

Developing Cultural Agility between Emergency Medical Providers and Vietnamese-Americans

in Santa Clara County

A Project Report

Presented to

The Faculty of the Department of Anthropology

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By

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The Undersigned Graduate Committee Approves the Project Report Titled

DEVELOPING CULTURAL AGILITY BETWEEN EMERGENCY MEDICAL PROVIDERS

AND VIETNAMESE-AMERICANS IN SANTA CLARA COUNTY

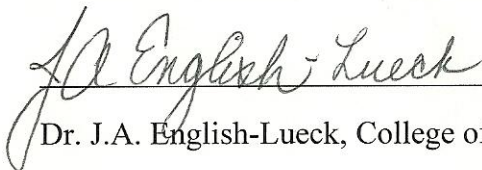
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Respectfully, Jason Vega

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Abstract

The overall goal of this project was to develop an informative guide that could be used to assist emergency medical providers while interacting with Vietnamese-Americans in an emergency medical context. This project report documents the process of the guide's development that is intended for prehospital emergency medical providers that work within Santa Clara County. The purpose of the guide is to develop and/or increase the cultural agility of prehospital medical providers in the context of delivering emergency medical care to Vietnamese-Americans. The finished product describes medically relevant aspects of sociocultural differences regarding patient/provider interaction, traditional Vietnamese theories of disease causation and transmission, and traditional Vietnamese theories of health, treatment, and healing.

The guide was informed by: 1) gathering data from semi-structured and non-structured interviews with Vietnamese-Americans, emergency medical providers, and both medical and cultural authority figures working in Santa Clara County; and 2) gathering relevant information from supplementary sources on Vietnamese traditional medicine such as literature, previous published reports, and public and government sources. The data was provided in a user friendly manner on the social network: facebook, in order to encourage user frequency and gain user feedback. The overall goal of the guide was to enhance cultural agility in an emergency medical setting.

I. Introduction

In the spring semester of 2011, I sat down with my graduate committee to discuss a potential graduate project. Since I have been involved in the emergency medical services in Santa Clara County for the past 11 years, I wanted my project to utilize anthropological methods to address the issues of cultural agility in emergency medicine, specifically within the Vietnamese-American community in Santa Clara County.

The creation of an informative guide that addressed cultural agility in emergency medicine would benefit both the EMS and Vietnamese-American communities. The EMS community benefits by having an increased understanding of Vietnamese-American health ways, social etiquette and beliefs, which in turn allow them to more effectively develop treatment strategies for Vietnamese-Americans and increase the quality of medical care. The Vietnamese-American community benefits through the reduction of barriers to health care that are influenced by socio-cultural confusion and discrimination.

I wanted to explore any barriers to emergency healthcare that members of the Vietnamese-American community experience here in Santa Clara County and chose to focus on this population for several reasons. First, the Vietnamese community in Santa Clara County is one of the largest of its kind in the nation (SCCDPH 2011), which makes it very likely for EMS providers to encounter Vietnamese-American patients in an emergency medical context. Second, traditional Vietnamese medical concepts such as health, illness, and treatment, are different than those of bio-medicine, which can cause confusion and misunderstanding between EMS providers and patients, as well as patient non-adherence to bio-medical treatment (Buchwald et al. 1992, Conrad 1985). Finally, according to the 2011 Santa Clara County Vietnamese Health Assessment

conducted by the Santa Clara County Department of Public Health (SCCDPH), Vietnamese-Americans have serious socioeconomic disadvantages that limit access to healthcare and may potentiate health conditions (SCCDPH 2011). The top three health issue priorities for Vietnamese-Americans living in Santa Clara County, as stated in the SCCDPH's report, are: health insurance and healthcare access, mental health, and cancer and cancer screening. These three health issue priorities illustrate that there are indeed barriers to healthcare for Vietnamese-Americans in Santa Clara County. I elaborate on these issues more in section II and describe their relevance to the health outcomes of Vietnamese-American patients.

The health issue priorities mentioned above, combined with unfamiliarity and limited access to the county healthcare system, creates a large potential for the existence of barriers to healthcare between EMS providers and the Vietnamese-American community (SCCDPH 2011). In order to effectively illustrate the socioeconomic and cultural condition of Vietnamese-Americans living in Santa Clara County in regards to health, I chose to divide this report into different sections that describe the different facets of Vietnamese-American society that influence their health ways and belief systems.

This report is divided into eight sections that examine the overall medical conditions and barriers between the Vietnamese-American community in Santa Clara County and the EMS community of medical providers. In section one, I illustrate some benefits of developing cultural agility among emergency medical providers along with some demographic information on the Vietnamese-American community in Santa Clara County, which emphasizes the need for increased cultural sensitivity and agility on the part of emergency medical providers. I discuss the waves of Vietnamese immigration to the United States and emphasize the conditions of

immigration and the effects that re-settlement and acculturation has on Vietnamese-Americans and their health status.

The second section clarifies the socioeconomic factors that create barriers to healthcare and limit social mobility for Vietnamese-Americans. I discuss these factors in order to emphasize the importance of increasing cultural agility and other cultural resources that reduce barriers to healthcare, not just for Vietnamese-Americans, but for all immigrants. The section also illustrates how health and illness are connected to socioeconomic conditions and education in order to draw parallels to the socioeconomic and educational condition of the Vietnamese-American community in Santa Clara County and how those conditions factors into their overall health status.

Section three illuminates the research methodology and interview protocol that used for this project. I give a detailed description of the goals for the project, the project timeline and budget, how and why the sample populations for the interviews are obtained and protected, as well as the limitations of the project's design.

The fourth section of the report contains the results of the interviews and their relevance to the creation of the informative guide. The interviews aim to understand: what barriers to healthcare, if any, exist for Vietnamese-Americans from the perspective of EMS providers, Vietnamese-Americans, and both medical and cultural professionals; and how these groups perceive the concepts of health, illness, and treatment.

In section five, I review the history of traditional Vietnamese medicine and the influence it has on contemporary Vietnamese-American medical treatment. I discuss the basic concepts and theories behind Vietnamese medicine, the influence that traditional Chinese medicine has on

it, the southern and northern schools of Vietnamese medicine, and the common medical treatments and procedures used in contemporary practice.

The sixth section introduces the finished product of the guide and how the information is disseminated to the emergency medical providers of Santa Clara County. I explain why I chose to use the social network facebook to communicate with the intended audience. It is a choice that has advantages and disadvantages, and those will also be discussed in this section. Section seven contains my future plans and intended actions for the guide. I describe my aspirations for the guide's use, effectiveness, and maintenance, as well as what factors determine if the guide was effective and useful for providers.

The eighth and final section of the report illustrates the limitations of the project. Also discussed is what future research may be done in order to expand on the topic of cultural agility in emergency medicine and cross-cultural healthcare.

Subsection 1.1 describes the background of the project and the significance that this project has for both EMS and Vietnamese-American communities. In this section, I emphasize the role that culture plays in delivering quality emergency medical care and argue the importance of cultural agility.

1.1 Background and Significance of the Project

Quality patient care is arguably the dominant priority, aside from personal safety, in emergency medical service (EMS). In order to provide the most appropriate and competent medical care at the best quality, it is not only necessary for EMS providers to effectively communicate with their patients, but also have a basic understanding of cross-cultural medical concepts and terminology about health and disease.

The lack of knowledge about a patient's culture limits the quality of health care that EMS providers can give (Caligiuri 2012). Therefore, the practice of effective cultural agility must be paramount in a culturally diverse area such as Santa Clara County, which is comprised of 35% Caucasian/White, 32% Asian, 27% Hispanic, 2.3% African-American, and 3% other/not listed (SCCDPH 2011). The ethnic distribution of the county is illustrated in Figure one¹.

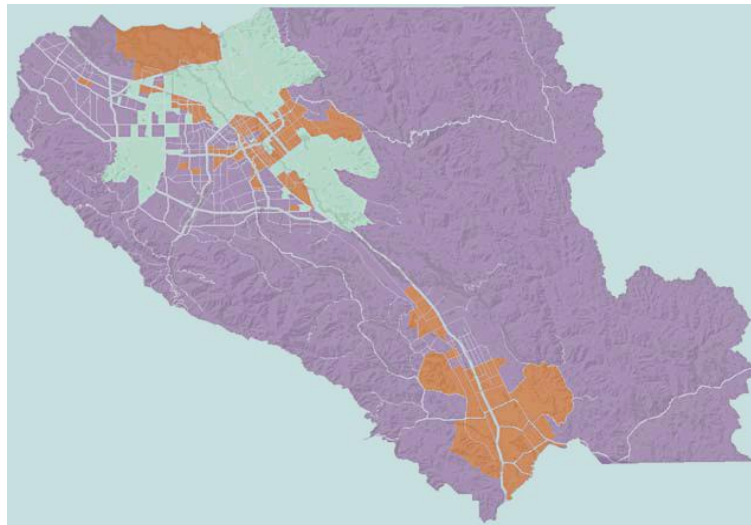


Figure 1: Racial/ethnic plurality in Santa Clara County by census tracts. The green color represents Asian ethnicities, while the orange represents Hispanic and the purple represents Caucasians. Courtesy of the Santa Clara County Department of Public Health.

Culture, defined by the medical anthropologists Pool and Geissler, (2005) is an ideational system or systems of shared beliefs, ideas, customs, rules, and meanings that underlie the way people live. By this definition, the concept of culture influences a population's perception of what constitutes a disease or illness, how disease and illness are transmitted, and the definition and meaning of medicine and treatment (Jenkins et al. 1996, Kleinman 1980, Pool and Geissler

¹ Figure 1 illustrates that the majority of Asian-Americans reside in the populated urban areas of the county, while Caucasians are mostly located in the suburban and rural periphery.

2005, Sobo and Loustaunau 2010). Knowledge of cultural backgrounds, values, and attitudes of the patient are indispensable for health care providers who wish to deliver healthcare that is culturally comprehensible and relevant. Therefore, it is of the utmost importance that emergency medical providers are culturally agile in patient interactions and treatments.

Cultural agility, as defined by Paula Caligiuri, (2012) is “the mega-competency which enables professionals to perform successfully in cross-cultural situations. Culturally agile professionals succeed in contexts where the successful outcome of their jobs, roles, positions, or tasks depends on dealing with an unfamiliar set of cultural norms—or multiple sets of them.” From a medical standpoint, possessing cultural agility can assist emergency medical providers in developing effective treatment plans that are culturally appropriate and respectful to patients, thereby reducing social and cultural barriers that may exist between the two parties (Caligiuri 2012).

Improving cultural agility involves understanding how socioeconomic and cultural conditions factor into barriers to healthcare and overall health status. In subsection 1.2, I specifically discuss these conditions and illustrate how the waves of Vietnamese immigration to the United States influence cultural isolation and American attitudes towards Vietnamese-Americans.

1.2 Santa Clara County Vietnamese Demographics

Demographic information for Vietnamese-Americans living in Santa Clara County is provided to highlight some of the historical, socioeconomic, cultural, and health disparities that exist for the Vietnamese-American community compared to other residents of different ethnicities residing in the county. Much of the demographic information provided in this section

is courtesy of the *Status of Vietnamese Health: Santa Clara County, California 2011*, a report conducted by the Santa Clara County department of public health in 2011.

The Vietnamese-American population in Santa Clara County is the second largest in the United States, surpassed only by Orange County, California (SCCDPH 2011). According to the 2011 Santa Clara County Vietnamese Health Assessment, the Vietnamese population of the county has substantially grown in the past few decades, being approximately 11,717 persons in 1980 and 134,525 persons in 2010 (SCCDPH 2011). This population level raises the probability of EMS providers encountering Vietnamese-American patients in the field.

In contrast to other Asian-American minorities living in the county, the Vietnamese community faces significantly large socio-economic challenges, as one out of every ten Vietnamese families in Santa Clara County lives in poverty (SCCDPH 2011). Poverty is a condition, which will be discussed at length in section II, which exacerbates poor health conditions and increases the potential occurrence and frequency of medical emergencies (Adler et al. 1992, Farmer 2005, Sobo and Loustaunau 2010).

According to the 2009 Behavioral Risk Factor Survey conducted by the Santa Clara County Department of Public Health, the Vietnamese-American community in Santa Clara County contains the highest rate of adults who have ever had a heart attack, angina/coronary artery disease, or stroke, as illustrated in Figure two. This directly relates EMS providers in that they are very likely to encounter Vietnamese-American patients that are having acute myocardial infarctions or infarction like symptoms. Therefore, it is important for EMS providers to recognize how Vietnamese-Americans culturally and socially present with the symptoms of a heart attack and/or angina.

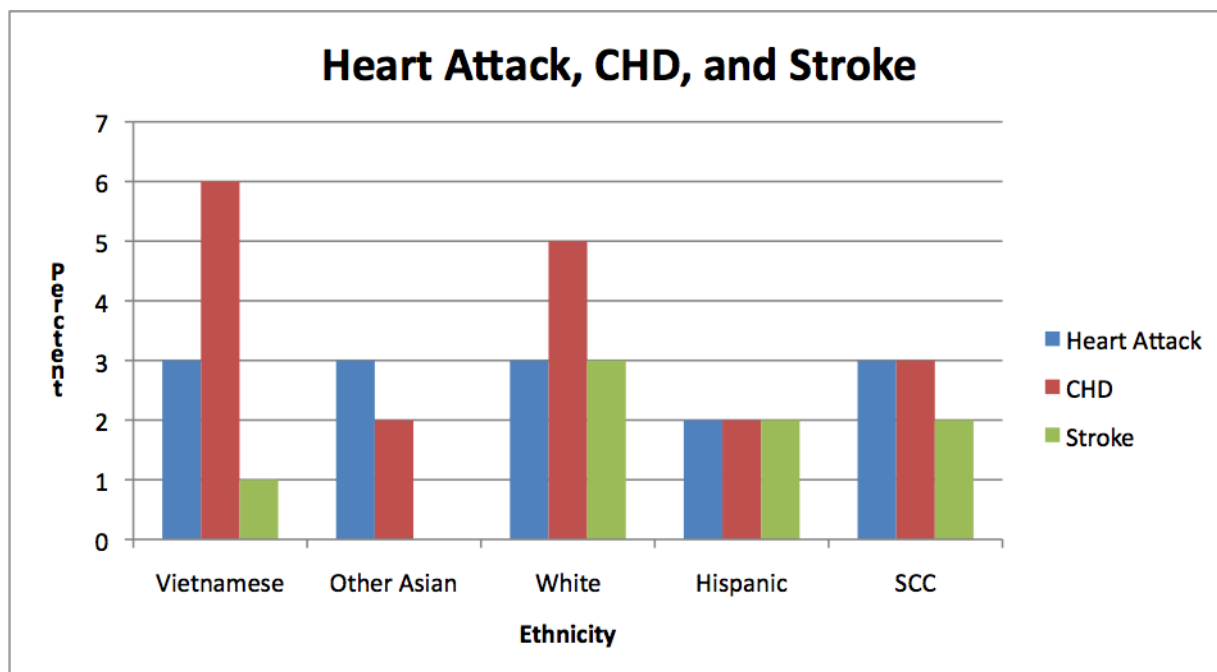


Figure 2: Percent of Adults who have ever had a Heart Attack, Angina/Coronary Heart Disease, or Stroke by Ethnicity. The Other Asian group includes Pacific Islanders. (SCC) is the population of Santa Clara County as a whole.

The Vietnamese-American community also has the third highest rate for diabetes as illustrated in Figure three; and the highest rate in the county (56 out of 100,000 people) for clinical tuberculosis infection when compared to all other minorities born outside the U.S. that currently live in the county (SCCDPH 2011). These statistics affect EMS providers in the recognition of diabetic emergencies within the Vietnamese-American community and the recognition of tuberculosis symptoms in order to don appropriate protective equipment.

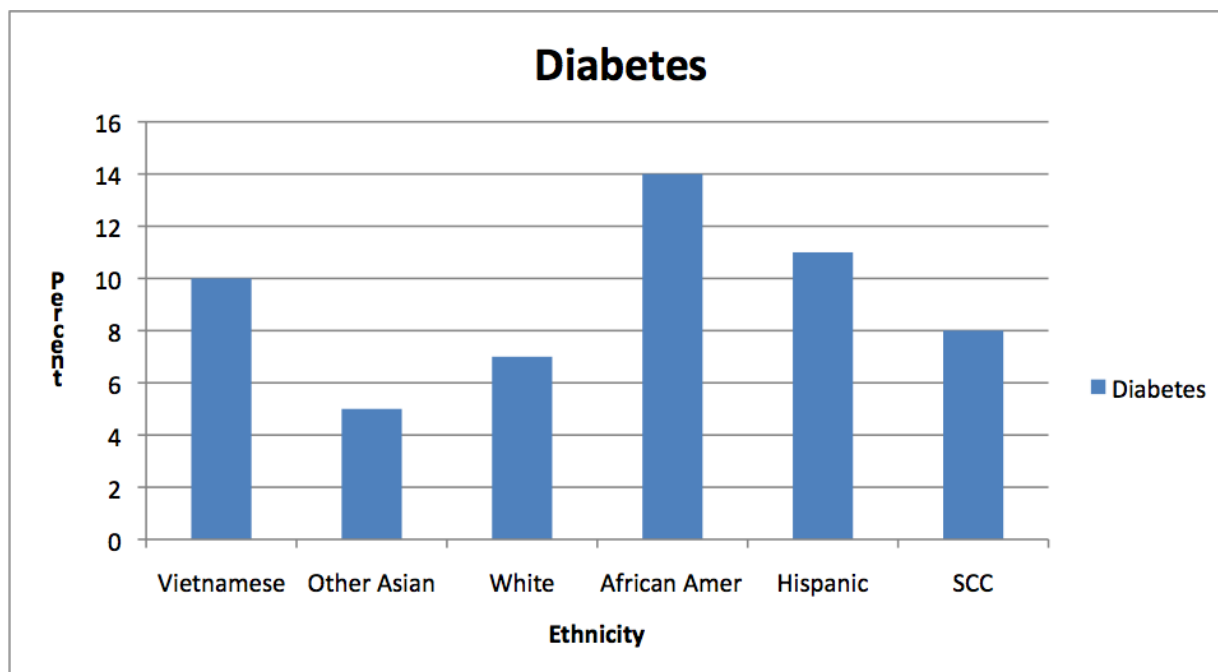


Figure 3: Percent of Adults with Diabetes. The Other Asian group includes Pacific Islanders. (SCC) is the population of Santa Clara County as a whole.

