

**2004/05 SUMMER STUDENTSHIP**  
**CULTURAL COMPETENCE OF HEALTH**  
**PROFESSIONALS: IS ASIAN HEALTH BEING**  
**CONSIDERED?**

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# CULTURAL COMPETENCE OF HEALTH PROFESSIONALS: IS ASIAN HEALTH BEING CONSIDERED?

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## **ABSTRACT**

**Aim:** To determine if health service delivery is responsive, accessible, and culturally appropriate for the Asian population group. The research question that served to be answered is whether general practitioners are culturally competent in health care delivery to their Asian patients. This was done by assessing the measures undertaken to improve service delivery to Asian patients.

**Method:** A qualitative study using content analysis of information gained from semi-structured interviews. General practitioners currently practicing in the Auckland region were selected to participate. Fourteen practitioners were randomly selected from the online register of general practitioners kept by the Medical Council of New Zealand, of this twelve agreed to participate in the study. The main outcome measures were responses to prepared questions.

**Results:** The information gained from the interviews was used to generate common themes. Listed below are the main findings from the study:

- Language was cited as the most significant barrier
- Practitioners had a minimal understanding of the Asian beliefs that affect health care
- All practitioners stated that they were open to complementary medicine
- The practitioners understood that differences in gender roles existed among Asian groups
- The varying degrees of acculturation was recognised
- There was an understanding that the family had an important role in Asian people's lives, but little attempts were made to involve the family in health care
- There was limited understanding of the needs and risk factors for Asian patients
- Little was done to ensure treatment plans had a cultural perspective
- Most practitioners felt that courses need to be provided to educate practitioners about Asian health

**Conclusion:** Results from the study revealed that due to the lack of information and resources available to practitioners, the delivery of culturally competent health care to

Asian patients is compromised.

In recent years the population of Asian migrant groups has increased markedly in New Zealand. The Asian ethnic group is the fastest growing ethnic group in New Zealand. According to May<sup>1</sup>, between 1991 and 2001, the Asian population more than doubled to nearly 240,000 (6.4%). By 2021, it is expected that New Zealand's Asian population will reach 604,000.<sup>2</sup>

With the increasing Asian population, it is being recognised that for the practitioner to be clinically competent, the practitioner needs to be culturally competent. Culture can be defined as a shared system of values, beliefs and learned patterns of behaviour.<sup>3</sup> Health and disease are integral parts of culture. The ways people perceive, interpret and treat illness vary by culture.<sup>4</sup> Culture impacts on an individual's health seeking behaviours and patterns of treatment. Cultural competency involves finding out and learning about the patient's beliefs of health and illness. To be culturally competent the physician needs to understand his/her own worldviews and those of the patient, whilst avoiding stereotyping and misapplication of scientific knowledge.<sup>5-8</sup>

A number of reasons have been identified that highlight the need to promote the cultural competence of practitioners. Firstly, there is a need to respond to the changing demographics. The 2001 Census found that the Asian ethnic group made up 6.6% of the population, compared with 14.7% Maori and 6.5% Pacific people. These results revealed that the Asian group outnumbers those identifying as Pacific people, with a count of 237,459 for the former and 231,801 for the latter.<sup>5</sup> In addition, it is essential to recognise that cultural differences can often lead to much misunderstanding. In the past, misunderstandings of the Maori culture had led to many health disparities between Maori and non-Maori. In order to avoid a repetition of past mistakes, it is important that steps are taken to ensure the cultural competence of practitioners in the delivery of health care to Asian groups. Finally, in order to deliver high-quality accessible health care, practitioners need to have a deeper understanding of their patients' socio-cultural backgrounds.

Culturally competent health care could result in:

- More successful patient education, because practitioners can communicate health-related messages more effectively
- Increases in patients' health-care-seeking behaviour, by improving trust and understanding between practitioner and patient.
- More appropriate testing and screening, as practitioners will have more knowledge about the risk factors in various cultural groups.
- Fewer diagnostic errors, as a result of more accurate medical histories.
- Avoidance of drug complications, by discovering home or folk remedies used by patients.

- Greater adherence to medical advice, because practitioners establish a treatment plan that is most consistent with the patient's cultural beliefs and lifestyle. Thus, patients better understand how to follow the treatment plan.
- Expanded choices and access to high-quality practitioners, because patients are no longer restricted to a small pool of practitioners who share their language and culture.

