The Indochinese Refugees as Patients

TRAN MINH TUNG, M.D

In the early days of the resettlement program, a common concern among the Indochinese refugees was whether they would find physicians who could speak their language and understand their problems. Five years later, only a few have actually received care from the handful of Indochinese physicians licensed to practice in this country. The majority have had to be content with what was available at the time of their illness, namely a non-Indochinese health professional with whom they rarely felt they had full communication.

Most patients have had only praise for their doctors and all have felt grateful for the services provided. Yet, as one refugee put it nostalgically, "That was not quite it, and it is not like when we were back home." There was no reproach, only regret and longing for something important which was missing. East is East and West is West, and though the refugee or his interpreter has put forth his best English, he is never sure that the American doctor has really grasped what he has tried to say or that the doctor will give him all that he needs.

For the American practitioner, the anxiety may be less, but certainly not the frustration. In these situations, it is usual to feel uncomfortable, often annoyed and angry. And this makes the bed for an uneasy relationship and poor medicine.

This paper is intended to contribute to the improvement of the process of communication between patients and health care personnel by describing the experience of the Indochinese as patients in their home country and in the U.S. I will present Indochinese concepts of health and disease, their views of medicine and medical practitioners, their experience with medical practice back home, and how all this affects their dealings with the American medical system.

The description focuses on the Vietnamese population, largest and best known of the different groups of Indochinese in the U.S. Most of what will be said, however, is generally applicable to the Cambodian, Lao, Hmong, or ethnic Chinese refugees. There are differences between these groups. But these, in my opinion, are less important than the similarities which stem from having lived in the same general geographic area, under similar socio-economic circumstances, and exposed to similar health conditions. The individual's level of sophistication and familiarity with Western ideology and technology -- rather than his cultural biases -- will determine his medical behavior: a Western-educated urban-dwelling Lao or Cambodian will be closer to his Vietnamese counterpart than to a poor, rural-dwelling compatriot with less exposure to Western medicine.

TRADITIONAL VIEWS OF MEDICINE

As in other facets of human life, an individual's approach to health care is the result of learning derived from actual experience or transmitted from the past, by tradition. The Vietnamese, strongly oriented in the past, unquestioningly hold to many ideas and practices handed down.
from generation to generation. Yet, as pragmatists who recognize a good thing when they see it, they would also be eager to adopt and use newly imported notions and techniques which proved to be advantageous and effective. The medical scene in Vietnam, therefore, presents a composite picture of multiple, parallel medical systems from which the patients pick freely (and rather indiscriminately at times), combining folk-medicine practices coming from their cultural heritage with the latest medical procedures coming from the West (Tung, 1972b; Republic of Vietnam, 1970).

Such an accommodating attitude can be seen first of all in the way Vietnamese people conceptualize the cause of their diseases. Pragmatism being the basic stance, the first movement will be to search for a "natural" explanation, that is, an immediately visible cause of the symptoms, such as rotten food which would cause an upset stomach. As the direct offshoot of this empirical approach, there exists an informal body of knowledge about medicinal herbs, special diets, and simple medical or hygienic measures based on experience, transmitted by oral tradition, preserved as family remedies. This true folk medicine, properly indigenous, is often referred to as southern medicine, in contrast to northern medicine which is more scholarly and esoteric and derived from a Chinese model that will be described below (Huard and Wong, 1968).

A second line of explanation is that disease is the manifestation of supernatural powers -- gods, demons, spirits. The punishment, illness, has come about after a fault, a violation of religious or ethical codes, or simply an accident which has caused displeasure to some deity. It could also be due to malevolence, the result of black magic and the dark machination of an enemy who has bought the services of a sorcerer.

Animistic explanations are much less often evoked nowadays, as people are more conversant with the natural sciences. They still lurk in many minds, however, and will be readily revived when the symptoms are unusual, obscure, or bizarre and no evident causal element can be incriminated, as in the case of mental disorders. The remedy in these instances is no longer within the realm of medicine, but lies in the use of charms, amulets, and expiatory or exorcism ceremonies to be performed by the bonzes (Buddhist priests) or sorcerers (Westermeyer and Winthrop, 1979).

