Care for Laotian Ethnic Minorities: A Cross-National Study of Medical Students in Laos and California

Katherine Crabtree*

UC Davis College of Medicine, Sacramento, CA, USA

*Corresponding author: Katherine Crabtree; katcrabtree@gmail.com

Background: *In both the United States and Laos, Lao ethnic minority patients face cultural and linguistic challenges to adequate medical care. We may be able to learn from Lao experiences to improve care for patients in the United States. This study explored Laotian and American medical students' experiences in care for these patients.*

Methods: *Laotian and American medical students (*n *= 19) participated in five interview groups discussing barriers to health care and strategies for addressing barriers for Laotian ethnic minority patients.*

Results: *The students identified similar barriers to care. Laotian students identified unique strategies to address barriers to care. American students focused on general approaches to cross-cultural care.*

Discussion: *The strategies that Laotian medical students learn in their training reflect their extensive exposure to Hmong and other Laotian ethnic minority patients, while American students learn broad strategies to care for many minority groups. Further work is needed to determine if their experience can be translated into the domestic context.*

Keywords: *Hmong; Mien; Laos; refugees; cross-cultural healthcare; medical education.*

BACKGROUND

After fighting alongside American forces against the North Vietnamese military in Laos, large numbers of Hmong and Mien Laotian refugees came to the United States in the 1970s.[1,2] Since 1975, an estimated 30,000 Mien[3] and over 130,000 Hmong[4] have settled mostly in California, Minnesota and Colorado.[5] The Hmong and Mien are also minorities in Laos[6] and in both the United States and Laos, these groups face barriers to healthcare including language discordant care, culture-based belief differences and distrust of the system.[7–19] These groups make up 100 times more of the population in Laos than in the United States, and the majority Lao Loum population has lived alongside them for centuries,[20] theoretically narrowing the cultural gap. With these differences noted, this study explored the experience of both Laotian and American students in caring for Hmong and other Lao ethnic minority patients.

METHODS

Interviews were conducted with a convenience sample of 10 students at the National University of Laos College of Medical Sciences in Vientiane, Laos, and 9 students at the UC Davis School of Medicine in Sacramento, CA, home to the third highest population of Hmong residents in the United States.[21] Interview groups were conducted between May and August 2011. The structure of these groups is described in Table 1.

The interviewer (KC) opened the discussion with two patient care examples from the literature[22,23] and continued with a question guide that was developed through literature review (see Table 2). Interviews ranged from 2.25 to 3.5 hours and were conducted in English. To protect student anonymity, interviews were not audio or video recorded but the interviewer took copious notes using shorthand and transcribed the notes for analysis. Participants were compensated with refreshments.

The University of California Institutional Review Board (IRB) approved the study. Interviews conducted in Laos conformed to United States IRB standards due to the absence of an IRB equivalent in Laos.

Two authors (KC and OM) reviewed transcripts independently, generated codes and identified salient themes,[24] collaborating to determine major themes around barriers to care and strategies to improve care. Coding categories were applied to transcripts using Dedoose (Los Angeles, CA) qualitative analysis software.[25]

Table 1. Interview groups and participant characteristics

	n	Interview length (h)	Gender (% female)	Age range, average	Ethnicity	Training level last preclinical year (%)[a]
Lao group 1	4	3	75	20–23, 21	Lao Loum, 100%	100
Lao group 2	6	3	83	21–32, 24.5	Lao Loum, 100%	100
US group 1	3	2.25	100	22–27, 24.7	African American, 33% Caucasian, 66%	66[b]
US group 2	3	2.5	33	23–24, 23.7	Chinese, 66% Taiwanese, 33%	100
US group 3	3	2.5	33	22–25, 23.3	Chinese, 33% Caucasian, 66%	100

[a]All students interviewed were in their last preclinical year, that is, the second year (total 4 years) for American students, and the third year (total 5 years) for Lao students.
[b]Other statements from a phlebotomy student were excluded in Dedoose analysis for themes.