*(Source: Brach and Fraser<sup>9</sup>)*

The purpose of this study was to identify whether health service delivery was responsive, accessible and culturally appropriate for the Asian population. It was hoped that the study would serve to identify whether practitioners were culturally competent in health care delivery to Asian patients. The overall goal of the study was to determine how general practitioners could improve their service delivery to Asian groups.

## **LITERATURE REVIEW**

### **Definition of cultural competency**

Cultural competency can be defined as a set of academic skills that serves to increase the understanding of cultural differences between groups.<sup>10</sup> The term has been used broadly in the health sector, whereby various derivatives of the above definition have been developed in different health care settings. In discussing cultural competence in health care for children, Barrera and Kramer<sup>11</sup> used the term to refer to the ability of providers to respond most favourably to all children, understanding the differences in sociocultural contexts in which children and families may be operating. In discussing health of women, Rorie, Paine and Barger<sup>11</sup> defined cultural competency as a set of behaviours, attitudes, and policies that enable a system to take into consideration culturally diverse communities. For the purposes of this study, cultural competency was taken to denote the ability to think, feel, and behave in ways that reflect an understanding of and respect for ethnically and linguistically diverse patients.

Virtually all literature highlighted the key concepts of cultural competency as cultural awareness, cultural knowledge, cultural skill, and cultural encounter.<sup>5,10,12,13</sup> Cultural awareness refers to the ability to accept and appreciate differences.<sup>13</sup> This concept does not merely denote an awareness of the values, beliefs, and practices of an individual; but also the incorporation of an individual's values, beliefs, and practices into a mutually accepted health care plan.<sup>12</sup> Gaining cultural knowledge involves acknowledging that culture influences the delivery of health services to ethnically diverse patients. Cultural knowledge entails seeking out different views on health and illness. Cultural skill involves learning how to assess a patient, and thereby gaining an understanding of the patient's concept of health and illness.<sup>13</sup> It involves learning techniques on how to assess a patient without relying on written facts about that specific ethnic group. Cultural encounters involve engaging in cross-cultural interactions with people of ethnically diverse backgrounds.<sup>13</sup> Meeting and interacting with people of different ethnic cultures will assist in dispelling stereotyping of patients to a particular ethnic group.

## **The Asian culture**

### **Communicating effectively**

Communication differences present themselves in many ways, such as in language, silence, and verbal and non-verbal behaviours.<sup>5</sup> Helman<sup>14</sup>, Spector<sup>5</sup>, Ma<sup>4</sup>, Henderson and Primeaux<sup>15</sup>, and Brownlee<sup>16</sup> have all cited language differences as the most significant obstacle in providing multicultural health care, as these differences affect all stages of the patient-doctor relationship. When communicating with individuals from different cultural backgrounds or for who English is a second language, Andrews and Boyle<sup>6</sup> suggest that slang, technical jargon, colloquialism, abbreviations, and excessive use of medical terminology be avoided.

Andrews and Boyle<sup>6</sup> have also noted that wide cultural variations exist when interpreting silence. Where individuals of the Western society find silence uncomfortable and make attempts to counteract it, in the Chinese and Japanese culture silence signifies that the speaker wishes for the listener to consider what has been just said before continuing. In addition, some Asians may respond “yes” to a question as a way of showing politeness and avoiding conflict, even when they do not understand the question being asked.<sup>17</sup>

Communication patterns vary widely transculturally even for conventional behaviours such as smiling and handshaking.<sup>6</sup> For example, restraint of strong feeling is seen as a sign of maturity and wisdom among many Asians.<sup>18</sup> Smiling is often an indication of embarrassment, discomfort, shyness, or weakness. Hugging, handshaking, and backslapping are not typical among Asian people.<sup>11</sup> Similarly, Brislin, Cushner, Cherrie and Yong<sup>19</sup> note that maintaining eye contact is not universally accepted norm, many Asian groups consider avoidance of eye contact as polite and a way of displaying respect. Standing with one's hands on one's hips is considered extremely hostile among Asians, and Muslims consider the use of one's left hand to touch someone or reach for something inappropriate.<sup>11</sup>

Effective intercultural communication requires careful consideration of nonverbal behaviours such as gestures, facial expressions, eye contact, posture, and space. Failure of health professionals to understand a patient's nonverbal actions could result in important information being overlooked.<sup>6</sup>

