

Generational Conflicts among Vietnamese Americans in the Health Care Decision Making Process

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1. Introduction

The United States population has changed over a decade; it has become more culturally diverse. With the cultural diversity continuing to progress in the U.S.; our society has shifted into a multicultural and pluralistic society. In fact, Asian and Pacific Islander Americans are one of the fastest growing populations in the U.S., “between 1980 and 1990 their numbers grew by 108 percent, more than 10 times the rate for the total U.S. population and between 1990 and 1999 their population grew [by] 43 percent to 10.8 million”.¹ The Vietnamese population represents one of the fastest growing Asian/ Pacific Islander group in the U.S. with approximately 1.3 million Vietnamese Americans in the U.S.² About forty-six percent of Vietnamese Americans live in California alone³. As time transcends, it is important to offer accommodation to all ethnic groups residing in the U.S. so that disparities within these groups will decrease.

The Vietnamese population is an interesting group compared to other Asian groups because unlike the other ethnic groups, they came not by will to seek better opportunities, but “arrived as political refugees or to rejoin family members, some doing so after spending time in Vietnam’s prisons or re-education camps⁴. As of September 1992, Vietnamese refugees resettlement reported 732, 971 living in the U.S.⁵ According to Le and Nguyen⁶, there are approximately 1, 548, 449 individuals who identify as Vietnamese and about 1, 651, 796 who identify themselves as Vietnamese with some other form of ethnicities residing in the U.S. The majority of the Vietnam-foreign born persons living in the U.S. arrived as refugees beginning in 1975.

The different degrees of immigration waves might explain generational conflicts in the health care decision making process, increased mortality among the elderly and lack or partial

¹ Surjit Singh Dhooper, “Health Care Needs of Foreign-Born Asian Americans: An Overview,” *Health & Social Work* (February 2003): 63-71.

² Giang T. Nguyen, Frances K. Barg, Katrina Armstrong, John H. Holmes and Robert

³ Christopher N. H. Jenkins, Thao Le, Stephen J. Mcphee, Susan Stewart and Ngoc The Ha, “Health Care Access and Preventive Care among Vietnamese Immigrants: Do Traditional beliefs and practices pose barriers?,” *Social Science Medicine* 43 (1996): 1049-1056.

⁴ Karen Pyke, “‘The Normal American Family’ as an Interpretive Structure of Family Life Among Grown Children of Korean and Vietnamese Immigrants,” *Journal of Marriage and the Family* 62 (February 2000): 240-255.

⁵ Thuy B. Pham and Richard J. Harris, “Acculturation strategies among Vietnamese-Americans,” *International Journal of Intercultural Relations* 25 (2001): 279-300.

⁶ Mai-Nhung Le and Tu-Uyen Nguyen. “Social and Cultural Influences on the Health of the Vietnamese American Population.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

acculturation could be the cultural determinant of increased morbidity and mortality among the Vietnamese American people living in America. The lack of education and knowledge about health care illnesses might justify a delay amongst the older generation who has not or partially acculturated in seeking the help they need. The lack of linguistic, culturally competent health services, lack of insurance, unaffordable health care costs, and not being able to access specialty care with language or cultural understanding⁷ may explain the disparities the Vietnamese Americans face in health care. The importance of addressing these concerns is that: In order to help Vietnamese Americans communities seek adequate health care needs, we must understand the disparities in health care that they have faced since their immigration to the U.S.

2. Acculturation

Acculturation is defined as a “process of adaptation to a new environment as a result of two independent cultures coming in contact with each other”⁸. This is important within the Vietnamese community because it allows us to understand why acculturation is difficult for some Vietnamese Americans. Each wave of immigration explains the acculturation process within the Vietnamese community in the U.S. Acculturation effects on the different Vietnamese generations are crucial in addressing the health care disparities that exist.