In 2011, one in four Vietnamese-Americans living in Santa Clara County lacked healthcare coverage, which was a higher proportion than for adults in the county as a whole in 2009 (SCCDPH 2011). The lack of healthcare coverage is a factor in how long chronic and acute health issues go unnoticed and/or untreated, which can influence the severity and frequency of emergency medical calls (SCCDPH 2011). Even for those Vietnamese-Americans that do have health coverage, to navigate the county healthcare system can be a barrier in itself. Vietnamese community leaders in Santa Clara County have indicated that the automated voice messages that are often encountered when a person tries to establish a medical appointment or gather medical information make it difficult to reach someone who speaks Vietnamese. Even if a person bypasses the automated voice message system, most receptionists or operators do not speak Vietnamese (SCCDPH 2011).

Only about 57% of Vietnamese-American women ages 21 to 65 that did not have health coverage received pap smear tests every three years as recommended to screen for cervical cancer, compared to 78% of women with health coverage. 56% of Vietnamese-American adults ages 50 to 75 met the national screening target for colon cancer prevention (SCCDPH 2011). The 2011 incidence in mortality rate for liver cancer in Vietnamese-American adults residing in Santa Clara County was four times higher than adults in the county as a whole. Vietnamese immigrants are also known to have higher rates of Hepatitis B, which is a big risk factor for liver cancer (SCCDPH 2011). The high incidence of cancer and liver diseases among the Vietnamese-American community is relevant to EMS providers because these illnesses may be projected as pain in the surrounding areas of the body, may exacerbate other illness and injury, and also pose infectious risk to providers.

Some of the most common barriers to healthcare that exist for Vietnamese-Americans in Santa Clara County are language barriers and socio-cultural barriers (SCCDPH 2011). These barriers limit and impede access to healthcare by socially and economically isolating Vietnamese-Americans from the services available to them (Ojeda and Bergstresser 2008, SCCDPH 2011).

The health disparities and barriers to healthcare mentioned above are but a few examples in the Vietnamese-American community of Santa Clara County (SCCDPH 2011). In the next sections I discuss some of the socioeconomic and cultural factors that influence the Vietnamese-American community's overall health status and access to healthcare.

Not all Vietnamese-Americans that live in Santa Clara County come from the same sociocultural, educational, and geographical backgrounds. In order to fully comprehend their

social, economic, and cultural disposition, it is important to understand the sequences in which Vietnamese immigrants came to the United States and how these sequences directly relate to socioeconomic status, acculturation, and access to healthcare. These sequences are discussed in subsection 1.3.

1.3 Vietnamese Immigration

Vietnamese immigrants have migrated to the United States for decades and still do so. However, between 1975 and 1995, the United States saw an exponential influx of Vietnamese immigrants largely due to escalating social and political conflicts within Vietnam (Vo 2006). Prior to 1975, the Vietnamese representation in the United States was significantly smaller compared with other Asian ethnic populations (Vo 2006). Immediately following the fall of Saigon in April of 1975, the first wave of Vietnamese immigrants resettled in the United States. Approximately 125,000 immigrants, mostly comprised of educated middle to upper-class Vietnamese citizens that supported the US during the Vietnam War and feared reprisal from the new communist government, were airlifted out of Vietnam (Vo 2006). This group faced American hostility associated with the Vietnam War and discrimination in attempting to resettle in the American social and occupational fields (Vo 2006).



Figure 4: An example of Vietnamese immigrants known as “The Boat People.” Courtesy of http://www.historylearningsite.co.uk/uploads/pics/boatpeople_005.jpg

The second wave of Vietnamese immigration occurred from approximately 1977 to 1980. Nearly 2,000,000 Vietnamese citizens attempted to evacuate Vietnam during this time (Vo 2006). Travel by boat was the most practical method to escape the country for most working class people. Thus, the immigrants in this wave of immigration became known as “The Boat People.” The boat people were comprised of Vietnamese of different socioeconomic statuses. The majority were small business owners, farmers, and laborers that were fleeing from the economic, political, and agricultural reforms in Vietnam. Many of the immigrants were ethnic Chinese Vietnamese that were being persecuted by the new government (Vo 2006). Figure four illustrates the typical overcrowded conditions that the boat people endured.

The boat people of Vietnam suffered unspeakable tragedies while attempting to escape the country. Many of the outbound ships and vessels that carried the immigrants were raised and sunk by pirates or captured by the Vietnamese coast guard (Vo 2006). Those immigrants who

survived and escaped were detained for long periods of time at refugee camps in Thailand, Malaysia, and Hong Kong before being sponsored and brought to the United States (Nguyen and Nguyen 2012, Vo 2006). According to Jackie Mac, who is a Vietnamese-American immigrant survivor of a boat that was hijacked by pirates, when pirates hijacked a boat, they would kill all of the men on board, rape the women, and throw the children overboard.

As refugees, many of the new Vietnamese immigrants arrived in a state of socioeconomic, political, emotional, and cultural shock (Vo 2006). Regardless of whatever economic class or educational background immigrants possessed, most Vietnamese lost the majority of their material possessions, social status, and wealth (Nguyen and Nguyen 2012). They had to build a new life for themselves in a foreign country that had foreign customs.

Most Vietnamese-American children born in the US are raised in families that are comprised of Vietnamese immigrants, first, and second generation Vietnamese-Americans (Vo 2006). Being such a new ethnic population in the US in comparison to other Asian-American ethnicities, Vietnamese-Americans face unique socioeconomic and cultural barriers in adapting to American life, which in turn influence their access to healthcare and other public services (Nguyen and Nguyen 2012, Vo 2006).

II. The Relation of Socioeconomic Factors to Vietnamese-American Access to Emergency Healthcare

Healthcare conditions that at first glance seem related to ethnicity may actually be due to poverty conditions and thus, related to social and economic status (Sobo and Loustaunau 2010, Yu 2009). When considering the factors that contribute to the health perceptions and healthcare access of Vietnamese-Americans, it is important to examine the structural and financial barriers

that limit their social mobility through ethnic discrimination, income, sex, age, and religion (Purnell and Paulanka 2004).

Many Vietnamese immigrants living in Santa Clara County face a unique set of socioeconomic problems including dissimilarity in cultural values and perceptions, lack of social capital or networks, and negative identification with the Vietnam War (Nguyen 1985). Likewise, many Vietnamese immigrants are refugees and their expatriation unplanned and often tragic (Morrissey 1983, Purnell and Paulanka 2004). Language and culture barriers make it equally difficult to find work outside the service industry, which reinforce American social models of specific ethnicities being inherently tied to service work (Strathmann and Hay 2008). All of these conditions and factors affect Vietnamese-Americans' access to, perceptions of, and expectations of healthcare.

In subsection 2.1, I discuss how socioeconomic status relates to overall health status through impeding access to expensive medicine, medical treatment, and preventative appointments. Also discussed, is how social and economic statuses influence the lifestyles that people live and the public perceptions of low income families.

2.1 Socioeconomic Status

Social status in the U.S. is generally measured by a combination of income, occupational prestige, and educational variables (Sobo and Loustaunau 2010). Therefore, one of the first things that needs to be better understood is the range of social status groups among Vietnamese immigrants in Santa Clara County in order to examine how the social structures influenced by both Vietnamese and American cultures have impacted immigrant outlooks on healthcare that create barriers between them and health care providers.

It is important to understand that aside from cultural differences, the social structures themselves are causal factors in health status, health perception, and access to medical care (Farmer 2005, Kleinman et al. 1978). While poverty influences the frequency of illness, frequent illness also influences impoverishment, as people with chronic conditions can be denied employment and insurance due to their illnesses. Chronic illness also financially burdens the already low income of an impoverished family (Farmer 2005).

In the United States, poor health, social status, and disability are often attributed to individual behavior and life choices, which overlook or ignore the influence of the social structures of a community (Farmer 2005, Sobo and Loustaunau 2010). The Vietnamese-American participant Solomon is a good example of how socioeconomic status can be a causal factor in health status. Solomon suffers from multiple chronic illnesses that require prescription medication to control. Solomon and his family struggle to pay for these medications due to their financial situation. He sometimes goes without medication because of his inability to pay for it and his belief that he can use other herbal remedies in place of pharmaceutical medication. Likewise, he stated that when he needs emergency medical care, he refuses much of the treatments due to his concerns of having to pay ambulance and care costs.

Social status largely influences lifestyle factors that relate to healthcare and related studies have shown marked evidence of a graded association with health at all levels of social status, even among American citizens (Adler et al. 1994, Yu 2009), revealing that even within the same culture a person's social status influences perceptions of what constitutes healthcare and medicine through types and methods of social programming around medical knowledge (Foucault 1972, Krieger et al. 1997). With difficult or no access to healthcare, Vietnamese-American immigrants utilize their native cultural knowledge of medical treatments, that are often

less expensive than biomedical treatment and culturally relevant to their perceptions of illness (Adler et al. 1994).

Economic status creates barriers for immigrants to healthcare by propagating the belief that they will be charged for the response and interaction of emergency medical providers, resulting in non-adherence to medical treatment in emergency situations (Adler et al. 1994, Sobo and Loustau 2010). It influences and can be influenced by social status and cultural beliefs, but as the sociologist Emile Durkheim states, this should not be assumed to be the case in every situation, as economic circumstance does not always determine social circumstance, and vice versa (McGee and Warms 2008).

Economic status is an important aspect to consider, as many traditional remedies utilized in place of biomedical pharmaceuticals are a result of not being able to afford health insurance and medicine (Buchwald et al. 1992, Jenkins et al. 1996, Uba 1992, Viladrich 2006). This is of course not to suggest that all traditional remedy usage is exclusive to the Vietnamese poor and un-insured, or that biomedicine is favored over traditional remedies. Rather, this statement suggests that some Vietnamese-American families are unable to use biomedicine, even when they prefer it over traditional medicine, because they cannot afford it (SCCDPH 2011). It is much more difficult for them to afford and access biomedical pharmaceuticals and biomedical treatment (Jenkins et al. 1996, SCCDPH 2011). Buchwald et al. (1992) suggest that Vietnamese-American populations of all socioeconomic statuses adhere to both traditional Vietnamese medical treatment and biomedical treatment, when available to them.

Subsection 2.2 illustrates how education levels influence health behavior and outcomes. I differentiate between formal education, which refers to institutionalized learning, and informal

education, which refers to learned experience. These types of education influence a person's knowledge of socially normative medical practices, risk behaviors, and preventative medicine (Kimbrow et al. 2008).

2.2 Education

Education is a powerful determinate of health behavior and outcomes, and in some cases may be the primary factor in health related issues and barriers to healthcare (Ihara 2009, Kimbro et al. 2008). It is therefore important to understand the education level and access to education that the Vietnamese-American community possesses. Access to education is largely related to and influenced by socioeconomic status as well as cultural background. The methods and languages in which education is taught may vary from culture to culture creating barriers and challenges for immigrants attending American schools (Ihara 2009, Sobo and Lousstaunau 2010). The level of formal education, which pertains to institutionalized learning, influences a person's knowledge regarding cultural concepts of medicine and health because, according to Durkheim, the main goal of institutionalized education involves the socialization of the human being, which infuses cultural models of learning and perception (McGee and Warms 2008). It is for this reason that the greater a person's level of formal education is, the greater that person's cultural understanding of normative medicine and health, as taught by his/her culture.

Informal education, which pertains to a person's empirical learned experience and social knowledge, also has a large influence on perceptions of medicine and healthcare, especially in immigrants that do not have high levels of formal education (Flores et al. 1999, Viladrich 2006). This type of education can be tied in with traditional cultural, religious, and social belief systems and practices that shape perspectives of medicine, healthcare, medical symptoms, and medical

etiologies (Conrad 1985, Horne et al. 2004, Ito 1999, Jenkins et al. 1996, Viladrich 2006). The level of Vietnamese immigrant acculturation to American standards may affect how much influence Vietnamese traditional informal education has on them, in regards to healthcare and medical treatment.

The information about socioeconomic status and education illustrates a parallel to health statuses and access to healthcare (Alder et al. 1994). However, this information is provided as a generalization and by no means applies to every Vietnamese-American living in Santa Clara County. Indeed, according to Dr. Karen Fjelstad, traditional Vietnamese medical techniques and treatments are practiced among all levels of education and social classes.

The information does suggest that impoverished individuals and families that lack high educational backgrounds and social networks are less likely to possess the social and cultural know-how to access biomedical care and biomedical pharmaceutical services (Jenkins et al. 1996, Uba 1992, Viladrich 2006). Rather, these individuals and families that have little to no access to biomedical healthcare are more likely to rely on traditional remedies, medicines, and treatments.

Section II illuminated how socioeconomic status and education levels may influence the health behaviors and outcomes of Vietnamese-Americans. While previous studies have shown that socioeconomic status and education can directly correlate to barriers to healthcare (Ojeda and Bergstresser 2008), I cannot directly assume that the same applies to the Vietnamese-American community in Santa Clara County without properly researching the issue. Section III illustrates the research methods and interview protocols that aim to understand what barriers to healthcare exist for Vietnamese-Americans and what factors create them.

III. Research Methods and Protocol

The research methods for this project included: 1) semi-structured interviews with emergency medical providers, cultural/medical professionals, and Vietnamese-Americans regarding aspects of patient care, medical beliefs and traditions and 2) data collection from relevant published literary sources and reports. The approaches to this research were informed by the methods described by H. Russell Bernard (2011) in his book *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. These approaches pertained to the formulation of questions for the interviews and research protocol. For example, I sequenced the questions starting with the most descriptive and moving to more abstract ones, used open ended questions and avoided those that could be answered simply with a yes or no, and used my questions to elicit stories from the actual experiences of the participants. Other anthropological methods, such as note taking, sampling, and research design came from Pelto and Pelto's *Anthropological Research*.

The preliminary research focused around several research questions that aimed to examine and increase the level of cultural agility and humility among emergency medical providers in cross-cultural emergency situations. All informant participation was based on informed consent.

Subsection 3.1 illustrates the characteristics of the population samples, how they were solicited, and why they were solicited. I mention what the criteria are for being a participant and the overall goals that the interviews aimed to achieve. Recruitment methods for participants are discussed for the Vietnamese-American, EMS provider, and professional group populations.

3.1 Population Samples

*Vietnamese-Americans*²

The criteria for selecting Vietnamese-Americans participants were designed to capture the maximum diversity in participant age, sex, education, and acculturation. I chose these criteria in order to examine any variation in participant responses according to these variables. While only seven Vietnamese-American participants were interviewed, there were a wide range of ages, acculturation levels, education levels, and sex. Recruitment for Vietnamese-Americans was accomplished through word-of-mouth by my discussion of the project with my Vietnamese-American co-workers and friends.

Seven Vietnamese-Americans were interviewed for a total of three females and four males. The population age range was from 25 to 85 years old and four out of the seven participants were born in Vietnam. The other three participants were born in the United States and were raised in traditional Vietnamese families. The three participants that were born in the United States all have college degrees. One of the four Vietnamese born participants has some college education, while the other three have high school education or lower. The Vietnamese born participants come from the Vietnamese cities of Saigon, Hue, and Da Nang. All of the participants spoke Vietnamese as a first language and five of the participants spoke English fluently. A Vietnamese-English translator was used for two participants. Some of the demographics that were pertinent to the research criteria are illustrated in Figure five.

² Note: Ho Chi Minh City will be referred to as Saigon in this report because that is how all of the participants that were interviewed referred to the city.

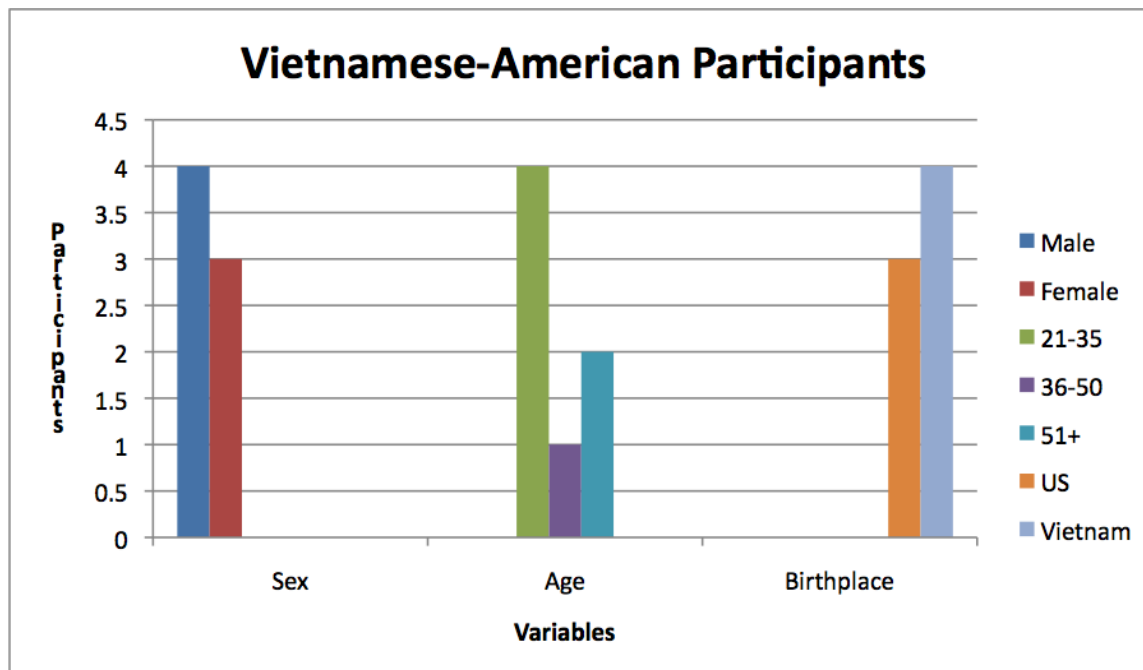


Figure 5: Demographics for the Vietnamese-American sample population

EMS Providers

The criteria for selecting EMS provider participants were designed to capture maximum diversity for the amount of field experience, age, sex, and occupational position (EMT or paramedic). I chose these criteria in order to examine any variation in participant responses according to these variables.