### **Family and Society**

Disparities in the concept of family structure and identity present health professionals with many dilemmas.<sup>20</sup> Spector<sup>5</sup> notes that Asian families are hierarchical in structure, with male and older individuals occupying a higher status. Filial piety is strife among Asians, whereby there is an unquestioned respect for and deference to authority. There is an unquestioned expectation that each individual will comply with familial and social authority.<sup>14</sup> In traditional Asian culture, the individual puts the family's needs above his

or her own needs.<sup>18</sup> In addition, Asian societies promote that notion of interdependence and group welfare.<sup>1</sup> Many Asians consider themselves extensions of their families and often the individual puts the family's needs above his or her own needs. All relatives are interdependent socially, culturally, and financially. They tend to seek help first from immediate and extended family before turning to professionals.<sup>14</sup>

It is important to ascertain the family roles of the patient and support people. This is necessary as decision-making and orchestration of care may not be individual but rather group responsibilities.<sup>10</sup> More so, family members can provide valuable information regarding the patient's diet, health behavior, daily activities, and types of alternative medications used. Involvement of the family in the treatment could aid in ensuring the patient adheres to the recommended treatment.<sup>6</sup>

Sue<sup>21</sup> highlights the following differences between Western and non-Western cultures:

**Table 1: Comparison of common values from Western and non-Western perspectives**

<b>Western</b>	<b>Eastern</b>
Egocentric	Socio-centric
Nuclear family	Extended / joint family
Status achieved	Status in the family predetermined
Weak social links	Strong social links
Choice of partner	Limited or no choice of partner
Independence	Interdependence
Individual advance	Group advance
Emphasis on newness	Emphasis on traditions

The American Medical Student Association<sup>10</sup> notes that gender is a major issue in cross-cultural health care. In many Asian families, there are defined roles for males and females, in that the man is the breadwinner and taxpayer, and the woman is in charge of all home affairs.<sup>22</sup> Consequently, it is not surprising to find in the Asian culture that the male often takes on a domineering role and females a subservient role. This outlook plays an important role in healthcare. Many men find it inappropriate to be given advice from a female. The American Medical Student Association<sup>10</sup> recommends that female migrants should be attended by a female health professional, and males by a male professional.

### **Religion and Health Beliefs**

Religious attitudes have a major impact on health, health care, and illness.<sup>5,6,10,23,24</sup> The religious beliefs of Asians often result in the incorporation of values that sets them apart from Westerners. May<sup>1</sup> notes that Asian groups are distinguished in their beliefs, placing emphasis on being in harmony with nature, fate, and spiritualism. Thus, healing is spiritual as well as scientific.

These beliefs impact significantly on health care. May<sup>1</sup> notes that acceptance of medication varies across cultures. For example, Buddhism teaches that life is a cycle of

suffering and rebirth.<sup>23</sup> Thus, many Asians who follow the Buddhist religion may endure pain and illness, and delay health-seeking behaviours. In addition, the patient may attribute ill health to personal carelessness or weakness, viewed as punishment, or considered as a result of external forces that the patient has no control over.<sup>3</sup> Among some Asian groups, it is felt that ill health is caused by karma, a belief that actions of past lives have consequences for present situations.

According to the Asian culture, health is considered a holistic concept, encompassing physical, social, psychological, and spiritual wellbeing.<sup>3</sup> According to most Asian groups, the balance of *yin* and *yang* is considered critical in maintaining good health. To be in good health, there must be a balance in opposites. Foods are considered to have hot and cold properties which are used for their nutritional qualities, medicinal value and healing power.<sup>3</sup> In addition, acupuncture and herbal medicines are thought to have the ability to restore the body's balance.

Home remedies and folk healers are also commonly utilised in many cultures.<sup>1</sup> Ayurveda is a holistic system used by many South Asians, which gives food and lifestyle guidance for prevention and treatment of disease and for preservation of health. Ayurveda separates hot foods (meat and spices) from cold foods (milk, fruits, and vegetables). For a hot condition such as pregnancy, the patient will be advised to avoid hot foods.<sup>10</sup>

Religion often becomes a pillar of support for migrants, who may turn to religion because of problems in adapting to a new society and/or because of feelings of loss due to separation from family and friends. An understanding of the religious observances and customs of diverse migrant groups is essential in providing effective health care.<sup>25</sup> To be culturally competent, health professionals need to integrate different perspectives related to religion into their health services.