The first wave of Vietnamese immigrants comprised of more than 120,000 who left Vietnam before the Fall of Saigon⁹. This group consisted of well-educated individuals who had close connections to American servicemen. Due to their high level of education and skills, the first wave of Vietnamese immigrants easily adapted to American culture compared to the other waves of immigrants that arrived later¹⁰. While first wave Vietnamese immigrants adapted well to life in the U.S, other groups had greater difficulties adjusting¹¹. The second wave is referred to as “boat people,” who escaped communist Vietnam by boat and suffered tremendous hardships to come to America¹². Approximately more than 200,000 Vietnamese left Vietnam

⁷ C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

⁸ Thuy B. Pham and Richard J. Harris, “Acculturation strategies among Vietnamese-Americans,” *International Journal of Intercultural Relations* 25 (2001): 279-300.

⁹ Emeka Nwadiora and Harriette McAdoo, “Acculturative stress among Amerasian refugees: Gender and Racial differences,” *Adolescence* 31 (1996):477-487.

¹⁰ Mai-Nhung Le and Tu-Uyen Nguyen. “Social and Cultural Influences on the Health of the Vietnamese American Population.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

¹¹ Johanna Shapiro, Kaaren Douglas, Olivia de la Rocha, Stephen Radecki, Chris Vu and Truc Dinh, “Generational Differences in psychosocial adaptation and predictors of psychological distress in a population of recent Vietnamese immigrants,” *Journal of Community Health* 24 (April 1999): 95-113.

¹² C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

between 1977 and 1980¹³. Second wave immigrants fled to their neighboring countries, however, this “group suffered atrocities during their escape and were victims of torture, starvation, malnutrition, assault, rape, and/or robbery, with many children witnessing these atrocities¹⁴. This group consisted of older, less educated people who had difficulty acculturating to the U.S.¹⁵. The third wave and so on generally consisted of children fathered by American soldiers and their Vietnamese mothers¹⁶. There was also a group known as the Amerasians. Amerasians were individuals or groups of persons born of American servicemen and Vietnamese or Cambodian women during the Vietnam War¹⁷. Amerasians were also a group of refugees who were able to gain their U.S. citizenship due to a law passed in 1987 called Amerasians Homecoming Act. This was a law passed by congress permitting all Amerasians and their immediate families, including wives, half-siblings, and mothers, whether married or single, to immigrate to the United States as refugees but with full citizenship rights and obligations¹⁸. This particular group faced “accultural” hardship. Children of immigrants commonly lose their home country language and become predominantly English speaking in the U.S.¹⁹, showing signs of acculturation much faster than their parents.

3. Health Care Disparities in the Vietnamese American community

Racial and ethnic minority groups in the U.S. not only face social inequalities, but discrimination in our healthcare system, language barriers and limited access to health care

¹³ Mai-Nhung Le and Tu-Uyen Nguyen. “Social and Cultural Influences on the Health of the Vietnamese American Population.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

¹⁴ Rita Chi-Ying Chung, Fred Bemak and Sandra Wong, “Vietnamese Refugees’ Levels of Distress, Social Support, and Acculturation: Implications for Mental Health Counseling,” *Journal of Mental Health Counseling* 22 (April 2000):150-161.

¹⁵ Thuy B. Pham and Richard J. Harris, “Acculturation strategies among Vietnamese-Americans,” *International Journal of Intercultural Relations* 25 (2001): 279-300.

¹⁶ Sonia Gordon, Martha Bernadett, Dennis Evans, Natasha Bernadett Shapiro and Long Dang, “Vietnamese Culture: Influences and Implications for Health Care,” *Molina Healthcare* (2006): 1-8.

¹⁷ Emeka Nwadiora and Harriette McAdoo, “Acculturative stress among Amerasian refugees: Gender and Racial differences,” *Adolescence* 31 (1996):477-487.

¹⁸ Emeka Nwadiora and Harriette McAdoo, “Acculturative stress among Amerasian refugees: Gender and Racial differences,” *Adolescence* 31 (1996):477-487.