Emergency medical providers were solicited by me while they were off duty and in no way identifiable as emergency technicians or paramedics of specific ambulance companies or fire departments. Because of my affiliation with the emergency medical services, I am acquainted with many EMTs and paramedics working in the county, which made contact off duty possible.

Of the 22 interviewed EMS providers, five were female and 17 were male. 14 participants were paramedics and eight were EMTs. The population age range was from 20 to 55

years old. While the population sample consisted of multiple ethnicities, only three participants were born outside of the United States. 16 of the 22 participants interviewed have a four year college education. The population included emergency medical technicians (EMTs) and paramedics form multiple agencies in the County, which included private ambulance companies, the 911 contracted ambulance provider, and fire departments. Some of the demographics that are pertinent to the research criteria are illustrated in Figure six.

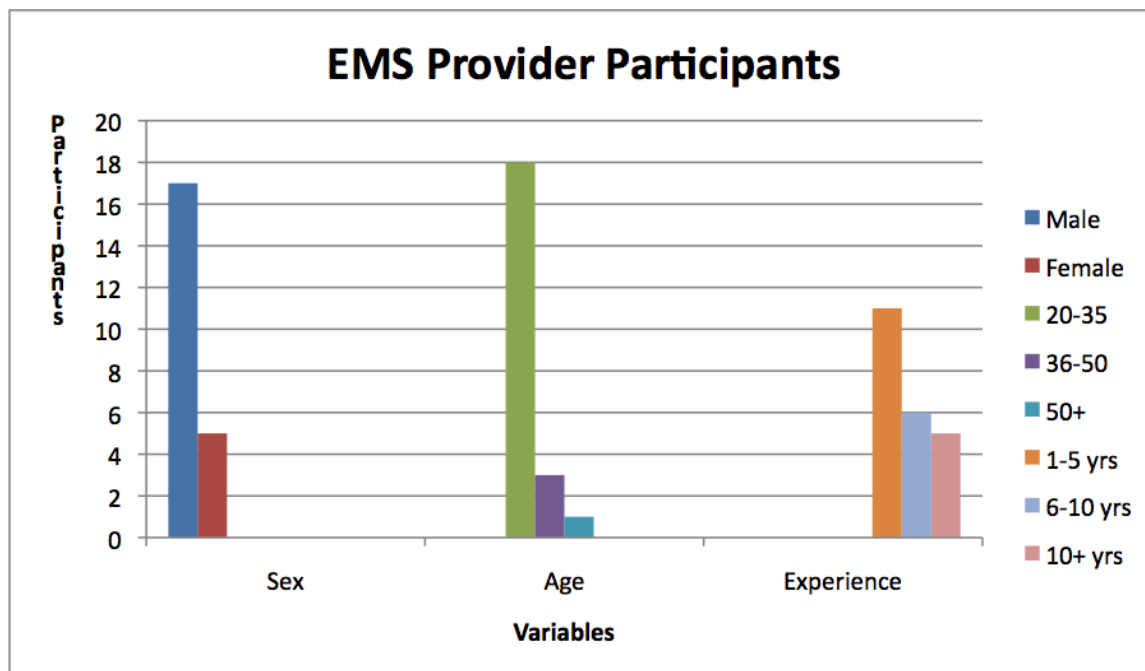


Figure 6: Demographics for the EMS provider sample population

Professional Group

The criteria for selecting both medical and cultural professionals were designed to maximize the diversity of sociocultural knowledge about the Vietnamese-American community in Santa Clara County, knowledge about biomedicine, and knowledge about traditional Vietnamese medicine. I chose these criteria in order to gain professional insights on the concepts of biomedicine, traditional Vietnamese medicine, and Vietnamese culture.

The professional group members were solicited by me through telephone calls and walk-in meetings. The sampling method for the professional group members is designed to capture maximum diversity of biomedical knowledge, traditional Vietnamese medical knowledge, knowledge about the American healthcare system, and knowledge about Vietnamese sociocultural norms.

The professional group consisted of four participants. All of the participants in this group gave their express permission to have their real names used in the report. Nam Pham is the deputy director of the Immigrant Resettlement and Cultural Center in San Jose, California. Dr. Mychi Nguyen is a medical internist who has knowledge of both traditional Vietnamese medical beliefs and treatments, and Western medical practices. Dr. Linh Dang is a medical general practitioner with knowledge of both traditional Vietnamese medical beliefs and treatments and biomedical practices. Professor Karen Fjelstad is a faculty member of anthropology department at San Jose State University and has a background in Vietnamese culture and Vietnamese spirit possession.

All participants were treated anonymously unless expressed permission was given to use actual titles and names. Participation was voluntary and completely dependent on participant approval. Each participant was fully informed about the nature of the research, what was required, any possible stresses and benefits, and that they had the right to withdraw without prejudice to their relations to San Jose State University. Consent forms included information that allowed participants to access the appropriate staff at San Jose State University if any problems were encountered. The participants were given pseudonyms that were made up by me which were used on all notes and recordings. Informed consent was collected for all emergency medical

providers and medical/cultural professional interviewees using a written consent form (found in appendix).

Since some of the target sample included people for whom English was not the primary language, both the protocol and all consent forms were translated into Vietnamese. Accuracy of translation was confirmed by Dr. Huyen Le and Dr. Hien Do. Both Hien Do and Huyen Le are professors at San Jose State University.

The participants read and signed either an oral or written consent form, which assured their understanding of what the research data was being used for and how it was protected. I verbally went over what the project entailed with each participant before interviewing them. A second signed copy of the consent form that included project information was offered to the participant at the time of interview for his or her records.

I opted to use oral consent forms because introducing a formal written consent form inhibited the process of creating genuine informative relationships with Vietnamese-American participants by giving me a false appearance of authority and expertise, and by giving the research a false appearance of narrow precision. Written consent forms have a tendency to undermine participants' abilities to direct conversation by positioning them as subjects to be studied rather than knowledgeable persons from whom the researcher is learning. Introducing written consent forms also tends to undermine the mutual trust which must be present in participant observation, an approach that depends on empowering people to determine their level of comfort in revealing information. This need for informality was particularly important in building trust among older Vietnamese-Americans, who are cautious of releasing information to cultural outsiders (Fjelstad 1995).

For this project, I worked to ensure that the people with whom I interacted were fully aware of their right to discontinue participation in the research (in which case I did not include them either in my field notes or in my subsequent writing). It was still important to obtain consent, which I did with an oral consent process. The documentation of oral consent, kept by me and the interviewee, fulfilled the spirit of informed consent without seeming intimidating or bureaucratic.

Semi-structured interviews were conducted with medical/cultural professionals, emergency medical providers, and Vietnamese-American patients and their families. Interviews with emergency medical providers and medical/cultural professionals included written consent, while interviews with Vietnamese-Americans included oral consent with written documentation signed by myself as confirmation that the interviewees are properly informed of their rights. The reason for this difference in consent was due to the sensitive nature of trust and suspicion among the Vietnamese-American community of cultural outsiders, and the professional and legal expectations of American medical providers.

I located themes within the data by clustering the transcribed interviews according to the stakeholder group and searched for three categories of data answering the research questions salient to my project goal. These questions were: 1. what are the cultural schemas that inform medical beliefs about health, illness, and treatment, such as explanatory models, or assumptions about individuality or family obligation? 2. In what areas are the conflicts between stakeholder beliefs and practices? 3. What solutions do people in each stakeholder group imagine would alleviate the situation?

All of the research was conducted in Santa Clara County. Vietnamese-American informants were found through snowball and opportunity sampling, and by their willingness to participate in the project. All informants were over 18 years of age and their identities remained and are to remain confidential. All informants were solicited by me while they were off work duty and off of the premises of their employers. Classroom announcements and flyers were used for soliciting informants at San Jose State University, but virtually no informant that participated in the project was recruited by such means.

The project was not without limitations and situations that required critical decision making. In subsection 3.2, I describe some of these limitations to the project design and decisions that I made in order to maximize the accuracy of the interview process and population representation. I also discuss my perspective bias due to my position in EMS and what I do to neutralize it.

3.2 Project Limitations and Decisions

There are several limitations and decisions regarding the project design that need to be addressed. First, the Vietnamese-American community is a difficult community to gain access to as a cultural outsider. I was able to solicit Vietnamese-Americans for the project through Vietnamese-American friends and coworkers. This confined the research to a specific Vietnamese-American subgroup of the larger Vietnamese-American community in Santa Clara County. The result of this small population sample may skew the perspective on what barriers to healthcare exist for Vietnamese-Americans living in Santa Clara County.

Secondly, the Vietnamese-American responses to my interview questions should be taken as the expressed opinions of those interviewed participants and not those of the Vietnamese-

American community at large. Even within the American healthcare system, the opinions and views of people and professionals differ on various healthcare topics. Some of the opinions expressed by the seven Vietnamese-Americans interviewed may not conform to what are considered the cultural norms in Vietnamese society. Also, as suggested in Dr. Karen Fjeldstad's doctoral dissertation (1995), some Vietnamese-Americans may limit or falsify their responses to questions, especially to cultural outsiders. Vietnamese-Americans are proud of their cultural heritage and any information or inquiries that are perceived by them to be culturally embarrassing or damaging to the reputation of Vietnamese people may be omitted or skewed in their responses to interviewers.

Thirdly, I am myself an EMS provider. Therefore, I approached this research from a somewhat biased perspective, which I aimed to lessen through the application of a concordant and logical research methodology and interview protocol. The research and interview protocol was developed in accordance with the San Jose State University Office of Graduate Studies and Research ethical standards, the American Anthropological Association, and the Society for Applied Anthropology.

Finally, the purpose of this project was to develop an informative guide for EMS providers, rather than Vietnamese-Americans living in Santa Clara County. Therefore, I found it necessary to interview more EMS providers than Vietnamese-Americans in order to identify the barriers to healthcare as perceived by the providers for whom the guide is being developed. Although the voice was small, it was important to include the seven Vietnamese-American participants in order to get a general idea of how some Vietnamese-Americans living in Santa Clara County perceive health, illness, treatment, and barriers to healthcare.

IV. Results and Discussion

The theme of the interviews surrounded the research questions of the project, which aimed to understand what factors contribute to the creation of barriers to healthcare for Vietnamese-Americans living in Santa Clara County, as well as to understand cultural perceptions of health, illness, and treatment. Although the interviews were conducted at separate times and with individuals belonging to three separate groups, i.e. EMS providers, Vietnamese-Americans, and professional group, their responses were grouped together in order to provide a comparative context and discussion.

Section IV is divided into two subsections which examine the perceived barriers to healthcare and perceptions of health, illness, and treatment. In subsection 4.1, I discuss the most common interview responses on the subject of barriers to healthcare. Those responses include language barriers, sociofamilial barriers, and cultural barriers. In subsection 4.2, I discuss the interview responses on the topics of health, illness, and treatment perspectives.

First, each of the groups discussed the barriers to healthcare as perceived by them, followed by their perspectives on health, illness, and treatment. The data gathered was used to inform the creation of the guide. One particular goal of the interviews was to understand what barriers to healthcare exist for Vietnamese-Americans living in Santa Clara County and how these barriers are perceived by EMS providers, Vietnamese-Americans, and other professionals.

4.1 Barriers to Healthcare

Language Barriers

Language was one of the most common themes in the interviews on the subject of barriers to healthcare. Language barriers arise in emergency medicine when EMS providers attempt to provide medical care in a language discordant situation, i.e. when EMS providers and patients speak a different language (Segalowitz and Kehayia 2011). These situations create problems in several ways for both EMS providers and Vietnamese-Americans. The most obvious problem identified from the interviews was unclear communication between Vietnamese-American patients and EMS providers. Non-English-speaking patients have problems relaying their medical symptoms to EMS providers and likewise, EMS providers have problems relaying what their concerns and questions are to the patients (Segalowitz and Kehayia 2011).

Part of this problem can be explained by the ways in which Vietnamese people act and react to the culturally unfamiliar questions and body language of American EMS providers (Chomsky 1975). According to the linguist Noam Chomsky, people act in “systematic ways with respect to the objects around them... and use and respond to expressions in organized ways” (Chomsky 1975:139). If the expressions and language of EMS providers are things that are culturally and socially alien to a Vietnamese-American medical patient, then their systematic and organized responses and reactions may break down (Chomsky 1975).

Another problem frequently discussed in the interviews that relates to language barriers was the patient’s necessity for a translator. In emergency medical services, there often exist language translation services via a radio or cell phone that EMS providers can use in circumstances involving non-English-speaking patients. If no translation services exist, as is currently the case in Santa Clara County, EMS providers may utilize a patient's friends and/or family members as translators, given that they speak English. This in itself is problematic, as different levels of Vietnamese language competency exist among the Vietnamese community.

Even if a patient has family members or friends that can translate English to Vietnamese and vice versa, this does not necessarily mean that that translator has the lexical competency to fully understand and accurately translate medical terminology.

The use of a patient's family member becomes especially troublesome when a family member is a first or second generation Vietnamese-American. Culture and language are directly connected to each other in terms of problem perception (Priya 2012, Shore 1996). According to Shore (1996), when considering cultural influence it is the method in which problems are described and handled that is important, rather than the problem itself. This is important to consider in situations in which a first generation Vietnamese-American is translating for a relative. The family member speaks Vietnamese fluently but has been raised in the United States, a socio-cultural environment that is ideologically different than that of Vietnam (Kleinman 1980, Shore 1996). Divergent sociocultural perceptions and absence of a common cultural environment between the patient and family member may render the patient's description of the medical issue incomprehensible to the family member. As a result, they may fail to fully fathom each other's perceptions of the problem (Priya 2012).

I have personally experienced this phenomenon myself as a paramedic. In my situation, the Vietnamese patient's granddaughter was translating for her. The patient would try and explain to the granddaughter the problem she was having but the granddaughter was having trouble understanding what her grandmother meant. The granddaughter looked at me and said "I understand what she is saying but it does not make sense to me." The granddaughter spoke English without an accent of any kind and wore clothes fashionable to American styles, which suggest she was born and raised in the United States.

There are situations in which EMS providers have no translators available. These situations are especially troublesome for both EMS providers and patients alike, as non-English-speaking patients cannot communicate what is wrong to EMS providers. The paramedic, Sara, commented on an emergency call that she remembered:

“There was one call where we had this old lady who was home alone with her husband, neither of whom spoke English. The lady was obviously having difficulty breathing, which we treated of course, but we couldn't figure out if the underlying cause of her shortness of breath was cardiac, pulmonary, neurological, Etc... I sent (my EMT) to look for any medication with her name on it that could give us an idea of her medical background but we couldn't find anything and I don't think the husband liked us looking around the house without knowing what was going on...It was a bad situation. It gets to be really frustrating.”

Many EMS providers mention their concern with the absence of an established language translation service. Cathy, who is an EMT that has worked in the County for nine years, commented:

“Because of the fact we don't have a language line, a lot of times we're forced to use the patient's family members as translators in order to figure out what's going on...Sometimes it feels like we're violating patient confidentiality when we have to ask the family to translate personal information about the patient that the patient may not necessarily want them to hear, or may be embarrassed about.”

The paramedic, Rich, who has worked in the County for almost 15 years and remembers a time when a language translation service existed, commented:

“It's not rocket science man! In order for me to know what's going on with you, we have to be able to fucking communicate and understand each other. In order for you to know what I'm talking about, you have to understand me, get it? Now all that happens is we show up on scene and play the damn mime game to try and guess what the chief complaint is. It really is harder than it has to be and makes a lot of people mad, including the patient... Sorry about all the cussing but it makes me mad.”

Aside from frustrations with not being able to understand Vietnamese-American patients, EMS providers worry about being able to keep patients' right of medical confidentiality confidential. Patient confidentiality is an important issue in EMS that can be neglected in situations when a translator is needed. When speaking through friends or family members, Vietnamese-American patients may withhold or falsify information about symptoms that they find to be embarrassing or shameful. According to Dr. Mychi Nguyen, who is an internist at a medical clinic in the Bay Area, in traditional Vietnamese culture, to show pain or weakness is not considered to be a masculine trait, therefore it can be shameful or embarrassing for males that project pain or weakness, especially around friends and family. For female patients, symptoms that suggest pregnancy out of wedlock or issues that pertain to feminine problems may also be withheld in the presence of family members and friends. The paramedic, Tony, recalls a specific event in which a Vietnamese-American patient withheld information that related to his pain because he had to translate through his brother. Tony stated:

“I used the patient's brother as a translator because he was the only person that spoke English. I asked his brother to ask the him (the patient) if he was having pain. The brother asked him and he said he wasn't, but this guy looked like hell; pale face, grimace, and profusely sweating. I got the whole medical assessment of the patient done via translating

through the brother and transported the patient to Valley (Santa Clara Valley Medical Center). When we got to the hospital, where they have Vietnamese speaking nurses, I gave my turnover report to the nurse and she goes and talks to the patient. He immediately started crying and was telling her that he had this excruciating pain in his stomach. Now I look like a dumbass saying the patient has no pain. The nurse told me that he may have not wanted his brother to know that he was in pain.”