### **Needs and Risk factors**

According to the Asian Public Health Report<sup>26</sup>, the six leading causes of potentially avoidable deaths among the Asian population are heart disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide, and the leading causes of avoidable hospitalisations are angina, gastroenteritis, respiratory infections, road injuries, dental conditions, and asthma. In addition, there are also concerns with regards to TB, hepatitis B, and thalassaemia among Asian groups. Also, immigration stressors can lead to a number of mental health issues related to language barriers, social isolation, under-employment and stigmatization.<sup>26</sup>

Pharmacological concerns also needs considering when treating Asian patients. For example, some Asian people metabolise some neuroleptic drugs, such as haloperidol and resperidone, more slowly due to a mutation of the CYP2D6 gene. Slow metabolism of these drugs could result in neuroleptic toxicity. Asians are also more sensitive to adverse affects of neuroleptic drugs, such as extrapyramidal symptoms.<sup>27</sup> Furthermore, some Chinese and Japanese people lack the active form of the enzyme aldehyde dehydrogenase, which results in an accumulation of aldehyde. This is a highly toxic

substance, which is responsible for the "flushing" response some Asian people experienced following the intake of alcohol.<sup>27</sup>

## **Refugees**

Refugees differ from migrants in that where migrants chose to leave their country, refugees did not choose to leave; instead they had to flee in response to a crisis.<sup>28</sup> The Ministry of Health<sup>28</sup> notes that many refugees have been subjected to various traumatic events including severe beatings, witnessing death squad killings, sexual abuse, starvation, and thermal and chemical burns. This being the case, health professionals need to exercise extreme sensitivity when delivering health care to refugees.

## **Models of Cultural Competency**

A number of resources have been constructed with the aim of educating health professionals on the provision of culturally appropriate care. These include guidelines, checklists, and models.

The Georgetown University Childhood Development Centre has developed a checklist to heighten awareness and sensitivity of staff to the importance of cultural competency in human service settings.<sup>29</sup> Divided into three sections, it covers key areas in physical environment, materials, and resources; communication styles; and values and attitudes. It makes such queries as "I use visual aids, gestures, and physical prompts in my interactions with children and their families who have limited proficiency in English" and "I recognise that the meaning or value of medical treatment and health education may vary greatly among cultures". Although developed with the aim of educating personnel involved in child health, it is possible to adapt the checklist to the setting at general practices.

Several mnemonics have been developed to facilitate the delivery of culturally competent care. Levin developed *ETHNIC: A Framework for Culturally Competent Clinical Practice*:

### **E: Explanation**

What do you think may be the reason you have these symptoms?  
What do friends, family, others say about these symptoms?  
Do you know anyone else who has had or has this kind of problem?  
Have you heard about/read/seen it on TV/radio/newspaper? (If patient cannot offer explanation, ask what most concerns them about their problems.)

### **T: Treatment**

What kinds of medicines, home remedies, or other treatments have you tried for this illness?  
Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.

What kind of treatment are you seeking from me?

**H: Healers**

Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems? Tell me about it.

**N: Negotiate**

Negotiate options that will be mutually acceptable to you and your patient and that does not contradict, but rather incorporate your patient's beliefs.

**I: Intervention**

Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers, as well as other practices (e.g. foods eaten or avoided in general, and when sick).

**C: Collaboration**

Collaboration with the patient, family members, other health care team members, healers, and community resources.

*(Source: Levin, 2000; cited in The provider's guide to quality & culture<sup>17</sup>)*

The *LEARN* mnemonic was developed by Berlin and Fowkes:

**L:** Listen with sympathy and understanding to the patient's perception of the problem.

**E:** Explain your perceptions of the problem.

**A:** Acknowledge and discuss the differences and similarities.

**R:** Recommend treatment.

**N:** Negotiate agreement.

*(Source: Berlin & Fowkes<sup>31</sup>)*

Andrews and Boyle<sup>6</sup> developed a list of assessment questions to help the physician understand the beliefs, values, and practices that may impact on the patient's care and health behaviours. It covers several areas including:

- level of ethnic identity
- use of informal network and supportive institutions in the ethnic/cultural community values orientation
- language and communication process
- migration experience

- self-concept and self-esteem
- influence of religion/spirituality on the belief system and behaviour patterns
- views and concerns about discrimination and institutional racism
- views about the role that ethnicity plays
- educational level and employment experiences
- habits, customs, beliefs
- importance and impact associated with physical characteristics

### **Research in New Zealand**

Majority of the research carried out in New Zealand regarding Asian health has focused on Asian people’s experience with the health system in New Zealand. The table below highlights key research carried out.