The third system of explanation, also the most unique, is more specific to those cultures of East Asia which are under the influence of China (Kleinman, et al., 1975). It combines naturalistic observations with philosophical considerations to build medicine into a metaphysical construct. From this perspective, health is but a facet of life in the universe which functions within a unified, comprehensive scheme. In tune with nature, the human body operates with a delicate balance between two basic opposite elements: Am (Yin) and Duong (Yang), or Male and Female, or Light and Darkness.

In medicine, the two poles become Hot and Cold, and health is the perfect equilibrium of hot and cold elements which results from the harmonious functioning of the viscera. Any excess in either direction leading to disequilibrium means a deranged physiology, discomfort, and illness. Certain diseases, for example, are said to be due to an excess of the cold element, such as diarrhea, attributed to a cold stomach. Others are ascribed to an imbalance toward the hot pole, such as pimples or pustules that come from too much hot element which then erupts through the skin.

The golden rule in medicine, then, consists in juggling the hot and cold qualities of drugs, foods, and other natural elements to fit the hot and cold status of the body organs in order to retain or regain the vital balance.
Among foods, most vegetables are cold; spices, sweets, and candies are hot. Most fruits are cold, but tangerines are hot. Tea is cold, while coffee is hot. Ice is hot, not cold, which explains the restraint put on its use in case of fever. Drugs and medicinal herbs are also carefully classified according to their properties along a scale of hot and cold effects. As a rule, Western medicines are all hot, and herb medicines, in general, possess more cooling properties.

Somewhat related to the above, the Vietnamese go about explaining their ailments with another distinctive theory of body humors. The principal protagonist of these humors is named gio or phong meaning wind, and it serves to indicate either the causal factor or an extremely acute disease or a pathological condition characterized by a skin eruption. A stroke or seizure is due to the wind, but so is a common cold. Hives and leprosy are also varieties of phong. Certain foods, especially certain meats, are said to carry phong effect and, as such, are looked upon with suspicion. Beef has this reputation, and buffalo meat is worse — as bad as certain seafoods — while pork and chicken are considered benign.

**PHYSICIANS AND MEDICINE**

In such a context, where an illness is thought to stem from the complex interaction of multiple factors, medicine also becomes multi-dimensional. It involves a body of empirical knowledge, combined with mystical beliefs and metaphysical postulates. The physician is cast in the role of a man of science, a depository of wisdom, at the same time that he is endowed with extraordinary, if not magical, powers. To the patient, it may seem that the doctor arrives at his diagnosis after threading his way through the mysterious paths of a system known only to himself and his disciples. The patient need not tell him the symptoms that caused him to come in, as the doctor should be able to identify the problem right away, at first sight. A physical examination is not necessary; only a delicate touch of the pulse at the wrist will tell it all. As a remnant of this tradition, one still sometimes witnesses a patient's reluctance to detailed history-taking and an occasional provocative reply: "Why do you have to ask? You are a doctor, you should be able to tell me what I have." There exists also a resistance to disrobing, which the patient will prefer to do in small steps, one article of clothing at a time.

The ingredients used in the treatment also contribute to this mystical atmosphere; the rarer or more extravagant or exotic they are, the more power they are reputed to have. Extraordinary cures for the most severe illnesses are expected from the use of monkey's brain, tiger's bones, horns of a rhinoceros, goat's testes, or bear's gall bladder.

The man-in-the-street's answer to minor ailments is somewhat simpler, but still in line with the traditional concept of disease. For example, most Asians never fail to keep in their medicine cabinet or to carry in their purse a vial of some oil or ointment, the names of which are household by-words: Nhi Thien Duong, Tiger's balm, Burma's Cula. The cure-all, with a menthol and eucalyptus base, can be rubbed under the nose, on the temples, on the belly, or even taken by mouth. It is said to help combat a cold, to calm indigestion, and generally to deter any kind of phong malady. The popularity of this Asian version of snake oil has not decreased at all among Indochinese in the U.S. and the Asian food stores here do a good business selling different brands of these nostrums.