Many Vietnamese-Americans acknowledge that not being able to speak English is a problem, especially in a medical situation. Solomon, who was born and raised in Vietnam and speaks no English stated:

“I know it would be easier to be able to speak English. I try. My children and grandchildren try and teach me but I am old and I forget.”

Dr. Mychi Nguyen has this to say about how language affects patient/provider interactions in a medical emergency:

“I think that many Vietnamese-Americans who don't speak English very well, and especially the older ones who don't speak English at all, are very cautious and hesitant about calling 911. Most of them have had direct experience with language barriers; whether it be in an emergency setting or in some other setting of daily life and they realize the difficulties in trying to communicate. These difficulties can be very stressful in an emergency situation and also very intimidating when you think about all of the people that show up to your house when you call 911... Most Vietnamese have been raised to be very respectful to authority figures such as firemen and EMTs and may appear to be very passive with them... In a lot of situations Vietnamese people who don't speak English

very well or at all are more likely to deal with things inside the family before they resort to calling outsiders and for help.”

Of course language barriers are not just specific to the Vietnamese-American community, but to all of the non-English speaking communities in Santa Clara County. The language barrier problem for EMS providers seems to be partially propagated by two things: 1) the absence of a pre-hospital language translation service, and 2) the large number of Vietnamese-Americans in Santa Clara County who do not speak English, or cannot express health related issues in English very well.

One concern of EMS providers is the perception that patient confidentiality rights are being violated by having the English-speaking friends or family members of the patient translate what is being said. As has been stated, patients may falsify or downplay medical symptoms in order to avoid ridicule and/or embarrassment by friends or family. Another concern of EMS providers involves the barrier to patient care that is created by not being able to understand what the patient’s medical complaint is.

Language barriers can be greatly reduced simply by the provision of a language translation service for pre-hospital emergency care providers. Language translation services offer professionals that are certified in language competency specifically for the medical field. These services can bypass the need to have family members and friends of the patient translate and can create a direct line of communication between the patient and the EMS provider that is accurate and can be easily understood by both patient and provider.

Sociofamilial Barriers

According to Nam Pham, the Vietnamese-American family household is a collective unit and often makes important decisions as a unit rather than individually. In situations that pertain to the healthcare of a family member, the family household plays a central role. For this reason, EMS providers often interact with a Vietnamese-American patient's family as much, if not more so, than the patient.

In discussing family structures, it is important to differentiate between actual family households and idealized family households in order to understand what constitutes a “family unit” in both American and Vietnamese cultures. An idealized family household is a sociocultural image of what a family unit is supposed to consist of in any given culture. An actual family household is what a family unit consists of in reality (Naylor 1998).

The idealized family household of Vietnamese culture is a bit different from the idealized family household of American culture, largely due to Confucian ideals of respect for elders and ancestor veneration (Naylor 1998, Nguyen and Nguyen 2008). In general, the idealized family household of American and European cultures consists of two married individuals and their offspring (Morphy 2006). The idealized Vietnamese family household, according to Nam Pham, is much broader and complex than its American counterpart and may consist of two married individuals, their offspring, their offspring’s offspring, and sometimes other more distant family members.

Nguyen and Nguyen (2012) find that members of American family households are seemingly more independent in terms of family relations when compared to Vietnamese-American family households. One finding illustrates that Vietnamese-American adults that have

lived in the United States for at least 15 years, still hold traditional Vietnamese family concepts and values (Nguyen and Nguyen 2012).

The EMT, Allison, has many experiences with Vietnamese families in the context of emergency situations. She understands that Vietnamese families will all collectively make decisions about what is best for a family member who is a medical patient. If the patient is okay with having their family make decisions for them, she will abide by the wishes of the family members. She commented:

“The thing people need to understand about the Vietnamese is that when you treat a Vietnamese patient, you treat the entire family. If you think that you're going to do otherwise you're in for a rude awakening and a rough time... It's not uncommon to walk into a Vietnamese household and find 5 to 10 people in the room with the patient. It's best to try and cooperate with the family because not cooperating seems to just make a situation worse for everyone.”

EMS providers perceive Vietnamese patients' large family households to be problematic at times. They can demand to be immediately informed about the patient's status, sometimes even before the patient. I can say from personal experience, that EMS providers in the United States are trained to respect patient confidentiality and the patient's individual choice in regards to their medical decisions, so long as that patient is with sound mental capacity. Therefore, many EMS providers are concerned about discussing a patient's symptoms with anybody but the patient, his or her spouse, or with the patient's durable power of attorney.

Likewise, in situations that require a family member to translate for a patient, EMS providers are concerned when family members answer questions for the patient before

translating the question to the patient or giving the patient a chance to answer first. The EMT, Bobby, recalled a car accident in which he had to assess a Vietnamese woman with her husband present. He stated:

“It was kind of an all-around awkward situation. The lady spoke a little English but she was super quiet and super passive to all of my questions and assessments. Sometimes she wouldn't even answer me but just looked at her husband, and he would tell me that she feels fine. The guy was kind of staring at everything I did so I made sure that I was explaining out loud what I was doing and why I was doing it. I guess I can understand the guy doesn't want me touching his woman but it was just kind of weird. Towards the end I felt like saying, ma'am YOU have to tell me if something hurts, not your husband.”

The paramedic, Pete, recalled a time when a patient's family member told him that he was not going to tell the patient that he may be having a heart attack because he did not think it was necessary and would just be worrisome to the patient. Pete commented:

“It didn't sit well with me at all. Any person who is mentally capable of making their own medical decisions should be able to do so and they need to be informed of the situation and their options. We were having a hard enough time trying to convince the patient that he needed to go to the hospital and having his son withhold the information that he was possibly having a heart attack was potentially lethal and dangerous. It made our job a lot harder.”

The Vietnamese family household is deeply influenced by the Confucian concepts of reverence for ancestors, respect for the elderly, and obligation to parents (Nguyen and Nguyen 2012). Confucianism depicts the Vietnamese family's role as the root of stability and it is

incumbent on Vietnamese family members to live with such virtues as benevolence, obedience, righteousness, loyalty, and obligation to parents (Nguyen and Nguyen 2012).

Nam Pham, the deputy director of the Immigrant Resettlement and Cultural Center in San Jose, had this to say about the Vietnamese family unit in regards to involvement in medical decision making:

“Generally, most Vietnamese families want to be involved in any decisions made for someone that needs to go to the hospital... Decisions are made together as a family and not by one person or another. The reason for this is because of hospital and ambulance costs and everyone wants to understand what is going on.”

Many Vietnamese-Americans are concerned with the high costs of medical treatment, ambulance transport, and hospital bills. As Nam stated above, financial concerns play a large role in the decisions made by Vietnamese patients’ family members. According to Lindsay, when someone in her family needs to be hospitalized, the entire family will pool their financial resources in order to pay for the bills. She stated that because the entire family must share the burden of hospitals, they all feel that they should make decisions together.

Linh Dang, who is a general practitioner in the Bay Area, was born in the United States but raised in a traditional Vietnamese family. She had this to say about the Vietnamese family unit:

“You can think of the family as the first responders in most medical situations. When someone gets sick, most families, well my family anyways, will first try and take care of that sick person the way they know how, with herbal remedies, massage, and maybe something like coining... Most Vietnamese families don’t have the money to hospitalize

their family members so they do everything they can for a person and calling 911 becomes sort of a last resort thing.”

There is much concern among EMS providers with the level of involvement of the Vietnamese-American family wishes to have in patient care. It is generally perceived by EMS providers that the family members of Vietnamese-American patients are involved or want to be involved with patient care to the point in which they begin to interfere or disrupt medical care and treatment.

It alarms EMS providers that some family members and/or friends of Vietnamese patients that serve as translators refuse to translate critical information to the patient that they believe would devastate the patient's morale. EMS providers see this as being problematic because their line of communication to and from the patient is now being dictated by someone who can control what information the patient receives and does not receive.

It is beneficial for EMS providers to understand the cultural schema of the Vietnamese family unit in an emergency situation. EMS providers should make the appropriate cultural adjustments in their treatment strategies in order to interact with their patient's family to ensure the best possible outcome for the patient. This is one goal that the informative guide aims to develop.

Cultural Barriers

The interviews revealed some barriers to healthcare that resulted from cultural differences and misunderstandings. Some instances lead EMS providers to report suspected child and elder abuse to the police, while others left them with feelings of disgust, shock, and

confusion. Barriers like these can disrupt the trust between patient and EMS providers and cause feelings of tension, frustration, and discrimination among EMS providers.

The paramedic, Ali, recalled an incident in which his unit responded to a Vietnamese household where a baby was having difficulty breathing and had a high fever. When his unit arrived they found that the patient had bruises on his neck. The firefighter first responders, who were on-scene before his unit is, were yelling at what appeared to be the patient's grandmother and parents. Ali commented:

“When we arrived on-scene the kid was in his mom's arms and looked to be okay. The (fire department) was there and the medic was yelling at the grandma and parents pretty good. I asked the firefighters what was going on and they said that they walked in to find the grandmother giving the baby fucking hickies on his neck! I looked at the kid and sure enough he had bruising and shit all around his neck. I was like are you fucking serious? I didn't say that out loud of course but I'm sure my face showed it. They (firefighters) were telling the parents and the grandmother that doing stuff like that was not okay and that they could report this to the police. I don't think anything was ever reported... I don't know what the grandmother thought she was accomplishing but I really don't think she meant to hurt the kid.”

Ali's experience seems like it was dramatic for everyone involved. Ali, his partner, and the firefighters all seemed bewildered and annoyed by the actions of the grandmother. Likewise, the patient's family members may have been surprised and upset that they were being yelled at by the people that they called for help.

Traditional Chinese medicine (TCM) therapeutic healing procedures such as coining, cupping, moxibustion, and acupuncture are commonly used among the Vietnamese (Thế Giới Publishers 1999). Some of these procedures leave bruises, welts, and scars on the bodies of patients that undergo treatment for illness. These marks are commonly misunderstood for abuse by EMS providers that are not familiar with TCM concepts and treatments (Nguyen and Nguyen 2012). Indeed, medical providers are aware that many Vietnamese refugees and immigrants have a difficult time understanding the American condemnation of striking children, an act which is condoned in Vietnamese society as a means for parents to discipline their children (Nguyen and Nguyen 2012). This is not to suggest that Vietnamese-Americans frequently abuse their children and/or elders, or that they do so more than any other ethnicity, however, EMS providers do not hesitate to document and report suspicious markings that are unfamiliar to them found on the bodies of Vietnamese-American patients.

The paramedic, Stephan, recalled an event in which his unit responded to a call for nausea and vomiting. When he arrived at the patient's apartment complex he found an elderly man with his wife and son. Neither the patient nor his family spoke English very well and upon examining the patient Stephan found bruising along his back, shoulders, and chest. He stated:

“First of all, the guy looked fucking emaciated!! The only reason I did a secondary exam on him was because I noticed some bruising around his neck and I followed it all the way down his back and around to his chest. One of the firefighters said it looked like it might be from ‘coining’. I looked at (my partner) and he asked me if we should report this or not. The son was trying to explain something to me about the bruises but I didn’t understand him. I didn’t really know what to make of it so to cover my ass I reported it to the police and documented it in my report... I didn’t know what coining was at the time

and even now I would say it still looks like abuse. I mean, how many people can use the excuse that they don't beat their kids or their parents and say 'no man it's just coining'?"

From a Vietnamese perspective, Solomon perceives that EMS providers often times do more than what is needed to help him when he calls 911. Solomon's main concern is that all of the treatment and transport cost him money. He also mentioned concern and confusion over why EMS providers initiate some types of procedures like establishing intravenous lines. He stated:

"The EMTs and Paramedics always try and make me to go to the hospital, even after I feel better. I tell them no but they make me go anyways. Sometimes they poke me with needles many times and I want to ask why!.. They are always rude to me and never respect my wishes... You young people need to learn to respect your elders, even if they don't speak English."

Solomon's response is a perfect example of a cultural barrier to healthcare. On the one side, the EMS providers were frustrated that Solomon could not understand what they were trying to do and why they were trying to do it, while on the other side, Solomon was frustrated because he was worried about the costs of medical treatment and the disrespect of the young EMS providers towards him.

Another cultural barrier to healthcare stems from Vietnamese standards in social etiquette. Politeness is a very important factor in Vietnamese culture. So much so, according to Dr. Mychi Nguyen, that Vietnamese patients may tell EMS providers information that they think they would want to hear, rather than factual information that pertains to their emergency situation.

Dr. Karen Fjelstad has studied the Vietnamese spirit possession phenomenon and has familiarity with Vietnamese culture and society. From her interactions with Vietnamese individuals she has knowledge of the types of idealized social etiquette that traditional Vietnamese practice and expect. She stated:

“Just because a Vietnamese person responds ‘yes’ to a question, doesn’t necessarily mean that they mean ‘yes’. In Vietnamese culture, when you ask someone a question, they first respond ‘yes’, meaning ‘yes I hear you’. So someone could respond to a question saying ‘yes, I hear you’, followed by the answer to the question, which could be ‘no’.”

According to Nam Pham, rudeness is frowned upon in Vietnamese culture, especially rudeness towards authority figures and elders. He stated that Vietnamese patients that do not speak English may simply smile in response to a question, not because they are happy or because they think it’s funny, but because they do not want to appear rude and do not know what else to do.

Nam stated that in Vietnamese culture, younger generations are expected to show their elders respect and courtesy. To not do so is considered inappropriate and extremely rude. While this expectation is generally the same in idealized American social etiquette, it is much looser in comparison to idealized Vietnamese social etiquette. Lucy, who is an elderly Vietnamese woman, explained that even though she does not speak English, she could tell when EMS providers were poking fun at her through their body language. She stated:

“I don’t speak English but I am not stupid! I can tell by the way they (EMS providers) look at me and treat me. They think that I am stupid. Sometimes they will say something to each other and laugh, then look at me... They are very disrespectful.”

The data from the interviews illustrated that there are linguistic, sociofamilial, and cultural barriers to healthcare that exist for Vietnamese-Americans in Santa Clara County. While these examples of barriers to healthcare reflect individual experiences in specific categories of barriers, the reality of the situation is that these barriers may all act simultaneously together rather than individually. In other words, cultural barriers may be a combination of linguistic and sociofamilial barriers, and linguistic barriers may involve sociofamilial barriers and or cultural barriers.

The development of cultural agility and the implementation of a language translation service can reduce barriers to healthcare in any of the categories that were described by EMS providers, Vietnamese-Americans, and professional group members. The goal of this project, however, was solely the creation of an informative guide which aimed to develop cultural agility.

4.2 Perspectives on Health, Illness, and Treatment

All of the participants described the concepts of health, illness, and treatment in their own words. I chose to have them define these concepts in their own words in order to establish if there exist any discrepancies between the ways in which EMS providers and the Vietnamese community perceives the concepts. Discrepancies that exist between healthcare providers and patients can create barriers to healthcare through conceptual misunderstandings.

Health

The interviews revealed that while all the stakeholders shared a similar notion of health, people trained in emergency medicine and the Vietnamese-American patients differ widely in their beliefs about how the body works. According to Ritter and Hoffman (2010:41), “theories about health and illness address the beliefs people hold about how to maintain health and the

causes of illness.” These theories influence the ways that people respond to health-related interactions and treatments (Ritter and Hoffman 2010).

The World Health Organization (2003) defines health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition is all-inclusive of the physical, mental, and social aspects of the human body. How one defines health can influence what is deemed to be appropriate medical treatment for a patient and what is not (Sobo and Loustau 2010). Therefore, I chose to have the interviewed participants define health in their own words in order to establish if there exists any discrepancies that may create barriers to healthcare. The paramedic, Jake, defined health in his own words:

“Health is the absence of illness. That really the simplest definition. But if you want to get into it more I suppose you could say that health is sort of a balance of stress factors, diet, and social life. The more risk factors that you add your life, the higher your odds are of becoming ill.”

Jake’s description of health can be compared to Steve’s. Being born and raised in Vietnam, Steve possesses knowledge of traditional Vietnamese perceptions of health, while also understanding biomedical perceptions. Steve described health as being:

“An equal balance of energy within the body. In Vietnam we believe that you have to work at maintaining a balance of energy through exercises and food choices. Certain things will change the flow of energy in certain parts of your body. If the energy slows down or gets blocked, then you get sick.”

Dr. Mychi Nguyen described health from both a professional biomedical medical and traditional Vietnamese standpoint. She stated:

“Being raised in a Vietnamese family has given me the advantage of understanding both ways of thinking. Vietnamese medicine is very much influenced by China, so we have principles of yin yang, hot-cold, etc. etc. In both American and Vietnamese cultures, we want to preserve that healthy state and to do so requires balancing aspects of life choices. In my experience the difference between American and Vietnamese perspectives on health is not the issue of health itself, but the definitions of the factors and choices that balance and maintain a healthy state. In the US we say that a healthy lifestyle consists of regular exercise, good dietary habits, stress management, and good sanitary habits. In Vietnam we say that a healthy lifestyle consists of balancing hot and cold influences and maintaining the flow of life energy, through exercise that is thought to stimulate energy movement throughout the body, through a balance of foods and beverages that influence the hot/cold balance; keep in mind that when I say hot and cold I don't mean temperature... In Vietnam stress is thought to slow down the flow of energy and relaxation is thought to stimulate the flow of energy... So the Vietnamese idea of health is really very similar to the American idea, whereas the definitions and ideas of what influence health are a little different.”