***Table 2: Asian health research conducted in New Zealand***

<b>Study</b>	<b>Researchers</b>	<b>Findings</b>
New Zealand's Asian population: Views on health and health services, 1998	Ratana, Wu, Soothi-O-Soth, Parr <sup>32</sup>	<p>Two surveys were carried under the HFA, the first a survey of Asian immigrants in the Auckland region was carried to determine their views on health and health services, the second was a survey of health professionals.</p> <p>The major findings were that language was a major barrier for Asian people in seeking health care, and about two-thirds thought it was important that their GP speak their language. In addition approximately 20% of the Asian people used traditional medicine.</p>

<p>Final report on healthcare needs of Asian people : surveys of Asian people and health professionals in the North and West Auckland, 1999-2000</p>	<p>Ngai, M.M.Y., Latimer, S., &amp; Cheung, V.Y.M.<sup>33</sup></p>	<p>The first survey of Asian people in North and West Auckland found that when encountering health problems most of the respondents would visit their GP. In addition respondents were dissatisfied with the cost of GP services and with waiting times and the health information available in publicly provided services. The respondents requested support services to combat language and cultural barriers including availability of interpreters, a helpline, information in their own language and Asian health support workers.</p> <p>The second survey of health professionals found that language barriers and cultural differences in treatment and assessment were major difficulties experienced. The professionals felt that information and training on Asian customs and cultural perspectives will be helpful.</p>
<p>Asian Public Health Project Report, 2003</p>	<p>Asian Public Health Project Team<sup>26</sup></p>	<p>The survey involved assessing the public health issues facing Asian people in the Auckland region.</p> <p>Findings from the work include that the Asian population has diverse health needs, the Asian communities want better access to health services</p>

		that cater to their needs, and that Asian people are willing to participate in improving their health of their community.
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## METHOD

The study was carried out in the Auckland region in summer 2004/2005. It was felt that imposing geographical restrictions would provide more valuable results, as the 2001 Census showed that Auckland had a larger Asian population (18.7%) compared with the national figure (6.6%).<sup>2</sup> The study population was general practitioners currently practicing in the areas of Auckland City, Manukau City, and North Shore City. The general practitioners were randomly selected from the online register of general practitioners kept by the Medical Council of New Zealand. The methodology selected was a survey in the form of semi-structured interviews. The following domains were considered in the interview:

- values and attitudes
- cultural sensitivity
- communication
- family and community participation
- policies and procedures

A total of 14 practitioners were selected for the survey, of which 12 agreed to participate in the study. Each interview took place at the general practitioner's practice, and the interviews took approximately 30 minutes. The average age group was 50 to 55 years; nine general practitioners were of the European ethnicity, two were Chinese and one Sri Lankan Indian. They all had different experiences with Asian patients; whereby, one had many Asian students, another had many Korean patients, and yet another had a larger Indian population.

A series of questions were prepared, which were used as guidelines for the interviews. The interviews were audio taped, and at the end of each interview the tapes were transcribed. The data was analysed largely based on content. Following the transcription of audiotapes, a line-by-line analysis was carried out. This was done to identify recurring issues, from which a summary of themes was compiled. In addition to content analysis, semantic analysis was carried out to determine the patterns of expression of each participant, to get an idea of the practitioners' attitudes towards issues related to Asian health.

## RESULTS

### Themes

When the transcripts of the interviews were compiled a number of common themes were revealed. For example, most general practitioners felt that language was a significant barrier in providing care to Asian patients. However, there were large variations in addressing this problem. A few practitioners sought to learn the languages of their patients, one used the technique of getting the patient to reflect back, and most general practitioners relied on patients' family members to act as translators. In addition to language barriers, a number of practitioners felt that a standard consultation time of 15 minutes was inadequate to interview and treat Asian patients.

All general practitioners were open to learning more about the different Asian cultures. One practitioner expressed that there was a need to act as a bicultural nation prior to acting as a multicultural nation; however, the general consensus was that more information needed to be provided on the Asian populations. Most practitioners felt that having a better understanding of the Asian cultures would lead to better diagnosis and treatment.