**Responses to Surgery** As medicine mainly deals with invisible fluids and immaterial elements, Indochinese feel there is rarely call for invasive techniques or surgery. Even lesions are expected to heal as the result of an adjustment of the body's internal economy, not by manual
intervention. Hence, there is a great resistance to any suggestion of surgery, accompanied by a great fear of mutilation.

The closest a Vietnamese would come to a manual medical procedure is through "rubbing out the wind," (cao gio), the rationale of which resides with the phong theory. The procedure consists of a forceful and insistent rubbing of specific areas of the forehead, the root of the nose, the neck, chest, and back, either with the fingers or with a coin. The maneuver is said to be successful when it leaves a dark bruise on the skin. This intrigues or alarms an uninformed observer, to the point that he will raise the question of possible trauma or poisoning (Yeatsman, et al., 1976). The cure is reputed to operate by uncovering the phong which has caused the cold, shivering, fever, or stroke.

The Physician

By virtue of his special attributes -- commanding life and death, and masterminding the operation of mysterious forces in the universe -- the physician commands veneration and demands absolute obedience. His pronouncements are definitive, and his decisions are not to be ignored. Many physicians might delight in wielding such authority and would have little motivation to change the situation or to foster more independence in their patients.

Further, Indochinese patients often relish the easy role of passive recipients of miraculous gifts and enjoy carrying no responsibility for their treatment. In fact, in an Asian culture, being sick is about the only time when an adult, especially a male, is allowed such a complete dependency and can expect the most devoted attention and sacrifices from his family while he relinquishes all responsibilities toward himself and others. By all standards, it represents so great a deviation from any normal social role that the individual will feel obligated in all likelihood to endure discomfort and to retain his composure for as long as possible and only give in when the pain or physical disability has become too great to be ignored. Stoicism, highly valued as a strength of character, cuts down complaints and the groaning and moaning from patients and means that they will be exceptionally "good" (compliant) patients. Oftentimes, however, it also keeps Indochinese patients from attending to their discomfort and delays their call for help so that when diseases are discovered, they are often in an advanced stage.

WESTERN MEDICINE AND MEDICAL PRACTICE

The legacy from the past is still very much alive in most Vietnamese minds and quite influential in shaping certain aspects of their medical behavior. As a system of medicine, however, the role of traditional cures has markedly declined since the advent of another brand of medicine which came from the West in the wake of the French colonial regime.

Modern medicine has made some inroads in health practices through the education of the population. For most Indochinese, however, practicality and the lessons of experience have been more powerful agents of change. And indeed, what many have experienced has been impressive -- Western medicine bringing almost instant, spectacular relief to diseases for which traditional medicine was of little or no help. For a population plagued by diseases resulting from poverty, ignorance, and substandard living conditions, chemotherapy, antibiotherapy, and vitaminotherapy have truly performed wonders and completely changed the outlook of the healing arts. Modern drugs have provided miraculous cures for the innumerable microbial infections, parasitic infestations, and nutritional deficiencies which constitute the staple of medical practice in a developing country. And more importantly, the feat is accomplished repeatedly, inexpensively, and, so it appears, quite simply and effortlessly.

In the last three decades, therefore, the Vietnamese people, even the less
educated among them, have discarded most of their qualms about embracing a system which, in many respects, departs substantially from their traditional views of medicine.

Such acceptance has come as a result of a real appreciation of the effectiveness of Western medicine. The basis of effectiveness, however, is sometimes perceived in quite an improbable manner. For example, the admiration may be less for Medicine than for medicines and medical gadgets, less for the new scientific ideology than for the novel paraphernalia --- capsules, ampules, hypodermic syringes --- especially since World War II. The populace has eagerly accepted the latest medical inventions coming from the West, but at the same time has made agonizingly slow progress in changing its lifestyle to be more compatible with the modern techniques of hygiene and preventive medicine.