Illness

The interviews revealed that the concept of illness was similar among EMS providers and Vietnamese-Americans, but the concepts of cause and treatment differed. Ideas about health maintenance vary among cultures and include aspects such as balanced dietary habits, proper exercise, prayer, and the wearing of amulets (Ritter and Hoffman 2010). It is important to understand that there are areas of overlap in American and Vietnamese ideas about illness, but it is also important to understand that even within a culture, ideas about illness have a broad range

(Ritter and Hoffman 2010). For example, ideas about illness causation that are similar between American and Vietnamese populations include ideas such as exposure to pathogens and a weakening in the body's immune system. Ideas that differ include the breach of taboo, prayer, soul loss, and an upset in the hot-cold balance of the body (Ritter and Hoffman 2010). As with the subject of health, I chose to have the interviewed participants define illness in their own words in order to establish if there exists any discrepancies that may create barriers to healthcare.

Dr. Linh Dang shared her opinion that the concept of illness is different between American and Vietnamese cultures in how it is approached. In American medicine, she stated that a doctor or medical professional focuses on the area in which the patient has a problem, and works to fix the problem at that localized area. In traditional Vietnamese medicine, a doctor or medical professional will acknowledge the problematic area of the patient, but assesses that person's entire being, both mental and physical; in order to establish if there is an energy imbalance or stagnation that causes the problem.

Dr. Dang's description of the Vietnamese approach to illness coincided with how Steve described health. Steve described illness occurring when the flow of energy in a person's body slows down or becomes blocked, while Dr. Dang described the Vietnamese approach to diagnosing illness as being an assessment of a person's energy flow.

There are some EMS providers that make an effort to understand cross-cultural perceptions that define illness. The paramedic, Chris, maintains an open mind while treating patients with different cultural beliefs about illness. He commented:

“If you can sift through all the surface shit, when you really get down to it, virtually everybody looks at illness the same way. It's basically just not being healthy. Everyone

has their own beliefs on why they're not healthy or what made them not healthy and I don't think it's my place to tell them that they're wrong about it in the back of an ambulance...When I had stomach problems, Western medicine could do nothing for me, so I tried acupuncture and whatever they did made me feel better. So who knows? Maybe it psychosomatic or maybe it actually works.”

The majority of Vietnamese-Americans that were interviewed agree that exposure to pathogens such as bacteria, viruses, and fungi can inflict illness. Not a single participant that was interviewed believed that illness is caused by supernatural forces or fatalistic principles. However, this statement does not suggest that no Vietnamese-Americans living in Santa Clara County believe in the supernatural or fatalistic etiologies of disease and illness. Solomon acknowledged that exposure to pathogens can cause illness; however, he did not believe that pathogens are the primary causes of most illnesses. He stated:

“You are ill when you feel bad, that’s all. When you are sick it doesn't always mean that you are infected with germs. I agree that if you have high stress and other problems in your life you have a better chance of being sick from germs but with me, I become ill with headaches and body aches and coughs without being infected by germs.”

Solomon’s response illustrates the point that not everyone defines illness as being infected with a pathogen. To Solomon, headaches, body aches, and coughs are considered illnesses, yet pathogens are not necessary causes for any of them.

All of the Vietnamese-Americans that were interviewed acknowledge the existence of mental illness and admit that there is a type of stigma that surrounds it. Kelly was born and

raised in the United States and traditional Vietnamese family. She described the stigma from it Vietnamese-American perspective:

“If someone has a family member that's mentally retarded it's very hard for them. But even in America it's emotionally hard for family to deal with someone who is mentally sick or retarded. I think the difference is in Vietnamese culture I can see the parents or family members of somebody who's mentally challenged thinking that it's somehow their fault, and that can be embarrassing for them.”

According to Dr. Fjelstad, many Vietnamese-American families believe in Karma and karmic debt. Karma, in Buddhism, is seen as the primary driver of cause and effect (Obeyesekere 2002). The events that happen in a person's life are due to their karma, which accumulates throughout a person's past lives and into the present (Obeyesekere 2002). Karma is not a punishment or reward, but rather a consequence of natural actions. According to the Vedas, when one sows goodness, one reaps goodness. When one sows evil, one reaps evil. A good American comparison for what karma is can be found in the saying: *what comes around goes around* (Obeyesekere 2002). So to put Kelly's statement into perspective, some Vietnamese-Americans believe that having a mentally handicapped child is the result of paying negative karmic debt.

Although Kelly suggested that concepts such as karmic debt are relevant within some Vietnamese-American households, Nam Pham suggested that beliefs about such concepts exist only within “very traditional Vietnamese” families and these families may perceive that having a family member that is mentally challenged or handicapped is a burden to the family and to

society. He stated that those views are mostly a perception of older generations and are no longer common. This is an example of how health perceptions vary even within a cultural community.

Treatment

The interviews revealed that the concept of treatment had the most variation among EMS providers and Vietnamese-Americans. According to Ritter and Hoffman (2010:41), the “theories of illness causation derive from the underlying cognitive orientation of a cultural group, and therapeutic practice usually follows the same cultural logic.” The concept of medical treatment is directly influenced by the cultural perspectives of health and illness. Therefore, I asked the participants to define medical treatment in their own words and give examples from their own treatment experience in order to illustrate the variation in what treatment is believed to consist of by both EMS providers and Vietnamese-Americans.

Nam Pham described treatment as “anything that makes a sick person feel better.” He commented on popular traditional Vietnamese treatments such as coining and cupping, as well as less common treatments such as moxibustion. He stated:

“Coining is something that really works and it makes patients feel better. The purpose of coining is to stimulate energy in the sick person’s body in order to get rid of whatever is making them sick... Cupping is similar (to coining) but it can be more specific to a place on a person's body. The cup creates suction which moves blood and energy to the specific sick or sore area of the person’s body... Moxibustion isn't used much anymore that I'm aware of, in the Vietnamese culture anyway.”

Dr. Mychi Nguyen commented on the array of herbs that are used in traditional Vietnamese medicine and made the point that many pharmaceutical medications are derived from plants and herbs. She stated:

“There are many plants and herbs that Vietnamese people use in order to help with a variety of ailments... There is a lot of caution in the Vietnamese community with taking pharmaceuticals because of all the side effects that they have. Vietnamese people believe that most pharmaceuticals are too harsh on the body, so they rely on plants, which are thought to be less harmful. Of course, this isn't always the case, as we know as medical people; some herbs can be very harmful if taken incorrectly or in combination with other medications... I think another reason that herbs and homeopathic treatment is so popular with the Vietnamese community is because a lot of times they cannot afford to pay for pharmaceuticals or medical treatment, so they rely on what they know to be effective and cheap.”

Some treatments are alarming to EMS providers, as is apparent in the situation involving Ali, in which he reacted to hickies on the patient's neck and Stephan's situation in which he reported bruising on a patient's body to the police as possible abuse. The paramedic, Andre, admits that there were plenty of cases in which he was confused by treatment beliefs that he saw with Vietnamese patients. He commented on one of them:

“I get Tiger Balm, okay? It's the same damn thing as Icy/Hot or Ben Gay. But I get worried when I know there are parents out there that believe that tying a ribbon around their daughter's wrist is going to stop her from having asthma attacks. But hey, who am I

to judge? Even in our culture some people think that wearing metal bracelets can cure arthritis and make you stronger! (laughs) I guess we all of our flaws.”

Traditional Vietnamese medicine has deep roots in Vietnamese culture and spans many generations, according to Lucy. She stated:

“In Vietnam, this (traditional Vietnamese medicine) was all we ever used. This is the way it always has been; my father and my grandfather the same. They never had to take pills every day and they never got sick as much as people do now.”

The perspective of one member of the younger Vietnamese generation is an interesting contrast to his elder. Michael, who is a 28 year old college graduate and holds a bachelor’s degree of science, was born and raised in the United States to a traditional Vietnamese family. Michael is an advocate for both biomedical treatments and traditional Vietnamese medical treatments. He believes that the two complement each other. He stated:

“The reason people think things like coining and cupping and taking herbs is so weird is because they don’t understand it; well most people don’t understand it. Vietnamese medicine works very well for preventing getting sick or minor issues like a cold or cough and body aches and things like the flu. But when you have things like heart attacks and strokes, that’s when Western medicine is better. When I was a kid and I got sick I remember my mom would rub coins on my shoulders and bruise me all up. Then I’d go to school and all my friends would look at me weird because their moms would just use Vicks vapor rub or some shit. (Laughs) Sorry, can I say that? Okay... The coining and teas always worked though, for minor things.”

Perspectives about health, illness, and medical treatment are concepts that are deeply affective, thus embodied in individuals (Lock and Farquhar 2007). The interview results show a clear severance in the way that some EMS providers and Vietnamese-Americans think about health, illness, and treatment. Section IV further explores the concepts of traditional Vietnamese medicine that were mentioned in the interviews in order to better inform EMS providers.

V. The Concepts of Traditional Vietnamese Medicine

In developing cultural agility between emergency medical providers and Vietnamese-Americans, it is important for providers to have a basic understanding of how their patients may perceive and project concepts such as health, illness, and treatment according to their own world views. While many Vietnamese-Americans may be adherent with biomedical medical treatment, they may not always fully understand its concepts.

Subsection 5.1 illustrates the spiritualistic aspect of traditional Vietnamese medicine. I describe the concepts of yin and yang in a medical context with yin pertaining to illness caused by fatalistic or spiritual forces, and yang pertaining to illness caused by physical agents such as bacteria, viruses and so forth (Nguyen 2008). I also mention the use of amulets that are believed by some Vietnamese to ward off malevolent spirits and heal spiritually and fatalistic illnesses (Vu 2008).

5.1 Yin Illness, Yang Illness, and the use of Therapeutic Amulets

The concepts of Yin and Yang as forms of illness were not discussed with the participants of the study for several reasons, the main being that the Vietnamese are very conservative with discussing such matters with cultural outsiders. However, according to

Fjelstad (1995), Nguyen (2008), and Vu (2008), these matters are integral components in traditional Vietnamese cosmology.

Yin and Yang Diagnosis, Illness, and Treatment

Yin illness is defined by Nguyen (2008:312) as an illness “resulting from sinning against one’s ancestors or otherwise offending the dead.” A *yang* illness, on the other hand, is “caused by physical or bodily disorders or viruses” (Nguyen 2008:306). Practitioners of biomedicine diagnose *yang* illness while spirit mediums diagnose *yin* illness. According to Dr. Karen Fjelstad, it is very common for Vietnamese-Americans to adhere to beliefs involving both *yin* and *yang* forms of illness.

The indications of *yin* illness vary in Vietnamese culture, but it commonly consists of an unexplainable change in character, insanity, knotting and clumping of the hair, and what is known as “false illness”, in which the patient is not physiologically sick, but still does not feel well (Nguyen 2008). *Yin* disease is diagnosed and treated by spirit mediums whose methods, according to Nguyen (2008), parallel those used in curative medicine and psychiatric treatment. There are an unlimited number of ways that one can offend or be possessed by the dead or his/her ancestors, but the most commonly reported ways include negligent or improper ancestor veneration, living in a place or visiting a place where restless spirits wander, and improper burial of one’s ancestors (Nguyen 2008).

Spiritual mediums treat *yin* illness by conducting healing rituals, which are composed of Vietnamese mythological concepts that in many cases are more salient to Vietnamese-Americans than the scientific truths of biomedicine because they represent solutions to personal human problems (Nguyen 2008). “Healing is based on a restructuring of a disorder, modeled in a

mythical world, and so depends on the explanatory model that mediums use to diagnose the cause of illness and cure the illness with rituals” (Nguyen 2008:311). Explanatory models like this one and their relevance to the barriers to Vietnamese healthcare are discussed at length in section 5.2.

Therapeutic Amulets

Amulets are used in Vietnam for a variety of purposes that include warding against evil spirits, protecting a household, curing illness, and bringing luck, love, and reputation (Vu 2008). The amulets can consist of ornamental jewelry such as bracelets, necklaces, pendants, etc, but the primary requisite of an amulet is that it is magically or supernaturally imbued by a medium or ritual master through phrases or symbols (Vu 2008). The most common amulets are made of paper and contain sacred symbols and phrases that are the source of the amulets power.

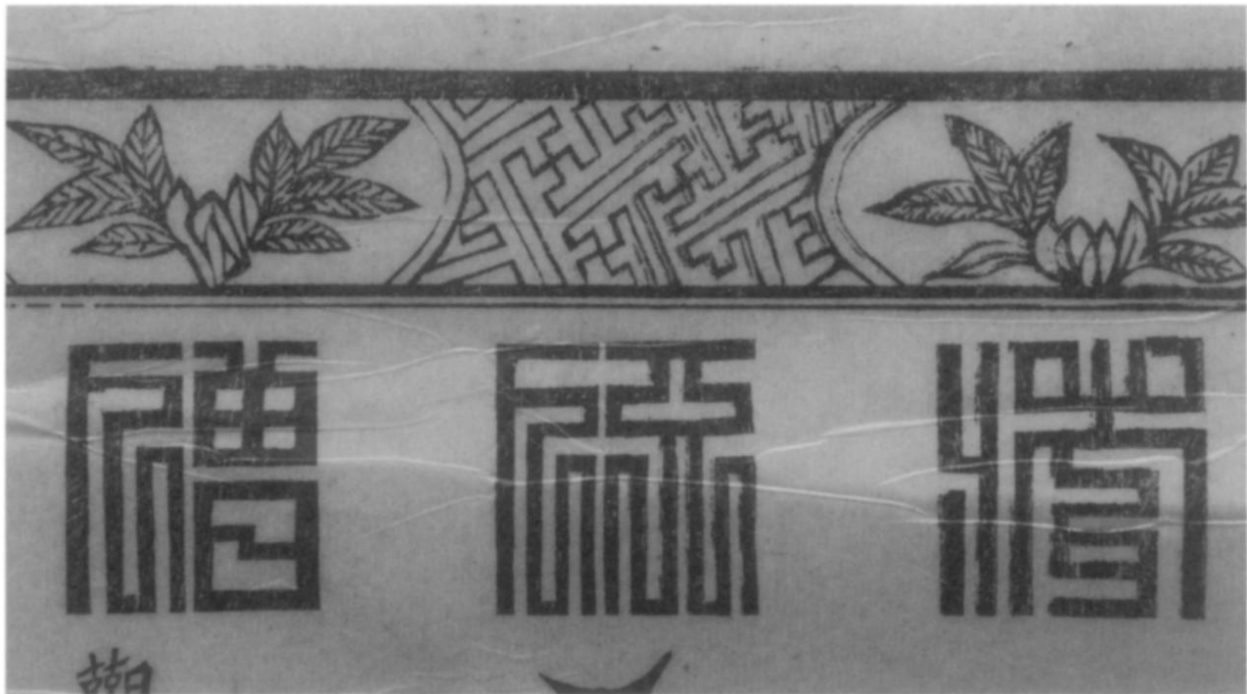


Figure 7: A paper amulet that is imbued with power through symbols and phrases.
Courtesy of Vu 2008.

Amulets created to cure a *yin* illness are made for a patient to wear on their person or hang above his/her bed and are meant to be used in conjunction with a healing ritual. The loss, damaging, or desecration of an amulet can worsen a patient's symptoms (Vu 2008). Protection amulets are believed to prevent a reoccurrence of *yin* illnesses (Vu 2008).

The principals of *yin* illness are shaped and reinforced by folk beliefs in supernatural causes and the effectiveness of healing methods such as rituals and amulets. The mythical models that influence these beliefs are well-known cultural patterns and explanatory models (Vu 2008). In order to understand how these treatments make sense and are effective to Vietnamese-Americans, it is important to examine the concept of explanatory models in depth, which section 5.2 does.

5.2 Explanatory Models

An explanatory model is a description of how and why a thing or phenomenon works, and can be used to explain the etiologies of disease and illness (Kleinman 1980). Explanatory models are useful in examining how abstract medical theories or belief systems are translated into practical clinical perspectives. From explanatory models arise questions for the medical practitioner to ask, such as: What do you call the illness? What do you think the illness does? What do you think caused the illness? How do you think the illness should be treated? By getting a better idea of what the patient's medical perspective is, the emergency medical provider is able to better explain their cultural standpoint and negotiate a treatment plan that will be both effective and culturally relevant to the patient.

The answers to these questions may parallel the biomedical translation of medical scientific theory into clinical strategies, revealing that traditional Chinese medicine (TCM) also makes use of clinical concepts that are transforms of theoretical concepts, although markedly different from biomedical ones (Kleinman 1980, Kleinman et al. 1978). For example, foods and beverages that biomedical practitioners would describe as promoting hypertension, diabetes, or hyperlipidemia, TCM practitioners may describe as being excessively "hot" or "cold" (Kleinman 1980, Nguyen 1985). Both are clinical concepts drawn from different theoretical approaches to health, disease and illness.

Other theoretical concepts may be mistranslated and clinically mistreated due to differences in culture, resulting in a potentially dangerous treatment or differential diagnosis. For instance, in a situation observed by Arthur Kleinman in which a Chinese patient was seen at the medical office of a biomedical doctor of Chinese decent, the patient states: "I have a bad taste in

my mouth, swelling of my gums, congestion in my nose. Perhaps I have *huo-ch'i ta*?" The doctor then replies: "You don't have a fever, so you don't have an upper respiratory tract infection. I will give you a shot for it. It will make you better" (Kleinman 1980:296). This brief conversation between patient and doctor is typical in biomedicine, in which a patient complains of specific symptoms and the doctor follows with a brief examination and diagnosis. In this situation the doctor, who speaks the dialect of the patient but is acculturated to biomedical practices and theories, responds by translating *huo-ch'i ta* into what he wrongly believes is its biomedical equivalent, fever. The patient didn't agree with the doctor's reasoning that because there was no fever there was no *huo-ch'i ta*, but he felt too intimidated to contradict the doctor and also thought the doctor may have known something he did not. He was also hesitant to receive a shot as he felt this type of treatment was too "hot" or aggressive (Kleinman 1980). This is a clear example of clinical miscommunication based on distinct medical and cultural phrases.