¹⁹ Monica M. Trieu, “The Role of Premigration Status in the Acculturation of Chinese-Vietnamese and Vietnamese Americans,” *Sociological Inquiry* 83 (August 2013): 392-420.

which leads to higher rates of morbidity and mortality²⁰. Vietnamese Americans have the lowest income and education level amongst the Asian American group and the second lowest group to have health insurance facing barriers to obtain adequate preventative health care²¹. Due to the widening generation gap between the older Vietnamese generation and the younger U.S. born generation, “there is a conflict on how to care for [...] older adults while still maintaining filial piety towards [them]”²². Understanding the acculturation process within the Vietnamese American community will allow us to tackle disparity issues in healthcare amongst the group who have not yet been fully acculturated. Some Vietnamese immigrants in the U.S. face acculturation challenges and “experts suggest[ed] that immigrant family members acculturate at different rates resulting in an acculturation gap” which can influence the negative impact of not seeking adequate health care²³. There are three waves’ of refugees within the population as a whole.

4. Health distribution among the Vietnamese and intergenerational conflicts

After settling in the U.S., some were able to adjust to their host environment but others were unable, “especially those who were older, less educated, and ha[s] not lived as long in the U.S.”²⁴ For this reason, the population of the older generations of Vietnamese Americans struggle with acculturation and face cultural and language barriers in health care as compared to younger generations. Foreign born Vietnamese are a disadvantaged group with “14% in poverty and 30% of adults having under high school education, poverty rates for Vietnamese immigrants age 65+ are even worse [at] 16.6%”²⁵. The cultural shift resulting from a complete acculturation process can be proved for the young generation of Vietnamese Americans but is debatable and

²⁰ Duy Nguyen, Leigh J. Bernstein and Megha Goel, “Asian American elders’ health and physician use: An examination of social determinants and lifespan influences,” *Health Affairs* 4 (2012): 1106-1115.

²¹ Melissa McCracken, Miho Olsen, Moon S. Chen Jr., Ahmedin Jemal, Michael Thun, et al, “Cancer Incidence, Mortality, and Associated Risk Factors Among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese Ethnicities,” *CA Cancer Journal Clinical* 57 (2007):190-205.

²² C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

²³ Joyce Ho, “Acculturation gaps in Vietnamese immigrant families: Impact on family relationship,” *International Journal of Intercultural Relations* 34 (2010): 22-33.

²⁴ Thuy B. Pham and Richard J. Harris, “Acculturation strategies among Vietnamese-Americans,” *International Journal of Intercultural Relations* 25 (2001): 279-300.

²⁵ Duy Nguyen, Leigh J. Bernstein and Megha Goel, “Asian American elders’ health and physician use: An examination of social determinants and lifespan influences,” *Health Affairs* 4 (2012): 1106-1115.

incomplete for the old generation²⁶. Due to acculturation hardship for the older Vietnamese generation, they are less likely to seek medical attention and treatment unless extreme circumstances arise. The Vietnamese population is susceptible to chronic illnesses such as: cancer, heart disease, stroke, hypertension and diabetes²⁷. This different degree of acculturation might explain generational conflicts in the health care decision making process. It is important that we address concerns regarding generational gaps and protect the rights and preferences of those who have not practiced acculturation within the Vietnamese American community because cancer is the leading cause of death within this group.

Due to the impact of the Vietnam War, children who were born to American soldiers face identity issues. Amerasians dealt with assimilation the hardest because they were rejected from the Vietnamese community due to their American affiliation²⁸. Rejections from the Vietnamese community led the Amerasians to identify themselves with their Americaness. Because of identifying to their American side, the Amerasians do not practice Vietnamese traditional values such as that of a collectivistic approach when dealing with informed health care decision-making. This group in itself shows a cultural shift. As time transcends, a generational gap is prominent due to acculturation that occurs within the Vietnamese American community in the U.S. and traditional roles are reversed, “elderly Southeast Asians must cope with their rapidly acculturating younger family members, while taking on different roles and expectations in a confusing and often frightening culture that’s divergent from and foreign to Southeast Asian cultures”²⁹. With Asian Americans is one of the fastest growing groups in the United States. 135 percent are identified as Vietnamese Americans³⁰ and although Vietnamese are categorized as Southeast Asians; we cannot assume that their approaches to health care decision-making are the same as other group of Asians. There is evidence of acculturation within the Vietnamese population in the U.S. because of their exposure to Westernization by the French and Catholicism between 1857-1955 and this “Westernization was more readily adopted by the upper