A further distortion occurs when the use of medicines becomes equated with symptom relief and recovery. Given the often-witnessed sequence of illness - medication - remission, the conclusion would be almost inescapable that no cure could ever come about unless one was given some medicine, or better, many medicines. Hence, the constant expectation of the Vietnamese is to be medicated when they are ill. And if they go to a doctor, the insistence is even more strenuous on obtaining a prescription for medication, more medicines, "stronger" medicines. The emphasis, in particular, is on getting something "better," i.e., different from what they took before they came to the doctor, because, as a rule, they would have prescribed for themselves some medication when the symptom first appeared.

Indeed, the practice of self-medication is another major feature of the popular medical behavior in Vietnam. Here again, one sees pragmatism in action. Self-medication first started as an expedient, almost a necessity for people who could not afford the trouble, time, and money to procure proper medical care from qualified health personnel. The expedient, however, soon became a reasonable and acceptable way of dealing with health problems, thanks to the modern drugs, which were readily available, relatively inexpensive, convenient and easy to use, and, above all, eminently efficacious. As a result, fewer patients reached the doctor's office or the hospital. When they did, their pathology would probably be more severe and the clinical picture more muddied than warranted by the original distress.

In practice, therefore, most patients go through all or part of a step-wise process which includes self-medication as the first stage, followed by a visit to an auxiliary health worker --- nurse, midwife, or paramedic; next there is consultation with a doctor, and finally the hospital as the last resort.

The progression is complicated, of course, by the fact that Vietnamese patients can choose among a variety of medical routes: traditional, magical, or scientific. Western medicine is often the first choice for practical reasons. Traditional medicine may be preferred for certain diseases, such as menstrual disorders or phong maladies. Magical or religious healing is generally in order for psychoses or protracted, wasting-type diseases. As a rule, however, no option is completely ruled out, and the Vietnamese patient may go back and forth, sampling a bit of everything or combining all the different brands of medicine, just to make sure that he does not miss any bet.

There is one reservation which prevents Indochinese adherence to Western medicine from being complete. This is a popular notion, shared even by the better educated portion of the population, that a drug or preparation originating from the West may not be suitable for people with a different body build or a more delicate constitution. Western medicines are powerful and effective, but their action can be crude and indiscriminate,
perhaps not quite appropriate to the fine-tuning necessary for an Oriental patient.

**The Vietnamese Patient and American Medicine**

This, in essence, is the concern most frequently expressed by the refugees coming in contact with American medicine — it may do them harm because of its very potency, and its potency may somehow be misguided. The implication is that the American approach to medicine is aggressive, mechanistic, and one may even say, not too artful. The Vietnamese patients admire machines and instruments used in support of medicine, they marvel at the thoroughness of medical work-up, and they stand in awe before the myriad of tests and procedures. They are impressed and they are scared. And they are disturbed by the fleeting thought that maybe their doctor is groping in the dark, since he is not familiar with their background, lifestyle, and pathology.

The core of Vietnamese patients' apprehension, then, and the view which most strongly affects their relationship with American health practitioners is their uncertainty that the American doctor could ever have real mastery over their disease, because they are different.

The doubt is rarely expressed, but frequently manifests itself at the moment of truth — when the patient has to carry out treatment prescribed by the American doctor. Then, it is a rare Indochinese patient who will not stall, procrastinate, and bicker about the medicine, its strength, its dosage, or even the fact that it should be taken at all. Ultimately, he may take it upon himself to reduce the amount of medicine, or cut short the length of the treatment, independently of whether he feels better or not. Even if he abides by his doctor's orders, it is always with much soul searching, for constant is his fear that "My doctor may not have remembered that I am not American, and what he prescribed seems to be more than enough to kill a horse or a buffalo."

It is unlikely that health personnel ever hear direct or insistent queries on such issues during or after the consultation, when the patient is handed his prescription. Questions and resistance will come later, always in a covert fashion. And the changes in the therapeutic regimen will be often surreptitious, not because of duplicity, but in order to save face for both parties and not to hurt anybody's feelings.