The way in which healthcare is perceived and practiced by both the provider and the patient influence the events and outcomes of medical situations (Fadiman 1997). In Anne Fadiman's book *The Spirit Catches You and You Fall Down*, she explains the predicament of a Hmong family's experience with an American biomedical healthcare system. While the family that is discussed is not Vietnamese, the book provides examples of what can happen in situations where perceptions of what health, illness, and treatment are different between provider and patient. In the Hmong cultural domain, similar to the Vietnamese, health is tied into a complex cosmology that includes religious beliefs, social structures, and environmental influences. What the American healthcare system would consider to be the basic tools of modern medicine, the Hmong see as invasive and horrific, violating taboos on the body that are punishable by one's ancestors (Fadiman, 1997). While there are marked differences between traditional Hmong and

Vietnamese beliefs about healthcare, they also share many similarities that can be traced back to influences from traditional Chinese medicine and Confucian ideologies (Fadiman 1997, Monnais et al. 2012).

These types of encounters exist in the emergency medical field as well as the clinical field and can be just as confusing for American emergency medical providers as for the patient. Patients may describe medical symptoms, many times through a translator, with terms that they are familiar with, such as “hot”, “cold”, “fiery”, “icy”, “slippery”, “damp”, or “watery” that may confuse and mislead medical providers (Kleinman 1980). Likewise, when medical providers attempt to describe treatment plans that may cause “vasodilatation”, “vasoconstriction”, or “bronchio-dilatation” to patients, confusion and non-compliance are not uncommon, even among patients that are acculturated to biomedical standards (Kleinman 1980).

In many cases such as the examples above, communication between the American medical provider and the patient takes place in a technical, professional idiom that is not accessible to most patients (Kleinman 1980). However, often times TCM practitioners will translate their conceptions into popular terms more or less understandable to the lay person.

It is important to understand that explanatory models are not shared by everyone within the same culture and differences may vary depending on education level and regional affiliation (Kleinman 1980, Nguyen 1985). Likewise, patient and practitioner views of clinical reality are often different and may conflict, but such discrepancies are less frequent in TCM situations, than those found in biomedical practitioner-patient relationships (Kleinman 1980).

It is sometimes taken for granted that the meaning of medical terms such as “disease” and “illness” are synonymous across cultures. This is far from being the case, especially between

cultures that have radically different cosmological approaches to health (Tseng and Strelzer 2008). Many Asian countries, including Vietnam, have been influenced by Traditional Chinese Medicine and its underlying philosophies. Traditional Chinese Medicine (TCM) differs from biomedicine in its theories of disease causation, its diagnostic system, treatment, and in the social realities of clinical practice (Kleinman 1980). Medical patients that adhere to TCM may present health complaints and symptoms that reflect the principals of mind/body unity (Nguyen 1985, Tseng and Strelzer 2008), yin yang, and/or hot/cold balances (Jenkins et al. 1996, Nguyen 1985, Purnell and Paulanka 2008, Tseng and Strelzer 2008). For emergency healthcare providers that are trained by the schools of medicine that recognize mind/body duality, compartmentalization of health, complaints and symptoms, and germ theory, complaints that reflect TCM schools of thought appear bizarre and confusing indeed.

These explanatory models of how and why a thing or phenomenon works are set into a larger framework of cultural influence. This influence, according to Shore (1996) is “a high-level model of great generality and abstractedness” known as schema theory. In subsection 5.3, I explain how these models and schemas apply to cross-cultural medical situations.

5.3 Foundational Schema and Cultural Models

In many cases, old cultural knowledge, thought, and memory is applied to new and unfamiliar cultural situations causing confusion and misunderstandings between healthcare providers and Vietnamese-American immigrants. Schema theory is very valuable in understanding the sociocultural methods in which Vietnamese-American immigrants learn about and apply meaning to concepts about healthcare and medicine (Brewer and Nakamura 1984).

While explanatory and cultural models are particular and concrete in terms of specific subject matter, schemas are more general and abstract, encompassing entire groups of models (Shore 1996). In particular, role and context schemas play a big part in regards to how social status affects perceptions of healthcare, as these schemas pertain to learned information about the expected behaviors of people in particular situations, in this case emergencies, and the appropriate settings of behavioral factors (Brewer and Nakamura 1984). The content of these schemas vary between social status groups and between cultures, creating potential challenges and barriers for appropriate social interaction between healthcare providers and patients in emergency situations (Brewer and Nakamura 1984).

Foundational schemas organize a large number of specific cultural and explanatory models and are very influential not only in the context of emergency situations, but in all domains of sociocultural life (Shore 1996). They function as a type of underlying framework that connect explanatory and cultural models and contribute to the ethos characteristic of a culture (Shore 1996). Foundational schemas are relevant to emergency medical care and the interactions there in because they shape the roles of individuals, behaviors, and attitudes that should occur during an emergency within a specific sociocultural framework.

Within the United States, many spatial, social, and cultural models exhibit patterns that reflect the American ethos of independence and individuality. This ethos also permeates the attitudes, beliefs, and behaviors of many Americans and it is reflected in their actions and decisions (Shore 1996). Much of the foundational schema that influences the sociocultural landscape of the United States is in direct contrast to those schemas of the Vietnamese, which tend to be more inter-dependant and collectivist in nature (Do 1999, Thế Giới Publishers 1999).

The way a person acts and behaves during an emergency situation is in accordance with the foundational schema of that person's social group and culture. That person's behavior and actions in that situation may seem odd or inappropriate to someone that adheres to a different foundational schema. For example, in the case of the paramedic, Tony, the patient did not want his brother to see that he was in pain because according to the Vietnamese schema, it is not considered masculine for a man to show the effects of pain around friends or family members. However, once separated from his family and friends and attended to by a female nurse, the patient disregarded the schema.

I have much experience in the emergency medical field that reinforces the idea that the behavior of a patient, Vietnamese or any other ethnicity for that matter, is different when they are alone with a provider, opposed to being around friends, family, or acquaintances. Depending on certain factors, such as ethnicity, sex, age, occupation, etc. a patient may be expected or not expected to show differing degrees of emotion during an emergency situation (Shore 1996).

To further complicate these matters, there also exist contesting hierarchies within a Vietnamese family or group of friends. Vietnamese culture is patriarchal, and the eldest male of the household is generally the decision maker (Do 1999). However, this hierarchy is challenged in the cases where the eldest male of the household is the medial patient and cannot speak English, when the patient's children are Americanized and disregard their elder's wishes, or when there are differing generations in the same household that disagree on what should be done for a patient.

The challenges to this cultural hierarchy create familial barriers to healthcare for the patient. In my experience, family arguments over what should be done for the patient adds to the

patient's distress level, interferes with provider treatments, and increases the time it takes to get the patient to definitive care.

Subsection 5.4 illustrates the one of the physical manifestations of cultural models and schema. In this subsection, I discuss the concept of cultural somatization, in which a patient may develop physical pain as a result of suppressed psychological or emotional distress.

5.4 Cultural Somatization

Somatization is defined by Arthur and Joan Kleinman as “the expression of personal and social distress in an idiom of bodily complaints and medical seeking (Lock and Farquhar 2007:469). No matter what culture a person is from, the social structures and relations that are normative for that culture become embodied in that person. In egocentric cultures, such as American, depression, for example, may present with expressions of personal alienation and existential despair. These expressions seem intrinsic and, to some degree, expected in egocentric societies, while in a sociocentric society like Vietnam or China, these expressions may be seen as unacceptable according to cultural norms and non-liminal to social control and order. Since these expressions run contrary to the social norms of the society, they reflect feelings of shame and dishonor to the person experiencing them. The somatized affect of experiencing pain as a bodily phenomenon rather than psychic or mental, becomes much more socially and culturally acceptable (Lock and Farquhar 2007:469).

The concept of somatization is one that EMS providers should be aware of. It is very important for providers to be attentive to the behaviors of a patient when he/she is around his/her friends or family and when he/she is alone with the provider. It is also good practice to hold off on questions pertaining to psychological issues until the patient is away from friends and family.

In American culture, it is not uncommon for excess stress and anxiety to present as tightness in the chest and difficulty breathing (Lock and Farquhar 2007). Likewise, being worrisome and visibly stressed is not considered a masculine trait for American males (Kleinman 1980). The internalization of anxiety and stress can result in physical symptoms that mimic more serious acute illnesses.

Dr. Mychi Nguyen states that in Vietnamese culture it is considered masculine to display stoicism in psychologically stressful situations. She says that many of her male patients that present with acute onsets of pain will only admit to doctors and other medical professionals that they are under a great deal of stress. According to her, Vietnamese American males “are very proud and believe that they must maintain composure in front of their friends and families to keep them strong.”

The next two subsections contain information on the philosophical and cosmological foundations of traditional Vietnamese medicine and the influence that traditional Chinese medicine has had on Vietnamese thought. I discuss the differences between the northern and southern schools of Vietnamese medicine and the conditions in which they are used together.

5.5 Traditional Vietnamese Medicine and Cosmology

Culture affects our perceptions and experiences of health and medical treatment in many ways; therefore, in order to understand the crucial differences between Vietnamese cultural perceptions and physical projections of health and medicine and their European and American counterparts, it is important to understand the cultural and social influences that aided their developments. The foundations of these influences lie in the philosophical, cultural, and spiritual

traditions that have shaped and structured the social systems in which we live, and the way that we think and interact with the world around us (Delvecchio et al. 2011).

5.6 Traditional Chinese Medicine and its Influence on Traditional Vietnamese Medicine

Traditional Vietnamese medicine (TVM) is very similar to and heavily influenced by traditional Chinese medicine (TCM). TCM is a system of medical beliefs and practices that spans over a period of more than 2,000 years in China and nations surrounding China (Flaws and Finney 1996). The core of TCM concepts are centered on the cosmological principals of *yin-yang* and the theory of five phases (Flaws and Finney 1996).

Yin-yang is the cosmological principal of balance. According to the principal, everything in the universe, including the human body, is governed by contrary forces that exist in harmony together as a balance. An inbalance of *yin-yang* in the human body can result in an increased susceptibility to illness (Flaws and Finney 1996).

The five phases (elements) theory is complimentary to the *yin-yang* principal and suggests that everything in the universe can be broken down into five basic elements, which are: earth, water, metal, fire, and wood. Each element corresponds to natural phenomena in the universe, as is illustrated in Figure eight.

Figure 8: Correlation between natural phenomena and the five phases (elements). Courtesy of Wikipedia.

Phenomenon	Wood	Fire	Earth	Metal	Water
Direction	east	south	center	west	north

Color	green/blue	red	yellow	white	black
Climate	wind	heat	damp	dryness	cold
Taste	sour	bitter	sweet	acrid	salty
Yin Organ	Liver	Heart	Spleen	Lung	Kidney
Yang Organ	Gallbladder	Small Intestine	Stomach	Large Intestine	Bladder
Sense organ	eye	tongue	mouth	nose	ears
Facial part	above bridge of nose	between eyes, lower part	bridge of nose	between eyes, middle part	cheeks (below cheekbone)
Eye part	iris	inner/outer corner of the eye	upper and lower lid	sclera	pupil

The five phases, or elements, are depicted in a circular fashion, as Figure nine illustrates. This theory correlates man's interconnection to the natural environment by depicting internal organs as being influenced by these elements. For example, the element fire reflects aspects of passion, aggression, and heat. Therefore, within the body these aspects are attributed to organs such as the heart, the small intestines, and the sexual organs (Flaws and Finney 1996).

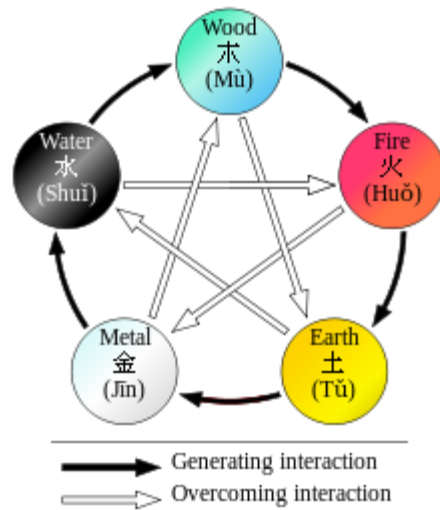


Figure 9: The Five Phases Cycle

The Chinese medical influence in Vietnam is most likely due to the Chinese invasion of Vietnam in 179 B.C., which lasted approximately 1,000 years (Thế Giới Publishers 1999). Because of its geographical location along Indian trade routes, Vietnam also has blends of Indian medical traditions as well, especially in the southern schools of medicine (Thế Giới Publishers 1999). TVM is comprised of two recognized schools: Southern Medicine and Northern Medicine/Sino-Vietnamese Medicine.

Northern (Chinese) Medicine

Northern medicine is considered the prestigious medical practice by Vietnamese academia and is heavily influenced by TCM. Northern medicine stems from the principal that man is an integral part of nature and cannot be separated from the universe or its laws (Thế Giới Publishers 1999). It recognizes two primary forces in which the dialectic interaction governs the universe: the female negative (*yin*-Vietnamese: *Âm*) and the male positive (*yang*- Vietnamese: *đương*). These two forces coincide with the five elements that become the common substance of all animate beings. These substances are: metal, wood, water, fire, and earth (Thế Giới Publishers 1999).

Each force is represented by organs and structures in the human body and is thought to have a cosmic counterpart that is affected or governed by one or more of the five elements. For instance, the heart is governed and influenced by the element fire while the kidneys are governed and influenced by the element water (Thế Giới Publishers 1999). These elements are governed by the principals of the universe, therefore, so is the anatomy and physiology of humans. As long the elements and positive/negative forces exist in a balance within the body, so does well-being. Illness and disease are a result of imbalance (Thế Giới Publishers 1999). Figure 8 illustrates the forces and elements that correlate to the main organs of the body.

Southern Vietnamese Medicine

According to Vietnamese tradition, in the 14th century A.D. a Buddhist monk from China by the Vietnamese name of *Tuệ Tĩnh* wrote a medical treatise called the *Miraculous Medicines of the South*. It is believed that this text was created to explain Vietnamese medical practices and beliefs within the theoretical framework of traditional Chinese medicine (Monnais et al. 2012). The text argues that Vietnamese medicine, being a product of the southern Vietnamese environment, works best for the Vietnamese, being a people of the South (Monnais et al. 2012). The practice of southern medicine is favored by the tropical conditions of Vietnam, and most medical treatments consist of rough tropical plant products that are easily attainable (Thế Giới Publishers 1999). *Tuệ Tĩnh*'s argument comes from the concept in TCM that people are all products of the environments they thrive in; therefore, effective medicine should come from the same environment as that of the patient (Monnais et al. 2012). Since the 14th century, the Vietnamese have made a distinction between *Thuốc Nam*, i.e. southern medicine, and *Thuốc Bắc*, i.e. northern (Chinese) medicine (Monnais et al. 2012).

Of the southern and northern schools of TVM, the southern school is considered less prestigious by contemporary practitioners (Thế Giới Publishers 1999). Southern medicine has in fact been defined by most scholars by a description of what it is not, i.e. northern or Chinese medicine, which has a methodology and theoretical framework for identifying and treating illness and injury (Monnais et al. 2012).

Southern medicine was historically not as institutionalized as northern medicine. It lacked a uniform methodology and theoretical framework for identifying and treating illness and injury (Monnais et al. 2012). There were no formal regulations on who could practice medicine and medical treatments for an injury or illness among southern healers would vary and sometimes conflict with each other (Monnais et al. 2012, Thế Giới Publishers 1999).

Regardless of how southern medicine is viewed by Vietnamese scholars, it is widely used in contemporary Vietnamese society (Monnais et al. 2012, Thế Giới Publishers 1999,). Southern medicine played a crucial role during the Vietnam War for the healthcare of Vietnamese soldiers cut off from modern medical supplies (Monnais et al. 2012).

The southern tradition of Vietnamese medicine, ironic given the discourse of scholars, played a crucial factor in building nationalism in Vietnam (Monnais et al. 2012). *Thuốc Ta*, i.e. our medicine, which is a blend of both northern and southern schools, is the favored practice of the majority of the Vietnamese population. The contemporary Vietnamese see *Thuốc Ta* as “being less aggressive, less likely to have serious side effects, and more familiar than western/modern medicine” (Monnais et al. 2012:5).

Integration of the Two Schools of Medicine

In contemporary Vietnamese society it is now commonplace to see a combination of the two schools in practice (Monnais et al. 2012, Thế Giới Publishers 1999). Most contemporary practitioners of TVM integrate aspects of both southern and northern schools (Monnais et al. 2012, Thế Giới Publishers 1999, Tseng and Strelzer 2008,). Although many historic practitioners integrated concepts and techniques from both southern and northern schools, the formal integration of the two schools was institutionalized in 1955 when president Ho Chi Minh urged, after setting up the government for the Democratic Republic of Vietnam, that the two schools of medicine be combined to form *Thuốc Ta*, i.e. our medicine (Monnais 2012 et al.). This led to the nationwide development of institutions that practice both TVM and *Thuốc Tây*, i.e. Western medicine (Monnais et al. 2012).

The Vietnamese used concepts and theories from TCM to develop a medical framework that fit the Vietnamese environment and cultural worldviews (Monnais et al. 2012). The concept of *qi*, or vital energy, is central to the TCM concepts of health, illness etiology, diagnoses, and treatment. This concept is spelled *khí* in TVM and has an identical meaning (Thế Giới Publishers 1999). *Khí* is the vital energy that sustains health and when its flow is impeded in the body, illness or injury occurs. Therefore, the goals of TVM are to ensure, maintain, and correct the proper flow of *khí* throughout the body (Thế Giới Publishers 1999, Tseng and Strelzer 2008). This is done by maintaining a diet that promotes proper *yin-yang* and hot/cold balances, proper exercise, and conditioning of the meridians in the body that influence the flow of *khí* (Jenkins et al. 1996, Monnais et al. 2012, Nguyen 1985, Purnell and Paulanka 2008, Thế Giới Publishers 1999, Tseng and Strelzer 2008, Watts 1975).

