

Virtual Mentor

Ethics Journal of the American Medical Association
July 2005, Volume 7, Number 7

Medicine and Society

Culture Within a Culture: US Immigrants Confront a Health System that Many Citizens Can't Manage

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Nearly a quarter of the US population is either foreign-born or has foreign-born parentage [1]. In Minnesota, the foreign-born population more than doubled, from 110 000 to 240 000 during the 1990s, an influx of immigrants that brought many ethnic Hmong, resettled from refugee camps in Thailand.

The Refugee Act of 1980, a humanitarian bill passed with strong bipartisan support, guarantees funds to states to ensure that all new refugees are covered by Medicaid for their first 8 months in the US. A refugee is defined as someone who has fled his or her homeland and cannot return because of a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. This act recommends that, within the first 90 days, each refugee have a comprehensive medical exam for 2 main reasons: (1) to determine conditions or illnesses that may interfere with the individual's ability to adjust to life in the US and (2) to screen for and treat common infectious diseases for the protection of the existing population.

Many refugee groups suffer a higher rate of infectious diseases such as tuberculosis and hepatitis than do other members of the communities they enter. It is also a fact that, as refugees acculturate to life in the US, they tend to fall prey to many of the chronic diseases that plague the American poor: diabetes, hypertension, obesity, and other conditions that require ongoing care. Members of this population are often predisposed to psychiatric symptoms and disorders due to their exposure to war, state-sponsored violence and oppression, internment in refugee camps, displacement to a new country, loss of family members and prolonged separation, low socioeconomic status, and unemployment. In addition, they must adapt to new societies that almost always present an unfamiliar language and culture.

Gaining access to western health care is complex and difficult for new immigrants. Many seek to combine traditional remedies from their own culture with standard American treatment. As the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care states:

The increasing diversity of the nation brings with it a host of opportunities and challenges that are experienced with increasing frequency and immediacy in health care facilities, from small rural clinics to large urban medical

centers...personal efforts are usually not enough to overcome the common organizational barriers presented by mainstream health care organizations. These barriers affect how diverse patient populations navigate their health care and how health care organizations and providers deliver that care [2].

The following are some of the most significant barriers faced by foreign-born new arrivals to the US :

1. *Language barriers.* A recent civil-rights complaint claims that the lack of basic translation services at 4 New York City hospitals endangers immigrant patients and violates state and federal law [3]. While many states require that interpreters who work in the judicial system must complete certified training, few states require the same for those who work in the medical field. The use of untrained interpreters who are bilingual, but who may not know much about anatomy, physiology, pharmaceuticals, or medical terminology is generally insufficient. Few hospitals or clinics provide prescription labels in languages other than English, making compliance with medication all but impossible. Some recent immigrant groups, eg, Somalis and Hmong, have relied for generations on oral traditions of sharing information and have only recently developed written languages, a cultural fact that renders them functionally illiterate in their new home.

2. *Cultural barriers.* Most developing countries do not use an appointment system for delivering health care services. Instead, people who are sick go to the doctor and wait to be seen. Many people have no tradition of going to the doctor when they are well and find it difficult to understand why that is recommended here. Many patients expect that a pill or a shot will cure whatever is wrong with them, thinking that, in America, certainly there is medicine to cure everything. While many are familiar with infectious diseases that were common in their former home, they know little about chronic disease. Health behaviors and attitudes may be influenced by cultural and spiritual norms of accepting one's fate as God's will. In many cultures elders or family members are the decision makers and must be consulted for any important medical matters that can compromise treatment and frustrate time-constrained American physicians. These elders often base their decisions upon the needs of the community as a whole in addition to what is best for the individual. Overall, patriarchal thinking is common, and talking about sexual health is taboo. These many differences in health-related behavior can delay and complicate care in the Western system.

3. *Logistic barriers.* The ability to maneuver through the bureaucratic and administrative maze commonly found in modern hospitals and clinics is essential for accessing clinical resources. Navigating these systems is not easy for many of us who were born here, and for the foreign-born these complex networks can cause feelings of confusion and hopelessness. Western medicine works best for the compliant, sophisticated user who has time to spare and understands that he or she must go to 1 room for a blood draw, another room to get a prescription, and yet another to see the doctor, only to get a referral to see a specialist.

Unreliable transportation systems, inflexible work hours, and night time or multiple shifts make it difficult for most newly arrived foreign-born workers to keep strict Western style medical appointments. This is compounded by the fact that minority patients are more likely than whites to live in communities with fewer physician offices [4].

4. *Societal barriers.* Many foreign-born refugees feel marginalized in American mainstream society, sensing they are not a part of it and acknowledging that they do not understand it. Physicians and community workers must work actively to develop respect for varying languages, skin color, personal beliefs, and cultural traditions in order to deliver sensitive and effective health care services. The Institute of Medicine report, *Unequal Treatment*, concurs with this line of thinking:

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patient's insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants...[5].

Some foreign born, especially those who are undocumented, may avoid seeking health care until illness or injury has reached emergency levels, hoping to avoid contact with "the government" or "the system" for fear of deportation.

Last year Minnesota concluded a 2-year Immigrant Health Task Force that looked into improving health care for the immigrants of Minnesota. The task force came up with 8 recommendations for improving access to and higher quality of health care for immigrants [6].

1. Provide equal access to care for all, regardless of immigration or insurance status.
2. Collect information on race, ethnicity, and language preferences of all patients and on health care organizations' ability to meet the needs of immigrant patients.
3. Eliminate financial disincentives to health care for recent immigrants.
4. Diversify the health care workforce to include more immigrant and minority providers.
5. Use trained interpreters.
6. Develop clinical guidelines and best practice orders for immigrant health care.
7. Use community health workers, bilingual, bicultural individuals to serve as a bridge between the health care system and immigrant patients.
8. Train physicians and other staff on immigrant health issues and best practices and teach immigrant patients how to navigate the Western health care system.

These recommendations, the rationale behind them, and the practical steps listed in the full report offer guidance in focusing efforts to effect change. While implementing these recommendations presents significant challenges, projects at every level raise awareness and build capacity for next steps.

References

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Additional Resources

www.hmongnet.org. This site serves as a gathering place for references to Internet resources and is aimed at anyone seeking more information about the Hmong people.

www.learnaboutmong.org. A unique multicultural education site devoted to teaching about the Hmong experience for the purposes of promoting cross-cultural awareness and understanding. *Learn about Hmong* is also intended to provide greater exposure to the Hmong folk arts tradition.

<http://www.diversityrx.org/HTML/DIVRX.htm>. Diversity Rx. Promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities.

<http://www.omhrc.gov/clas/>. Recommendations for national standards for culturally and linguistically appropriate services (CLAS) in health care. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

www.Ethnomed.org. This site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle or the US, many of whom are refugees fleeing war-torn parts of the world.

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