circumstances so as to understand that individual's "culture of health."

How This Book Was Written

We have asked members of cultural minority groups to speak for themselves, through the authors of each chapter. In most cases, our authors are members of the cultural groups they describe. Yet most are also health or social service professionals with day-to-day experience with patients and families from that group. They have drawn upon their own experiences as well as their cultural knowledge. We also asked professionals who work with, but do not belong to, that cultural group to read and comment on the work. Thus each chapter is the work of one or more authors who were helped by a number of contributors. All the contributors besides the authors are listed at the end of each chapter.

New Information in This Second Edition

All chapters have been completely revised and updated using information obtained from interviews of practitioners and immigrants themselves. Some very significant changes have occurred since 1988-89 when the first edition was completed. For example, by 2000 the majority of immigrants of Chinese background came from mainland China, not from Hong Kong or Taiwan as in the 1980s. The Vietnamese who arrived in Canada as refugees in the latter part of the 1970s are now, in the early part of the new century, sponsoring mostly elderly family members as well as new young wives. The first wave of Iranians, mostly from the upper middle class, is now being joined by working-class families. All of the shifts in these and other immigrant populations mean different settlement problems and new issues for health professionals.

By the turn of the century, about 30,000 refugees were arriving in Canada every year. We have recognized the special circumstances of refugees with a new chapter that provides an overview of the formal definitions of different types of refugees and the health and other services available to them, along with some of the social, physical, and mental problems many of them face. This new information highlights the need for professionals to know whether their clients are immigrants who chose to come to Canada or refugees who were forced out of their home countries. The experiences and problems of these two groups are often radically different.

We have included a few short immigrant and refugee stories, set in boxes, to bring to life some of the experiences and problems that people from other cultures bring when they settle in Canada and seek health care. These vignettes are based on real-life experiences and have been disguised to protect privacy. The subtle implications of a story can be more fully understood by reading the chapter in which it appears.

How To Use This Book

A problem identified in the first edition of this book was the potential for stereotyping different groups of people. We take this concern seriously, because it assumes the opposite of our intention. We suggest ways in which the book can be used to see through the casual assumption that all members of a particular cultural group share certain characteristics. We want our book to help health professionals recognize how ethnic stereotypes may prevent them from understanding the individual patients they are seeking to help.

Use the Book as a Starting Point in Work with a Client

We provide concrete information about the backgrounds from which different groups of people come. For example, we have included histories of different groups, political and economic factors that influence decisions to migrate, and the experiences people have had with physicians and hospitals in their home countries that may have an impact on their experiences in Canada. Although chapter authors discuss beliefs and practices at the group level, obviously there are individual variations within each group, differences based on social class, length of time in Canada, and so on. Moreover, cultures are continually changing. Therefore, each chapter should be regarded not as a portrayal of a foreign way of life but rather as a resource for clues and indications about where to begin learning about a client as a person living in Canadian society.

Get To Know the Individual Client

The information in this book is meant to encourage interaction, not replace it. The professional should get to know his or her clients by inquiring about their past experiences with health care, their beliefs and current practices, the circumstances under which they live and work, and the obligations they carry – which often have a profound effect on how they manage health and illness. For example, since the first edition of this book, major changes in the Canadian health care system often require patients and families to take on a more central role in caregiving. Hospital stays are shorter, and clients usually go home while they still experience significant symptoms

and require complex treatments. In these circumstances it is imperative to learn about the client's home situation. Background information in the relevant chapter will point to important issues a professional might follow up.

Know Yourself

We professionals, no less than our clients, have personal values that are deeply embedded in our own histories, in our upbringing, and in the cultures that continue to shape us. These personal values influence our professional identities and how we use professional knowledge. As professionals, therefore, we ought to be self-reflective about the personal values we bring to each health care encounter, how our personal values may affect what we hear and see, and how we interact with people. We are not just passive observers, objectively viewing the "Other," but active participants in interactions with clients.

We have to find a way to connect with each person regardless of how different we might at first perceive that person to be from ourselves. Professional and client may find themselves sharing the discovery that neither fits the other's cultural stereotype. A client sensing such sharing and connections will begin to participate more openly in the meeting. For the professional this implies more than "knowing the right questions to ask." It means establishing a relationship of mutual respect, opening up a space where differences in perspective can be recognized and managed.

It is in the spirit of a common humanity that we invite you to engage with *Cross-Cultural Caring*. The book provides background information that may offer clues to a client's experiences, perspectives, and values. Your ability to connect at a human level with clients from all cultures and backgrounds remains central to professional practice.