Massage therapy in TVM is not unlike biomedical massage therapy, in that the primary goal is to increase circulation and decrease tension within the muscles. In TVM, excessive

muscle tension may impede circulation and the proper flow of *khí*, leading to illness or injury (Thế Giới Publishers 1999). Massage therapy focuses on releasing tension, promoting circulation, and stimulating the meridians of the body by means of acupressure (Thế Giới Publishers 1999).

Acupuncture is the practice of stimulating vital energy by inserting small needles into the epidermis that correspond to specific meridians (Deadman 2007). In TCM and TVM alike, acupuncture has five cardinal functions, which are: 1. The actuating of circulation; 2. warming the body; 3. strengthening immunity; 4. Containing bodily fluids (prevent leaking); 5. transforming consumed products such as food, beverages, and medicine into vital energy (Aung and Chen 2007, Deadman 2007).

Moxibustion is the practice of burning or heating the skin with herbs (usually mugwort) at specific meridians on the body in order to expel illnesses caused by dampness and cold and to promote circulation and strengthen the blood (Wilcox 2008). It is often used in conjunction with acupuncture, either placed directly on the skin or on top of the acupuncture needle. This treatment can leave bruising or burn marks on treated individuals.

Coining is a treatment that used to induce a fire-elevated condition within the body to battle illness caused by excess wetness or cold (Tseng and Strelzer 1997). This is done by rubbing a copper coin against the bare skin of the back, shoulders, and chest. The result may leave streaks of bruising and welts along the torso of the treated person, which may confuse and alarm emergency medical responders that are not familiar with this kind of therapy.

Cupping is a practice that involves the application of heated glass or porcelain cups to the bare skin of the back, neck, or shoulders at specific meridian points, in order to dispel stagnation

of blood and lymphatic fluid (Jackson 2011). As the heat from the cups dissipates, it creates a vacuum inside the cup which creates suction on the skin and promotes blood flow in and around the corresponding meridian. Cupping is also used to treat respiratory illnesses such as the common cold, bronchitis, pneumonia, and tuberculosis (Jackson 2011). Like coining, cupping commonly leaves welt marks and/or bruising in the areas of cup application due to the intense vacuum effect caused by the suction.

In this report I mentioned the socioeconomic, cultural, and educational factors that influence the creation of barriers to healthcare for the Vietnamese-American community in Santa Clara County. Also examined were the firsthand opinions and comments of EMS providers, Vietnamese-Americans, and local professionals on the subject of barriers to health care. The purpose of exploring these areas was to gain an overall understanding of the conditions and types of barriers to healthcare that exist between EMS providers and Vietnamese-American patients in Santa Clara County.

All of this information and data were used to inform the creation of an informative guide for EMS providers that illuminates and explains many social, economic, and cultural differences that contribute to the barriers for healthcare. It is my hope that the guide will be utilized by EMS providers in the county in order to reduce some of these barriers and increase patient outcomes. Section VI contains the methods and decisions that were used in the product format and dissemination.

VI. Product Format and Dissemination

In part six, I discuss the format of the informative guide and the method of dissemination. The principal idea behind the guide format was to maximize the potential for usage by EMS

providers. In order to make the guide as user-friendly as possible, I chose to emphasize the use of simple text rather than technical jargon, succinct narratives and illustrations, and webpage links that save space within the guide and allow users to access source information. The topics in the guide were informed by the data gathered from interviews and data collection from relevant published literary sources and reports.

The guide's format is an interactive webpage on the social network: facebook (FB). I chose to develop the guide on FB for several reasons. First, FB is more than just a social space. It is now used by many as a tool for organization and communication across many aspects of daily life (Lampe et al. 2010). Many of the EMS participants that were interviewed stated that they were more likely to use the guide if it were linked to their FB accounts rather than if it were an independent web page. Secondly, at the time of writing this report, the creation of a FB page is free of charge, allowing a cost effective method of dissemination. Thirdly, the format of FB allows for users to instantly comment and give feedback on information. It also allows me to make updates and amendments to posts, as well as add web page links to outside source information sites.

The guide was set up using the business format that FB offers, which offered more options in terms of posting information than the personal format. The title for the guide is *Cultural Guide for EMS Providers: Vietnamese-Americans* and the URL is <http://www.facebook.com/CulturalGuideForEmsProvidersVietnameseAmericans?ref=hl>. Choosing this title leaves open the possibility of creating future guides for other ethnicities in Santa Clara County as well as others.

I posted information for EMS providers through status updates and comments, external webpage links, and illustrations, largely because status updates and comments are automatically added to the “news feeds” of all users that are linked to the page. This feature allows for users to be alerted to new information without having to visit the actual site.

The guide was disseminated to EMS providers by means of my requesting their FB friendship on the FB network, under the role of the guide’s administrator. It is hoped that the acceptance of FB friendship with the site will create a chain reaction of FB friendship requests through the FB feature of FB friend suggestions. This feature encourages friendship with the site to FB users that have FB friends that are already FB friends with the site.

At the time of this report, I am currently FB friends with all of the EMS providers that participated in the project and upon the guide’s completion, a FB friendship request will be extended to them. One limitation of using FB as a method of dissemination is that usage of the guide is dependent upon the user having a FB account. While an FB account is free of charge, not every EMS provider wants to have one. In order to counter this limitation, I chose to change the guide’s security settings to allow non-FB users to view the basic information and illustrations of the guide. The only limitation that non-FB users face is that they are not allowed to post feedback or comments on the page.

VII. Future Actions and Follow-Up

It is my hope to maintain the guide on FB, so long as FB remains a relevant and effective form of dissemination. By relevant and effective, I mean that the guide continues to receive comments, additions, and feedback from users and that the usage of FB remains free of charge.

Information about the Vietnamese-American community and healthcare will be added as deemed relevant by me.

The guide's creation will be deemed successful if it engages and stimulates conversation and awareness regarding cross-cultural healthcare among EMS providers. As with any social network platform, I expect there to be some negative attitudes and comments towards the idea of cultural agility along with positive ones. However, any comments or feedback that present as racist or demeaning will be deleted and the commenter removed from the guide's forum.

Six months from November 5, 2012, the guide's date of creation on FB, I plan to conduct a survey of the guide's effectiveness by posting a comment that asks users if the site is effective and if there is any area that needs to be expanded, reduced, or clarified. Based on the responses, the appropriate adjustments will be made.

VIII. Conclusion and Closing Thoughts

This project was a very eye opening experience for me. I learned a great deal not only about the barriers to healthcare for the Vietnamese-American community here in Santa Clara County, but also about the processes and necessities of conducting a project at the county level.

This project helped EMS providers in a way that I had not initially intended. It allowed them to vent their concerns and frustrations about the difficulties that cultural barriers to treatment presented in confidentiality and allowed them the sense of contributing to the betterment of patient care, as the paramedic, Pete, stated:

“If anything, at least I got to say what I had to say. I feel better about that.”

The EMT, Sara, also stated:

“I really hope what I have to say helps out in the bigger scheme of things.”

A large issue for me in conducting these interviews and developing an overall design for this project was to control my bias. I am an EMS provider and in some cases I have shared many of the same concerns and frustrations as other providers. It was hard for me not to make assumptions about beliefs and treatment methods. Thankfully, my graduate committee was able to assist me in creating a research and interview protocol that reduced any biases and assumptions to a minimum.

The next steps for research within the context of healthcare and the Vietnamese-American community should focus on understanding the ways in which health concepts like disease etiology, patterns, and effects are perceived by traditional Vietnamese-Americans. Understanding how communicable diseases are perceived and defined by Vietnamese-Americans that are adherent to the beliefs of traditional Vietnamese medicine is a major step in developing cultural agility and culturally appropriate prevention programs. Targeted patient and community education is needed to address cultural and social conceptions about communicable diseases among Vietnamese-Americans and to help ensure adherence to prescribed traditional and biomedical treatment regimens (Carey et al. 1974). Information about cultural health concepts can inform the development of disease prevention and treatment programs that are culturally relevant to not only Vietnamese-Americans, but all residents that adhere to other cultural and medical beliefs. Through understanding and respecting the health beliefs of other cultures, our medical system can improve patient outcomes and well being.

IX. Works Cited

Adler, Nancy, with Thomas Boyce, Margaret A. Chesney, Sheldon Cohen, Susan Folkman,
Robert L. Kahn and Leonard Syme

1994 Socioeconomic Status and Health: The Challenge of the Gradient. *American Psychologist* 49(1):15-24.

Aung, Steven, and William Pai-Dei Chen

2007 *Clinical Introduction to Medical Acupuncture*. New York: Thieme Medical Publishers, Inc.

Bernard, Russell H.

2011 *Research Methods in Anthropology: Qualitative and Quantitative Approaches*, Fifth Edition. New York: Altamira Press.

Brewer, William and Glenn Nakamura

1984 *The Nature and Function of Schemas*. Technical Report, 325. Cambridge: Bolt, Beranek, and Newman Inc, National Institute of Education.

Buchwald, Dedra, with Sandjiv Panwala and Thomas M. Hooton

1992 Use of Traditional Health Practices by Southeast Asian Refugees in a Primary Care Clinic. *Western Journal of Medicine* 156(5):507-511.

Caligiuri, Paula

2012 *Cultural Agility: Building a Pipeline of Successful Global Professionals*. San Francisco: Jossey-Bass.

Carey, James, with Margaret Oxtoby, Lien Pham Nguyen, Van Huynh, Mark Morgan, and Marva Jeffery

1974 Tuberculosis Beliefs among Recent Vietnamese Refugees in New York State. *Public Health Reports* 112(1):66-72.

Chomsky, Noam

1975 *Reflections on Language*. New York: Pantheon Books.

Conrad, Peter

1985 The Meaning of Medications: Another Look at Compliance. *Social Science & Medicine* 20(1):29-37.

Deadman, Peter, with Mazin Al-Kafaji and Kevin Baker

2007 *A Manual of Acupuncture*. East Sussex: Journal of Chinese Medicine Publications.

Delvecchio Good, Mary-Jo, with Sarah Willen and Seth Hannah,

2011 Chapter One: Shattering Culture: An Introduction. *In Shattering Culture: American Medicine Responds to Cultural Diversity*. Mary-Jo Delvecchio, Sarah Willen, Seth Hannah, Ken Vickery, and Lawrence Park, eds. Pp. 1-34. New York: Russell Sage Foundation.

Do, Hien

1999 *The Vietnamese-Americans: The New Americans*. Westport: Greenwood Press.

Fadiman, Anne

1997 *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus and Giroux.

Farmer, Paul

2005 *Pathologies of Power: Health, Human Rights, and the New War on the Poor*.

Berkeley: University of California Press.

Fjelstad, Karen

1995 *Tu Phu Cong Dong: Vietnamese Women and Spirit Possession in the San Francisco Bay Area*. Ph.d. Dissertation, Department of Anthropology, University of Hawaii.

Flaws, Bob, and Daniel Finney

1996 *A Compendium of TCM Patterns and Treatments*. Boulder: Blue Poppy Press.

Flores, Glenn, with Howard Bauchner, Alvan Feinstein and Uyen-Sa D.T. Nguyen

1999 The Impact of Ethnicity, Family Income, and Parental Education on Children's Health and Use of Health Services. *American Journal of Public Health* 89(7):1066-1071.

Foucault, Michel

1972 *Power/Knowledge: Selected Interviews and Other Writings 1972 – 1977*. New York: Random House, Inc.

Horne, Robert, with Lida Graupner, Susie Frost, John Weinman, Siobhan Melanie Wright and Matthew Hankins

2004 Medicine in a Multi-Cultural Society: The Effect of Cultural Background on Beliefs about Medications. *Social Science and Medicine* 59:1307-1313.

Ihara, Emily

2009 Ethnicity Matters: The Socioeconomic Gradient in Health among Asian Americans. *Journal of Sociology & Social Welfare* 36(2):125 –144.

Ito, Karen

1999 Health Culture and the Clinical Encounter: Vietnamese Refugees' Responses to Preventive Drug Treatment of Inactive Tuberculosis. *Medical Anthropology Quarterly* 13(3):338-364.

Jackson, William

2001 A Short Guide to Humoral Medicine. *Trends in Pharmacological Science* 22(9): 487 – 489.

Jenkins, Christopher, with Thao Le, Stephen McPhee, Susan Stewart, and Ngoc The Ha.

1996 Healthcare Access and Preventative Care among Vietnamese Immigrants. *Social Science and Medicine* 43(7):1049 – 1056.

Kimbrow, Rachel T., with Sharon Bzostek, Noreen Goldman, and German Rodriguez

2008 Race, Ethnicity, and the Education Gradient in Health. *Health Affairs* 27(2):361-372.

Kleinman, Arthur, and Joan Kleinman

2007 Somatization: The Interconnections in Chinese Society among Culture, Depressive Experiences, and the Meetings of Pain. *In* Beyond the Body Proper: Reading the Anthropology of Material Life. Margaret Lock and Judith Farquhar, eds. Pp. 468 – 474. London: Duke University Press.

Kleinman, Arthur

1980 Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press.

Kleinman, Arthur, with Leon Eisenberg and Byron Good

1978 Clinical Lessons from Anthropological and Cross-Cultural Research. *The Annals of Internal Medicine* 88:251-258.

Krieger, N., with D. R. Williams and N. E. Moss

1997 Measuring Social Class in U.S. Public Health Research: Concepts, Methodologies and Guidelines. *Annual Review of Public Health* 18:341-378.

Lampe, Cliff, with Donghee Wohn, Jessica Vitak, Nicole Ellison, and Rick Walsh

2010 Student Use of Facebook for Organizing Collaborative Classroom Activities. *International Journal of Computer-Supported Collaborative Learning* 6(3): 329 – 347.

McGee, Jon, and Richard Warms

2008 *Anthropological Theory* fourth edition. New York: McGraw-Hill Companies.

Monnais, Laurence, with Michele Thompson and Ayo Wahlberg

2012 Southern Medicine for Southern People: Vietnamese Medicine in the Making.

Newcastle: Cambridge Scholars Publishing.

Morphy, Frances

2006 Lost in Translation? Remote Indigenous Households and Definitions of the Family.

Family Matters 73: 23 – 31.

Morrissey, James

1983 Migration, Resettlement, and Refugeeism: Issues in Medical Anthropology.

Medical Anthropology Quarterly 15(1):11-14.

Naylor, Larry

1998 American Culture: Myth and Reality of a Culture of Diversity. Westport: Bergin

and Garvey.

Nguyen, Chau, and Tuyen Nguyen

2012 The Relationship between Obligation to Parents and Life Satisfaction for

Vietnamese-American Adults. Asian Social Science 8(6):11-19.

Nguyen, Duong Maj

1985 Culture Shock- A Review of Vietnamese Culture and Its Concepts of Health and

Disease. Western Journal of Medicine, 142(3):409-412.

Nguyen, Thi Hien

2008 Yin Illness: Its Diagnosis and Healing within Len Dong (Spirit Possession) Rituals of the Viet. *Asian Ethnology*, 67(2):305-321.

Obeyesekere, Gananath

2002 *Imagining Karma: Ethical Transformation in Amerindian, Buddhist, and Greek Rebirth*. Berkeley: University of California Press.

Ojeda, Victoria, and Sara Bergstresser

2008 Gender, Race-Ethnicity, and Psychosocial Barriers to Mental Health Care: An Examination of Perceptions and Attitudes among Adults Reporting Unmet Need. *Journal of Health and Social Behavior* 49(3): 317 – 334.

Pelto, Pertti and Gretel Pelto

1970 *Anthropological Research: The Structure of Inquiry*. Cambridge: Cambridge University Press.

Pool, Robert, with Wenzel Geissler

2005 *Medical Anthropology: Understanding Public Health*. New York: Open University Press.

Purnell, Larry, and Betty Paulanka

2008 *Transcultural Health Care: A Culturally Competent Approach*. Philadelphia: F.A. Davis Company.

Ritter, Lois, and Nancy Hoffman

2010 Multicultural Health. Sudbury: Jones and Bartlett Publishers.

Shore, Bradd

1996 Culture in Mind. New York: Oxford University Press.

Santa Clara County Department of Public Health

2011 Status of Vietnamese Health: Santa Clara County, California, 2011. San Jose: Santa Clara County Department of Public Health, Vietnamese Health Assessment.

Sobo, Elisa, and Martha Loustaunau

2010 The Cultural Context of Health, Illness, and Medicine 2nd Edition. Santa Barbara: ABC-CLIO, LLC.

Strathmann, Cynthia, and Cameron Hay

2008 “I’m Paying Your Salary Here!”: Social Inequality, Consumerism, and the Politics of Space in Medical Clinics. *Human Organization* 67(1):49-60.

Thế Giới Publishers

1999 Vietnamese Traditional Medicine second edition. Hanoi: Thế Giới Publishers.

The World Health Organization

2003 WHO Definition of Health. <http://www.who.int/about/definition/en/print.html>. Date accessed: September 6, 2012.

Tseng, Wen-Shing, and Jon Strelzer

1997 Culture and Psychopathology: A Guide to Clinical Assessment. New York:
Brunner/Mazel, Inc.

Uba, Laura

1992 Cultural Barriers to Health for Southeast Asian Refugees. Public Health Reports,
107(5):544-548.

Vo, Nghia

2006 The Vietnamese Boat People: 1954 and 1975-1992. Jefferson: McFarland and
Company Inc.

Viladrich, Anahí

2006 Botánicas in America's Backyard: Uncovering the World of Latino Healers' Herb-
Healing Practices in New York City. Human Organization 65(4):407-418.