RESULTS

Common Barriers

American and Laotian students both raised concerns about cultural barriers to healthcare for Laotian ethnic minority patients. Identified barriers in both Laos and the United States included language, religious differences, expectation of involvement of elders in care decisions, limited health literacy and preference for herbal medicine rather than Western medicine. Other barriers that were more specific to the Laotian experience included access problems such as cost of care and distance to care facilities, and barriers at the level of the health care provider such as concerns about provider shortages and inadequate compensation.

Despite their agreement that significant barriers to care exist for Laotian ethnic minority patients, the students were similarly optimistic about the patients that sought care. A Laotian student said, 'If they [Hmong patients] are coming to you [the physician], somewhere in them they're open even if they don't think so. It was their choice to come in'. In an American group, a student echoed this sentiment; 'The fact that the patient came to see the doctor is because they have some small part of belief in the doctor'.

Table 2. Discussion guide

Question stem: 'Based on your current level of education and experience . . .'

1) What barriers to health care face the Lao ethnic minority community?
2) What steps can be taken to overcome these barriers for Lao patients?
3) How is the Lao patient's perspective addressed?
4) What approach do you take when the problem is discomfort with Western medicine?
5) What kind of practice do you get with these situations in school?

US Approach to Barriers

US students offered general solutions rather than specific strategies for overcoming barriers, including broad concepts such as community empowerment, improving trust and patient-centered care. Students suggested that providers could address barriers to care by having knowledge of available community resources, working as a team with other healthcare providers and employing 'cultural humility' but were unable to provide specific strategy examples based on their preclinical exposure to the hospital setting. For instance, they believed it would be useful to employ more interpreters and cultural brokers, but after speaking about cultural brokers used in Hispanic populations, an American student was asked if this kind of solution existed for Hmong patients. He responded, 'Not to my knowledge, I'm just envisioning a perfect system'. They also felt conflicted about some specific approaches, such as their ability to discuss herbal medicine use with patients in the absence of support from attending physicians. One student explained, 'If we ask, ''Hey, can they take herbal?'' and [the attending] won't discuss, over time the more likely we are to be that way ourselves'.

American students drew from their knowledge of diverse groups in discussing barriers faced by Lao ethnic minority patients, referencing experiences with AIDS patients in Africa, Jehovah's Witnesses and blood transfusion, Ayurvedic medicine, the history of the Tuskegee experiment, traditional medicine use among Asian and Russian patients, and cultural brokers with Hispanic patients.

Lao Approach to Barriers

Laotian students discussed specific approaches to learning about care for Lao ethnic minorities (see Table 3). They discussed a month-long rotation during their first clinical year requiring students to live in a rural village providing care for a Laotian ethnic minority group, including both Hmong and others. The experience involved teaching the village about Western medicine and learning about traditional medicine, cultural practices and recipes for herbal remedies from the villages. One student summarized, 'First, the team [that] go to the village should know about how they live, not ''talk talk talk'' then come straight back . . . or else it is like the man who went to give a speech to a crowd, and he talked and talked but didn't look around him, and when he finished he looked out and only one person was left standing in the crowd'.

In the hospital, Laotian students reported that in preclinical shadowing, it was standard practice for an educated Hmong layperson to be available to explain health problems and decisions to Hmong patients. According to one student, 'If a Lao person tells something to a Hmong patient, they don't believe as they would if a Hmong person tells a Hmong person'. They also reported education on herbal remedies in their course work and a willingness to use herbal medication for minor illnesses. They described using that as leverage to persuade patients to use Western medicine when needed. 'For simple disease(s), like fever, we can let them take [herbs] and they get less side effects, but for severe disease(s) they have to take the correct medication'.

Finally, Laotian students reported that during their preclinical years they had often seen an entire extended family come to the hospital with a sick Hmong patient. The students assumed that the decision to treat the sick person did not lie with the parents or the patient only, but with the clan elders and family. They noted discordance with Western medicine practice in which patients were expected to make health-related decisions immediately, whereas for Hmong patients, these decisions often could not be made quickly or individually and depended on the opinion of the elder. One student summarized, '. . . they always have one person they respect the most. The doctor needs to go to that family member to explain what they have to do and if they don't what could happen to the patient'.