After amalgamating the themes from all the interviews, the main themes were drawn up. These are highlighted in Table 3.

*Table 3: Analytical themes*

Themes	
Cultural differences creates differences in response to health and health care	<ul style="list-style-type: none"><li>• recognise that religion and other beliefs affect patients' response to illness, disease and death,</li><li>• most have moderate understanding of the beliefs that affect health care,</li><li>• open to the use of complementary medicine</li></ul>
Acculturation	<ul style="list-style-type: none"><li>• recognise and accept that Asian patients' have varying degrees of acculturation</li></ul>
Language differences	<ul style="list-style-type: none"><li>• seen as a barrier affecting assess,</li><li>• make use of pt's family and friends,</li><li>• limited use of translated materials</li></ul>
Time barrier	<ul style="list-style-type: none"><li>• pressure to maintain patient flow as</li></ul>

	well as provide quality care
Non-verbal conversation	<ul style="list-style-type: none"> <li>• aware that there are certain behaviours that differ from the conventional Western society but are not clear on what these are</li> </ul>
Family participation	<ul style="list-style-type: none"> <li>• understand and accept that gender roles vary,</li> <li>• understand that a familial hierarchy exists,</li> <li>• understand that family is an important aspect in the patient's life, but little attempts are made at involving the family in health care</li> </ul>
Information source	<ul style="list-style-type: none"> <li>• seek information from colleagues and patients,</li> <li>• no coalitions have been established with ethnic groups in the community</li> </ul>
Treatment/Procedures	<ul style="list-style-type: none"> <li>• no formal plans are in place to aid in assessing and treating Asian patients,</li> <li>• no difference in approach compared with non-Asian patients,</li> <li>• little understanding of needs and risk factors associated with Asian patients</li> </ul>

## DISCUSSION

The results from the study confirm that general practitioners are open and willing to work with Asian populations; however, they lack the information and resources to provide culturally appropriate care. General practitioners' attitudes towards Asian health were positive, whereby all displayed a respect for the patient's immigration and acculturation experiences. In addition, all displayed an interest in learning more about the cultures of their Asian patients.

A number of general practitioners felt that their knowledge on the culture of the various Asian groups were limited. Most practitioners understood that one's culture affects one's views on health and illness; however, it was felt that more information needed to be provided on the impact of the Asian culture on a patient's wellbeing. Knowledge on the various Asian health practices was scattered. One practitioner was able to identify the practice of *coining* among Cambodian patients, a few were able to identify differences in

diet between Asian and non-Asian people, and all practitioners stated that they were open to complementary and traditional medicine provided it was safe. In addition, and very importantly, all practitioners realised that the degree of acculturation varied amongst their Asian patients. Hence, they knew not to stereotype patients into cultural groups. Most practitioners sought information about a particular patient's culture by directly asking the patient of the differences between cultures. Whilst this assists greatly in learning about an Asian patient's culture, Kleinmann provided a more structured plan of learning about a patient's culture, by asking the following questions:

- What do you call your problem (sickness)? What name does it have?
- What do you think has caused your sickness?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Do you think it will last a short or long time?
- What do you fear most about your sickness?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

(Source: Kleinmann, 1980; cited in *Cross-Cultural Health Care Programme*<sup>30</sup>)

Ideally, in the general practice setting a cultural assessment is carried at the first consultation to determine the level of cultural affiliation of the patient, by asking such questions as those listed below:

- Where was the patient born?
- How long has the patient been in this country?
- What is the patient's ethnic affiliation?
- Who are the patient's major support people?
- What are the patient's primary and secondary languages, and his or her reading and writing ability in these?
- What is the patient's religion, its importance in daily life, and current practices?
- What are their food preferences and prohibitions?
- What are their health and illness beliefs and practices?
- What are their customs and beliefs around life events such as births, illness and death?

(Source: Lipson, 1996; cited in *Queensland Health*<sup>20</sup>)

None of the practitioners interviewed carried out a cultural assessment of their Asian patients; however, attempts were made to gain such information with each consultation. Most sighted that time barriers prevented them from gaining complete cultural background information of their Asian patients.