Vũ, Hồng Thuật

2008 Amulets and the Marketplace. Asian Ethnology 67(2):237-255.

Watts, Alan

1961 Psychotherapy: East and West. New York: Random House, Inc.

Wilcox, Lorraine

2008 Moxibustion: The Power of Mugwort Fire. Boulder: Blue Poppy Press.

Yu, Sam Wai Kam

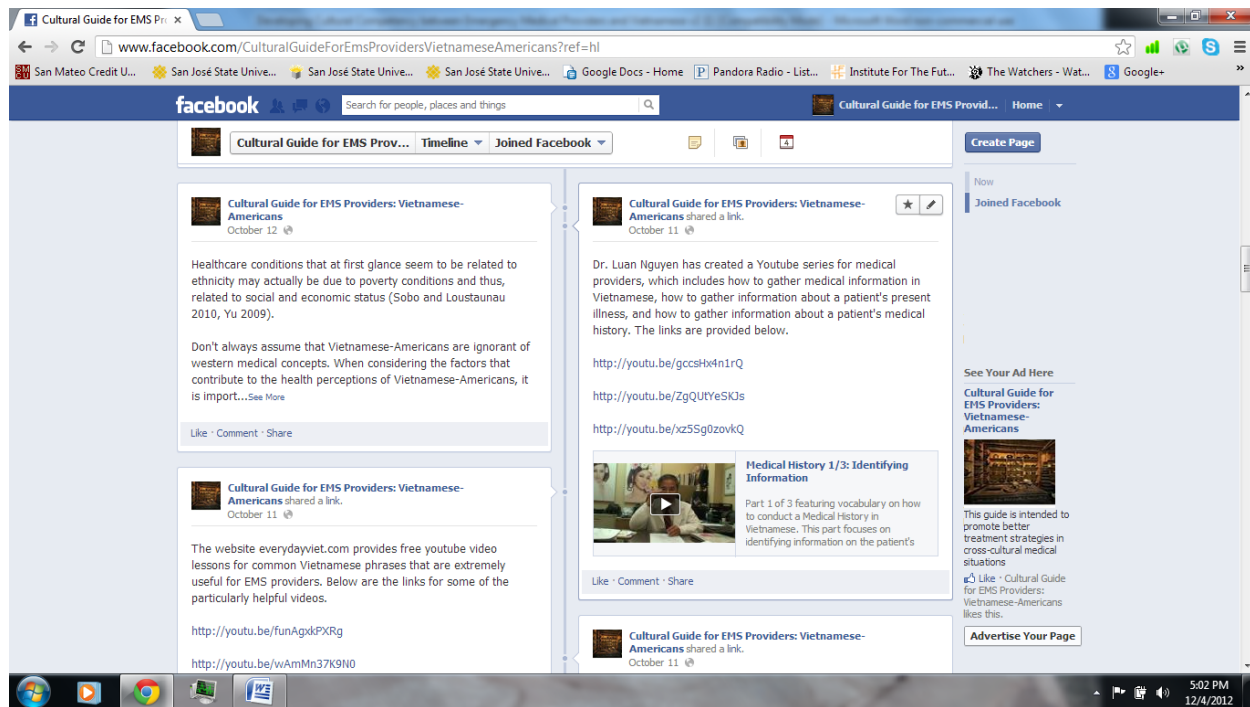
2009 The Barriers to the Effectiveness of Culturally Sensitive Practices in Health and Social Care Services for Chinese People in Britain. *European Journal of Social Work* 12(1):57-70.

Appendix A

This appendix contains screenshots of the guide from a PC perspective, although the guide is also accessible through facebook's smart phone applications. The guide features interactive links and photo albums that expand on the written content. The following screen shots are but a few pages from the actual guide.



This is the title page for the guide. It depicts therapeutic cupping being done on the back of a patient. Notice the reddish skin being sucked into the cup as a result of the glass being internally heated. The smaller picture in the lower left illustrates a traditional Vietnamese herb shop. The grey bar in the lower part of the screen discusses the purpose of the guide. By clicking “about” in the lower left corner of the screen, the user can expand the description of the guide to gain a full understanding of the guides function and purpose.

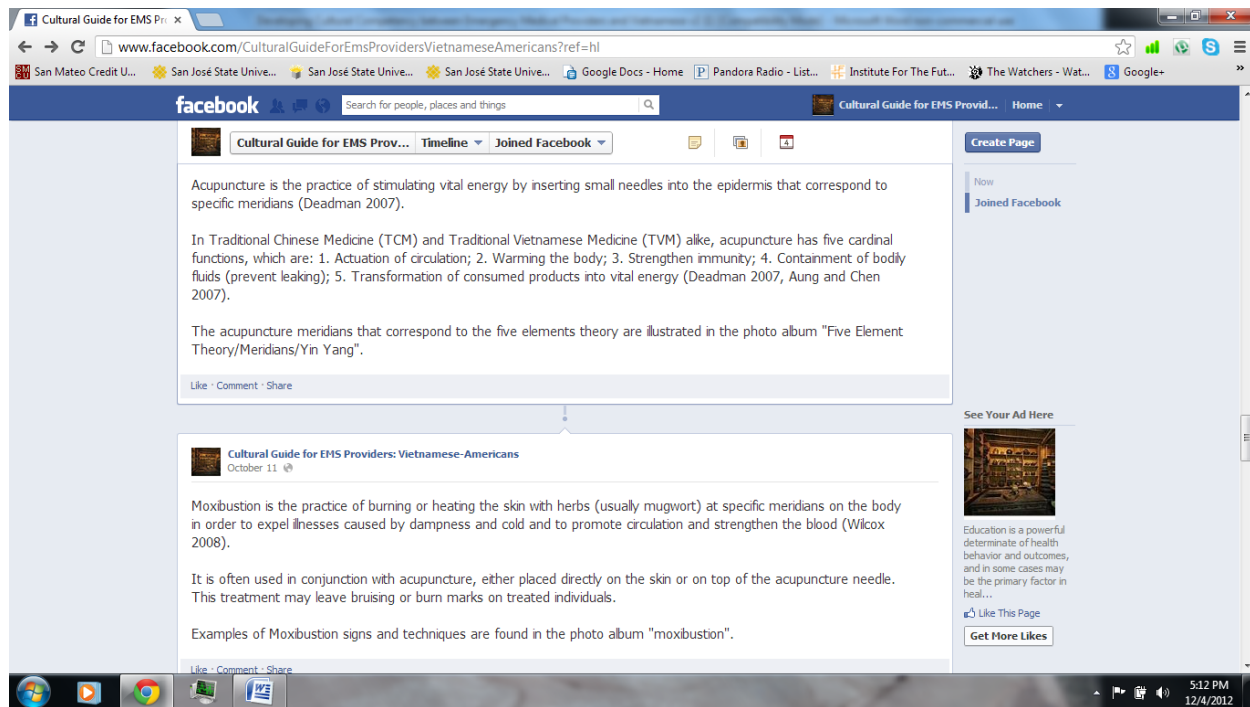


This screenshot depicts some comment bubbles within the guide. These bubbles describe various topics, information, and facts about traditional Vietnamese, culture, medical belief systems, popular therapies, and language. Many of the bubbles summarize information when viewed from the title page, but can expand to reveal detailed information and resources should the user require them. Some of the bubbles provide links to other websites, which contain indispensable information for EMS providers on the topics of language, medicine, social etiquette, and cultural history.



The next two screenshots depict several photo albums in the guide. The photos are linked to the comment bubbles that describe what they illustrate. Each photo is capable of expanding into a full-screen image and allows users to comment on descriptions.





The next two screenshots depict very important information. The format of the comment bubbles for information and topics that I consider very pertinent to the care Vietnamese-American patients are horizontally expanded to the width of the page. As this feature takes up a lot of room on the website, it is reserved for the topics more relevant to patient care.



X. Consent Forms

Agreement to Participate in Research

Responsible Investigator: Jason Vega

Title of Study: Vietnamese Healthcare: An Informative Guide for EMS Personnel

1. You have been asked to participate in a research study investigating the facilitators and barriers in emergency medical service (EMS) between EMS personnel and the Vietnamese community within Santa Clara County.
 2. You will be asked questions by the researcher regarding your experience either as a medical provider, a patient, or family member of a patient, in order to better understand the social, cultural, and situational factors that influence emergency medical care. These interviews will not occur during the time in which emergency medical treatment is being provided or received.
 3. The probability and magnitude of harm or discomfort involved in this research are no greater than would be encountered in daily life.
 4. This study is directed at benefiting the participants by expanding the cultural competency of EMS personnel as to better develop treatment strategies that are culturally relevant to the Vietnamese community, thereby alleviating any socio-cultural tension that may otherwise exist.
 5. Although the results of this study may be published, no information that could identify you will be included. Information will only be shared with faculty directly involved in this study.
 6. Questions about research may be addressed to Jason Vega at 408-529-8726 or Jasonvega1981@gmail.com. Complaints about research may be presented to Dr. Jan English-Lueck at 408-924-5347 jenglish@email.sjsu.edu, or Dr. Pamela Stacks at 408-924-2427. Further information can be obtained through the SJSU Office of Graduate Studies and Research: 408-924-2427, website: <http://www.sjsu.edu/gradstudies/>.
 7. No service of any kind, to which you are otherwise entitled, will be lost or jeopardized if you choose not to participate in this study.
 8. Your consent if being given voluntarily. You may refuse to participate in the entire study or in any part of the study. If you participate in an interview, you have the right to not answer any question you do not wish to answer. If you choose to participate in the study, you are free to withdraw at any time without any negative effect on your relations with San Jose State University or the Santa Clara County Emergency Medical Services. You have the right to not answer questions that you do not wish to answer.
 9. At the time that you sign this consent form, you will receive a copy of it for your personal records, signed and dated by the researcher.
- The signature of a subject on this document indicates agreement to participate in the study. The signature of the researcher on this document indicates agreement to include the above named subject in the research and attestation that the subject has been fully informed of his/her rights.

Participant's Signature

Date

Researcher's Signature

Date

Oral Consent Form

Responsible Investigator: Jason Vega

Title of Study: Vietnamese-American Health Care: An Informative Guide for EMS Personnel

I am currently working on a project for my anthropology degree from San Jose State University, and part of that requires that I conduct fieldwork in Santa Clara County. Please let me describe the main features of this project. This assignment involves conducting interviews and surveys to collect information about patient/provider interactions in emergency situations in order to better understand the barriers and facilitators to healthcare.

Confidentiality: Neither you nor your family will be identified in the paper I submit, nor will any other identifying characteristics be given to anyone.

Voluntary: Participation in this project is voluntary. You may choose not to talk with me about certain topics and you may decide to end your participation at any time without any penalties to you or your family. I shall not use any information that you provide should you so choose.

Benefits: The purpose of this project is to better educate emergency personnel about the social and cultural differences that may exist between themselves and the Vietnamese community. Therefore, promoting cultural understanding may lead to the betterment of emergency medical care to Vietnamese patients and their families. I will provide you with a copy of the report I turn in for a grade if you wish.

Risk: While there is little risk to you in participating since I am taking steps to protect your privacy, there is always the chance that someone could identify you in spite of those steps.

If you have any questions regarding my research, you may contact myself or my professor at the following phone numbers and email addresses, as well as Pamela Stacks, Ph.D., Associate Vice President, Graduate Studies and Research, at (408) 924-2427.

Jason Vega
408-529-8726
Jasonvega1981@gmail.com

Jan English-Lueck
408-924-5347
jenglish@email.sjsu.edu

Thank you for your time and participation.

BY SIGNING THIS FORM THE STUDENT IS CERTIFYING THAT THEY HAVE ORALLY INFORMED THE PARTICIPANTS OF THE PROJECT AND OF THE ITEMS AND STATEMENTS ABOVE. THE STUDENT WILL PROVIDE THE PARTICIPANT WITH A COPY OF THIS SIGNED DOCUMENT.

Students Signature: _____

Students Name: _____

Thỏa Hiệp Tham Dự Cuộc Nghiên Cứu

Người Phụ Trách Điều Tra: Jason Vega

Tiêu Đề Nghiên Cứu: Chăm sóc sức khỏe cho người Việt Nam: Cẩm Nang Hướng Dẫn Cho Nhân Viên Dịch Vụ Y Tế Cấp Cứu

1. Bạn được yêu cầu tham dự vào một cuộc nghiên cứu để điều tra về những sự thuận lợi và trở ngại trong dịch vụ y tế cấp cứu (EMS) giữa nhân viên EMS và cộng đồng Việt Nam thuộc quận hạt Santa Clara.
 2. Bạn sẽ được người nghiên cứu hỏi về kinh nghiệm của bạn dưới danh nghĩa là người cung cấp dịch vụ y tế, hay là một bệnh nhân, hoặc là thân nhân của bệnh nhân, để chúng tôi hiểu rõ hơn về những yếu tố xã hội, văn hóa, cũng như những hoàn cảnh có ảnh hưởng đến việc chăm sóc y tế cấp cứu. Cuộc phỏng vấn này sẽ không diễn ra trong lúc bạn đang điều trị hay đang được điều trị khẩn cấp.
 3. Xác suất và mức độ tổn hại hay phiền phức bao hàm trong cuộc nghiên cứu này không thể cao hơn mức độ mà bạn thường trải qua trong cuộc sống hàng ngày.
 4. Cuộc nghiên cứu này rất có lợi cho những người tham dự vì việc mở rộng kiến thức văn hoá cho nhân viên EMS sẽ giúp họ phát huy những phương thức điều trị phù hợp với văn hóa cộng đồng Việt Nam hơn, nhờ đó giảm thiểu sự căng thẳng văn hóa xã hội có thể đang hiện hữu.
 5. Mặc dù kết quả của cuộc nghiên cứu có thể sẽ được công bố nhưng sẽ không bao gồm bất cứ dữ kiện nào để người ta nhận biết được bạn là ai. Thông tin chỉ được chia sẻ với các nhân viên đại học trực tiếp liên quan đến cuộc nghiên cứu này.
 6. Xin gửi những thắc mắc về cuộc nghiên cứu này đến Jason Vega tại số 408-529-8726 hoặc Jasonvega1981@gmail.com. Những khiếu nại thì xin chuyển về Tiến sĩ Jan English-Lueck, số 408-924-5347 hoặc Jenglish@email.sjsu.edu. Khiếu nại về nghiên cứu có thể được trình bày Pamela Stacks tại (408) 924-2427. Biết thêm thông tin có thể thu được thông qua Văn phòng SJSU học sỹ và nghiên cứu: 408-924-2427, website: <http://www.sjsu.edu/gradstudies/>.
 7. Bất cứ quyền lợi nào mà bạn đang hưởng sẽ không bị mất hay bị tổn hại trong trường hợp bạn quyết định không tham dự vào cuộc nghiên cứu này.
 8. Sự thỏa thuận của bạn là tự nguyện. Bạn có thể từ chối tham dự toàn thể cuộc nghiên cứu hay chỉ một phần nào mà thôi. Nếu được phỏng vấn, bạn có quyền từ chối bất cứ câu hỏi nào bạn không muốn trả lời. Nếu bạn nhận tham dự cuộc nghiên cứu, bạn có thể tự ý rút lui bất cứ lúc nào mà không bị ảnh hưởng xấu đến sự quan hệ với Đại Học San Jose State hoặc các Dịch Vụ Y Tế Khẩn Cấp Quận Hạt Santa Clara. Bạn có quyền không trả lời các câu hỏi mà bạn không muốn trả lời.
 9. Khi bạn ký vào tờ thỏa thuận này, bạn sẽ nhận được một bản sao do nhà nghiên cứu ký tên và đề ngày, để bạn giữ trong hồ sơ cá nhân.
- Chữ ký của bạn trên tài liệu này xác nhận bạn đồng ý tham gia vào cuộc nghiên cứu. Chữ ký của nhà nghiên cứu trên tài liệu này xác định sự chấp nhận người nói trên vào cuộc nghiên cứu, và chứng thực người đó đã được nghe chúng tôi trình bày về những quyền lợi của mình.

Người tham dự ký tên

Ngày

Nhà nghiên cứu ký tên

Ngày

XI. Interview Protocol

EMS PROVIDERS

Pseudonym:

Profession:

How many years of Experience:

Gender:

Age:

- 1) How do you define an emergency situation?
- 2) How do you define health? Illness? Healing?
- 3) What causes illness?
- 4) How is health maintained?
- 5) In general, how is illness treated?
- 6) Can you tell me about a memorable time when you interacted with a Vietnamese-American patient during an emergency?
- 7) How did that interaction go?
- 8) Did the patient or his/her family know what was going on? Was there a language barrier? Cultural barrier?
- 9) What do you think can be done to make the interactions between Vietnamese patients and emergency personnel better?

Vietnamese-Americans

Pseudonym:

Gender:

Age:

POB:

Highest Level of Education:

- 1) How do you define an emergency situation?
- 2) How do you define health? Illness? Healing?
- 3) What causes illness?
- 4) How is health maintained?
- 5) How is illness treated?
- 6) Can you tell me about a time when you interacted with emergency providers during an emergency that involved you and/or your family?
- 7) How did that interaction make you feel?
- 8) Did you understand what was going on? Was anyone rude or kind to you?
- 9) What do you think can be done to make the interactions between Vietnamese-American patients and emergency providers better?

Medical/Cultural Professionals

Pseudonym:

What is your Profession?

How many years of experience do you have in your field?

- 1) How does your field/culture define traditional medicine/biomedicine?
- 2) How does Western health care/Vietnamese traditional medicine define health? Illness? Healing?
- 3) What are some causes of illness?
- 4) How is health maintained?
- 5) In general, how is illness treated?
- 6) What is expected of an EMS provider during an emergency situation? / What is expected of a medical patient?
- 7) What types of social/behavior models are expected of the EMS provider when addressing the Vietnamese patient and his/her family? / Are there any social/behavior differences that you have noticed when treating Vietnamese patients opposed to western patients?
- 8) Are there any taboos in regards to medical treatment? / What do you do if there are taboos regarding medical treatment?
- 9) What do you think can be done to make the interactions between patients and emergency personnel better?