LIMITATIONS

Our study has some limitations. First, students were chosen via convenience sampling, which biased the sample to include only Lao students who were able to

Table 3. Summary of Lao medical educational strategies for improving care for Laotian ethnic minority patients, per students

Strategies to improve care	Examples from medical education	Possible applications for American students
Provide systematic, ideally immersive, opportunities for students to learn about communities	Laotian students spend a month in rural minority villages during clinical training to develop an understanding of culture and traditional medicine	Elective time in refugee clinic
Incorporation of education about use of traditional and herbal medicines	Laotian students learn to integrate traditional medicine into patient care, for instance, negotiating use of herbal medicines for minor illnesses in exchange for using Western medicine in the event of major illness such as malaria	Curriculum on herbal medication used in relevant patient populations
Allow for students to learn about family and elder involvement in care	Laotian students learn to allow elders to be involved in decision making for patients	Students should be trained to schedule family meetings with Laotian patients as soon as possible in hospital course
Increase opportunities for students to work with cultural brokers	Laotian students observed systematic use of not only a translator but also a transcultural mediator for care of Hmong patients	System-level endorsement of use of transcultural mediators in teaching hospitals
Build a conceptual framework around cross-cultural care	American students discussed need for cultural humility	Provide students with practical examples of community resources
Incorporate learning from other cross-cultural experiences	American students drew on their experience with diverse minority patient groups	Require in depth of relevant cultural groups during preclinical curriculum

speak English, a subset of students who may be different from their peers. Second, interviews were not recorded which could have resulted in some errors of omission; however, the pace of interviews was amenable to written transcription, and this method was chosen to minimize Lao students' concern of being identified as participants. Third, our small sample size could over- or underestimate students' exposure to Hmong patients. Finally, our study involved preclinical students with limited clinical experience. More clinical experience may improve student knowledge about cross-cultural care in the United States.

DISCUSSION

Medical school preparation to care for Lao ethnic minority patients differs greatly between Laos and the United States. Lao students reported receiving an education on Hmong and other minority patients that involved extensive interaction with them both inside and outside the hospital. Their educational experience gives them specific resources to apply to while caring for these patients. American students' education prepares them to care for different cultures in a more theoretical manner. Perhaps because American students are more likely to care for multinational patients, their education is less focused on specific minority groups. However, students would be well-served by a curriculum which introduces not only concepts and theories but also gives them an idea of what resources are available to assist them in caring for minority patients. Further studies should attempt to answer the question of how specific strategies used in Laos could be translated into the American context.

In a broader sense, the United States is culturally diverse, and refugees make up a particularly vulnerable patient population. Given that students will likely encounter a large number of refugees from around the globe,[26,27] who face various barriers to healthcare,[28] it is important to consider this as part of their medical education curriculum. As noted here with Lao students, the doctors in refugees' home countries naturally work with them more extensively than American physicians. American physicians therefore could potentially learn specific strategies from international providers for addressing shortfalls in health outcomes, for instance, in the case of Hmong patients, incorporating families into care and flexibility in use of herbal medicine.[29]

Future studies could attempt to implement specific strategies from refugee countries of origin, measuring effects on specific health outcomes and patient satisfaction. Implementation of strategies from the home country need to be considered within the context of the US healthcare system and will require innovation in international collaboration.

Conflict of interest and funding: The author has not received any funding or benefits from industry or elsewhere to conduct this study.