Majority of the practitioners interviewed felt that language was a significant barrier in providing culturally competent care. Those practitioners who did not identify this as a major barrier were either of Asian ethnicity or made attempts to learn the language of the Asian patients by attending language classes and/or making use of translation dictionaries. Language barriers were seen to hamper history taking and advice giving, and consequently lengthened the consultation time. Various methods were utilised to combat this barrier; the most commonly sighted method was the use of family members as interpreters. Whilst this provides a convenient and cost-free means of overcoming language differences, it is not the recommended method. Using the patient's family and friends as interpreters presents with a number of problems. Family and friends are more likely to modify what the patient has said in an attempt to be helpful.<sup>6</sup> In addition, issues related to confidentiality and asking sensitive questions such as domestic violence arise, when using family members as interpreters.<sup>30</sup> Ideally, a trained medical interpreter should be used; however, as mentioned by a number of interviewees, cost is a major barrier to utilising such services. So great is this problem, that one practitioner preferred referring Asian patients to hospitals where interpreter services were available, to combat this problem. Andrews and Boyle<sup>6</sup> discouraged the use of untrained individuals as interpreters, and recommended the following when consulting without an interpreter:

- Be polite and formal
- Greet the person using the last name or complete name. Gesture to yourself and say your name. Offer a handshake or nod. Smile.
- Proceed in an unhurried manner. Pay any attention by the patient to communicate.
- Speak in a low, moderate voice. Avoid talking loudly.
- Use words known in the patient's language.
- Use simple words like pain instead of discomfort. Avoid medical jargons and slang.
- Pantomime words and simple actions while verbalising them.
- Give instructions in proper sequence. For example instead of saying "Before you rinse the bottle, sterilise it" say, "First rinse the bottle, then sterilise it."
- Discuss one topic at a time. Avoid conjunctions.
- Validate that the patient understands by having him/her repeat instructions.
- Write out several short sentences in English and determine the person's ability to

read.

- Obtain phrase book and/or make flash cards.
- Ask who in the patient's family and friends they feel comfortable having as an interpreter.

(Source: Andrews & Boyle<sup>6</sup>)

In addition to language barriers, non-verbal communication was also viewed as being significantly different from the conventional Western society. However, whilst recognising that differences existed, practitioners were unaware of what the differences were. The general practitioners stated that they assessed what was acceptable and unacceptable behaviors by following the patient's lead. This approach is most ideal when unsure of the norms of a particular culture. The provider's guide to quality and culture<sup>17</sup> also stipulates this approach, and in addition, suggests the following to enhance non-verbal communication:

- Use hand and arm gestures with great caution. Gestures can mean very different things in different cultures.
- Be careful in interpreting facial expressions. They may lead you to misinterpret the patient's feelings or to over- or underestimate the patient's level of pain. This is also true of the presence or absence of crying and other expressions of pain, which are closely tied to a person's culture.
- Don't force a patient to make eye contact with you. He/she may be treating you with greater respect by not making eye contact.

When asked about the role of the family in the health care of their patients, the general practitioners recognised that male and the elderly were more highly respected in the Asian household. In some cases, practitioners made attempts to ensure that female patients were attended by female colleagues within the practice. In addition, the practitioners recognised that Asian families were interdependent and that the extended family had a significant role. However, little attempts were made to communicate with the family and involve family members in decision-making. The general practitioners failed to recognise that the family served as an important source of information about Asian culture. Most practitioners relied on information from peers. A number of practitioners had traveled and worked in Asian countries, which they felt have given them insight into the Asian culture. Few practitioners made alliances with key advocates in the Asian community and none had alliances with any of the Asian migrant groups. However, one practitioner attempted to make alliances with Asian health professionals, and a few had alliances with alternative therapists. The practitioners failed to recognise that migrant and cultural organisations served as a focal point for social activities, and contact with such groups provided a useful way of gaining information about the culture and health needs of the Asian population.<sup>30</sup>

About a quarter of the total participants recognised that patients with refugee status required special attention. These practitioners recognised that mental health issues among such patients and sought to address post-traumatic stress disorder. The practitioners aimed at getting their refugee patients to open up about their experiences and related feelings. Whilst this is the desirable approach, the Ministry of Health<sup>28</sup> also suggested consideration of the following in providing health care to refugees:

- Refugees may somatise their psychological stress, attributing physical symptoms and signs to psychological and social disorders.
- Early morning appointments may not be feasible as sleeping problems are common among traumatised refugees.
- Refugees may be reminded of past trauma during consultation. A common response being to 'switch off', which may range from an extreme catatonic state to a momentary 'absence'.
- Anger, hostility, and mistrust may interfere with effective communication