Indochinese reserve also makes these patients suffer from another handicap — that of not being able to understand or to communicate. The patient has a thousand questions in mind and dares not ask them. Even if he does --- and nurses and doctors are generally willing to talk --- what the latter describe in their answers evokes no image and makes little sense to him. He misses the familiar signposts which could help to situate the problem: a phong malady, a cold condition. These barriers to communication create frustration, reinforce anxiety, and soon enough foster a sense of helplessness and despair. This despair is reinforced by another fear: that of being deserted by those he counted upon the most, namely his family. "Back home," the family in its extended form would have provided essential support when one was ill (Tung, 1972a). But to many refugees, this does not seem as available as it used to be. Now, in exile, the family hardly has time to accompany him to the doctor, even less time to nurse him or take care of him at home. And if he is hospitalized, he fears he will be left alone with his pains, his anxiety, with nobody to turn to for comfort or to share his anguish.

**The Good Patient**

American health service professionals may remark that the patients they have met rarely look desperate or depressed, that they seem reasonably content, even cheerful, often smiling, seldom complaining or demanding.
This is precisely the point: the "good patient look" is what the culture demands. In addition, in Indochinese cases, denial and avoidance also play their role to cover up and defend against anxiety.

It has been observed that the use of medical services by refugees in the U.S. has been generally modest and definitely less than predicted, this despite a culturally determined tendency to use physical complaints to express psychological distress. This under-utilization may be the effect of the several responses — reluctance, stoicism, anxiety — of Indochinese to American medicine and health services. It also demonstrates the pre-eminence of good communication in delivery of any service offered to the refugees (Silverman, 1977).

WHAT TO DO?

The question now is what to do. The first step, an absolutely necessary one, is to acknowledge that a problem exists between Indochinese patients and their American health service providers. The problem is grounded in cultural differences and communication difficulties.

A second step will be to look for ways to increase, facilitate, or simply establish communication. A bilingual/bicultural aide would be ideal to help bridge the gap, especially if he or she has some professional responsibility in addition to serving as an interpreter.

But even if only minimal bilingual support is available, thoughtfulness and a little preparation on the part of those working with Indochinese refugees can go a long way to foster trust and to reassure the patients about their transactions with the system. Simple orientation pamphlets in Indochinese languages, translations of the medical history questionnaire, or at least a bilingual dictionary may relieve some of the patient's fear of the unknown, ease his tension, and permit him to use better his own capacity for communicating.

Most important and better than any gimmick is what can be conveyed to the patient. Their feelings of inadequacy render them sensitive to the slightest hint that they are being lightly dismissed, or belittled, or ridiculed. The worst attitude would be commiseration and condescendence. A simple instance can serve as an example. An American doctor asked an interpreter to explain to his Vietnamese patient that he was writing a prescription for some "happy pills." The patient knew some English, understood the funny name, and was angered for being talked down to by the doctor. He exploded in anger when he found out the prescription was for Valium. Most Vietnamese know about tranquilizers and he would have easily understood if the name had been given in a forthright manner.

Cultural specificity aside, the problem is basically that of health service providers relating to a patient — to any patient, Asian or American — hearing him out, talking to him in such a manner as to be understood, while conveying to him respect and consideration. Technical jargon should be avoided, but without implying that the patient is backward or ignorant. It does help to know about the patient's cultural background, if only because it is reassuring to have some familiarity with the terrain. But even if one's knowledge about the Indochinese is quite sketchy, the best instrument to work with the patient is still the capacity for empathy — to feel in tune with his difficulties; for tolerance — to accept that he can be different; and for compassion — always to see a human being as worth attention and respect. On all accounts, what these patients wish to see is attention to their special problems, and help for their special needs, and reassurance in order to feel that their foreignness is not depriving them of what the helping profession is meant to give to all patients: humane, purposeful, and compassionate service.
NOTES

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