REFERENCES

1. Ghent A. Overcoming migrants' barriers to health. Bull World Health Org 2008; 8: 583–4.
2. Habarad J. Refugees and the structure of opportunity: transitional adjustments to aid among U.S. resettled Lao Iu Mien, 1980–1985. Center Migrat Stud Spec Issues 1987; 5: 66–87.
3. Yeung B. We are the people: the history of the Iu-Mien. SF Weekly 2001; 20.
4. Lum T. Laos: background and U.S. relations. Congressional Research Service Report for Congress 2008. Available from: http://www.fas.org/sgp/crs/row/RL34320.pdf [cited 20 December 2011].
5. US Census Bureau, 2010 United States Census. 2010. Available from: http://www.census.gov/2010census [cited 20 December 2011].
6. Catanzaro A. Health status of refugees from Vietnam, Laos, and Cambodia. JAMA 1982; 247: 1303–8.
7. Laos overview. World directory of minorities and indigenous peoples. 2005. Available from: http://www.minorityrights.org/4014/laos/laos-overview.html [cited 20 January 2014].
8. Depke J. Coalition building and the intervention wheel to address breast cancer screening in Hmong women. Clin Med Res 2011; 9: 1–6.
9. Murphy-Thalacker K. Hypertension and the Hmong community: using the health belief model for health promotion. Health Promot Pract 2010; 13: 6.
10. Johnson S. Hmong health beliefs and experiences in the western health care system. J Transcult Nurs 2002; 13: 126–32.
11. Culhane-Pera K. 'We are out of balance here': a Hmong cultural model of diabetes. J Immigr Minor Health 2007; 9: 179–90.
12. BBC. Thai army deports Hmong to Laos. 2009. Available from: http://news.bbc.co.uk/2/hi/8432094.stm [cited 7 January 2013].
13. de Boer H, Lamxay V. Plants used during pregnancy, childbirth and postpartum healthcare in Lao PDR: a comparative study of the Brou, Saek and Kry ethnic groups. J Ethnobiol Ethnomed 2009; 5: 25.
14. Sydara K. Use of traditional medicine in Lao PDR. Complement Ther Med 2005; 13: 199–205.
15. Douangphachanh X. Availability and use of emergency obstetric care services in public hospitals in Laos PDR: a systems analysis. Biosci Trend 2010; 4: 318–24.
16. UN Committee on the Elimination of Racial Discrimination (CERD), UN Committee on the Elimination of Racial

Discrimination. Concluding observations, Lao People's Democratic Republic; 2005. Available from: http://www.unhcr.org/refworld/docid/42de64284.html [cited 23 December 2012].
17. Kanashiro J, Hollaar G, Wright B, Nammavongmixay K, Roff S. Setting priorities for teaching and learning: an innovative needs assessment for a new family medicine program in Lao PDR. Acad Med 2007; 82: 231–7.
18. Shirayama Y. Modern medicine and indigenous health beliefs: malaria control alongside 'Sadsana-phee'. Southeast Asian J Trop Med Public Health 2006; 37: 622–9.
19. Fadiman A. The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures. New York: Noonday Press; 1998.
20. Hmong American Partnership. Available from: http://www.hmong.org/page334122813.aspx [cited 27 November 2012].
21. Reznik V. Hais cuaj txub kaum txub – to speak of all things: a Hmong cross-cultural case study. J Immigr Health 2001; 3: 23–30.
22. Michaud J. Handling mountain minorities in China, Vietnam and Laos: from history to current concerns. Asian Ethnicity 2009; 10: 25–49.
23. Keomany S. Toad poisoning in Laos. Am J Trop Med Hyg 2007; 77: 850–3.
24. Miles B. Qualitative data analysis: an expanded sourcebook. Thousand Oaks, CA: Sage; 1994.
25. Dedoose web application for managing, analyzing, and presenting qualitative and mixed method data. Los Angeles, CA: Socio Cultural Research Consultants, LLC; 2012.
26. Martin D. Refugees and Asylees: 2011 annual flow report. US Department of Homeland Security Office of Immigration Statistics. Available from: http://www.dhs.gov/refugees-and-asylees-2011 [cited 1 November 2012].
27. Bhutanese refugee health profile. CDC; 2012. Available from: http://www.cdc.gov/immigrantrefugeehealth/profiles/bhutanese/background/index.html [cited 22 December 2012].
28. World Health Organization (2012). Country health profiles. Available from: http://www.who.int/countries/en/ [cited 22 December 2012].
29. Wong C. Adherence with hypertension care among Hmong Americans. J Community Health Nurs 2005; 22: 143–56.