In terms of consulting with Asian patients, no differences were mentioned in the assessment and subsequent treatment of Asian patients compared with non-Asian patients. A few practitioners have recognised some risk factors associated with Asian patients. One general practitioner noted that screening for vitamin D deficiency was essential in treating Asian females, a third recognised the effects of migration stress and separation anxiety among recent immigrants, and one was aware of the risk of TB among Asian patients. In addition, a number of practitioners described Asian patients as being hypochondriacs who were unfamiliar with the New Zealand health system. In general, the participants had a vague understanding regarding the risk factors for Asian patients. Overall, treatment plans did not contain a cultural perspective, except where attempts were made to take into account the diet preferences of their Asian patients. In addition, no attempts were made by participants to get feedback from their Asian patients as to how health service delivery could be more culturally directed. The general consensus among participants was that it would be more appropriate to treat all patients alike. Whilst this is the most just approach, there are significant differences between Asian and non-Asian patients that warrants an alternative approach to caring for Asian people. Queensland Health<sup>20</sup> suggested consideration of the following checklist in treating Asian patients:

- Have you checked English proficiency?
- Have you specifically encouraged the person to tell you about any issues, needs or problems they may be experiencing in the medical setting?
- Do you understand what the person believes is causing the problem?
- Are you aware of the person's priorities?

- Have you checked with the person about the level of family involvement they would like?
- Are you aware of any networks that may be available for support, for example religious networks, friends/compatriots?
- How did you check that the person has understood the diagnosis, what particular treatments are for, and how to do or use them? (for example, asked them to tell you in their own words or asked them to show you etc).
- Have you ascertained whether the person is using any alternative treatments?
- Have you checked if the person understood any follow-up required and the reasons for this? Including why they may have to come back and what is required in the meantime?
- Have you asked if the person has any questions?
- Do you feel you have a shared understanding of the problem and the plan of action.
- Do you know whether the person agrees with your plan of action?

The general view held by general practitioners in the study was that due to the lack of information and the absence of any pre-planned schematic in approaching Asian patients, barriers such as language and cultural differences are made significantly greater. The suggestions put forward included continued medical education courses on Asian health, more Asian health professionals, and reducing or eliminating the cost of interpreter services. However, concurrently, concerns have been put forward that the Asian culture is far too vast to allow for a complete understanding of all the ethnic groups. The study verifies that general practitioners are attempting to provide care that is responsive, accessible, and culturally appropriate for the Asian groups; however, lack of education and resources have hampered their attempts.

## **CONCLUSION AND RECOMMENDATIONS**

The study confirms that general practitioners are interested in, and willing to learn more about the cultural background of their Asian patients; and as such become more culturally competent in health care delivery to the Asian population. As described earlier the four goals of culturally competent care are cultural awareness, cultural knowledge, cultural skills, and cultural encounters. The results from the survey revealed that the practitioners possessed cultural awareness; however they lack the information and resources to build upon cultural knowledge, skills, and encounters. To aid practitioners in achieving these, the following are recommended:

- The Medical Council of New Zealand liaison with key advocates in the Asian community to aid in the development of a schematic that will serve as a framework for providing care to Asian patients

- Development of translated pamphlets and posters in the various Asian languages that could be used by general practitioners as health promotion material
- Set up Continued Medical Education courses (CMEs) on Asian health, which includes the provision of information on Asian health practices, risk factors, and approaches to treating Asian patients
- Resources such as Bell's *Ethnic New Zealand: Towards cultural understanding*,<sup>24</sup> which provides information on the various cultural groups in New Zealand, be circulated and offered to general practitioners
- Interpreter services be available at the general practice setting at no cost
- A directory is provided to practitioners which lists the Asian health professionals, and cultural and community Asian groups with who the practitioners could liaison
- More articles related to Asian health and the Asian culture be published in such journals as the *New Zealand Medical Journal*, *New Zealand GP*, and the *New Zealand Family Practitioner*
- As a means of educating practitioners set up seminars inviting individuals of different Asian ethnic backgrounds to give talks on their culture
- Flyers be posted on the cultural workshops offered by the Shakti Migrant Association
- Development of a cultural competency check-list which serves as a self-assessment for practitioners, enabling them to consider how the patient's culture is taken into account in diagnosis and treatment

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