²⁶ Jean S. Phinney and Anthony D. Ong, “Adolescent-parent disagreements and life satisfaction in families from Vietnamese and European-American backgrounds,” *International Journal of Behavioral Development* 26 (2002): 556-561.

²⁷ C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

²⁸ Emeka Nwadiora and Harriette McAdoo, “Acculturative stress among Amerasian refugees: Gender and Racial differences,” *Adolescence* 31 (1996):477-487.

²⁹ Barbara W. K. Yee, “The Social and Cultural Context of Adaptive Aging by Southeast Asian Elders,” *The Cultural Context of Aging Worldwide Perspective*. 3rd Edition. Jay Sokolorsky. Greenwood Publisher: 2009.

³⁰ Surjit Singh Dhooper, “Health Care Needs of Foreign-Born Asian Americans: An Overview,” *Health & Social Work* (February 2003): 63-71.

class and highly educated Vietnamese, as evidenced by their fluency with French and later English. These Western cultural skills and willingness to adopt European and American culture makes the cultural transition to the United States [readily easy, compared to other Asian groups]³¹, however, this does not pertain to all of the immigrants in the three waves presented prior. The non-acculturated Vietnamese view life in a collective matter. Any decision made would be based on how it would be affecting their family and relationship. There is no individuality when making decisions even in regards to their own health. The family is included in every important decision making process. Vietnamese immigrants do not practice individualistic model. Individuals think in terms of the individual, how it would affect them independently, and on behalf of their own well-being. Because of the collectivistic mentality, immigrants who are foreign born and unacculturated are less likely to have public or private insurance than those who are U.S. born and are twice as likely to be uninsured in the U.S.³² which can explain the mortality rate within the Vietnamese Americans community.

5. Individualistic approach to health care decision making in a multicultural world

Vietnam is a part of the Southeast Asians group. Even though Asian and Pacific Islanders are categorized as Asians, they are different based on language, culture and history, but they do share a commonality when approaching health care decisions³³. Eastern cultures are based on collectivism and filial piety. Decisions are made involving the entire family and they do not believe in the individual's right to autonomy. Vietnamese core cultural values are based on Confucian ideals, "Confucian ideals emphasize filial piety, loyalty, social harmony and hierarchical order"³⁴. There is less emphasis on individuality and more on collectivity. Collectivism is defined as people who "give priority to the goals of their in-groups, shape their behavior primarily on the basis of in-group norms, and behave in a communal way"³⁵. The Vietnamese culture is oriented more towards family; an individual (most commonly the eldest son) would represent the family as a whole. However, a study has found that younger generations of Vietnamese Americans have lost their culture by affiliating with other American

³¹ Barbara W. K. Yee, "The Social and Cultural Context of Adaptive Aging by Southeast Asian Elders," *The Cultural Context of Aging Worldwide Perspective*. 3rd Edition. Jay Sokolorsky. Greenwood Publisher: 2009.

³² Namratha R. Kandula, Margaret Kersey and Nicole Lurie, "Assuring The Health of Immigrants: What the Leading Health Indicators Tell Us," *Annual Review of Public Health* 25 (2004):357-369.

³³ Linda A. McLaughlin and Kathryn L. Braun, "Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision Making," *Health & Social Work* 23 (May 1998): 116-126.

³⁴ C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

³⁵ Harry C. Triandis, "Individualism-Collectivism and Personality," *Journal of Personality* 69 (December 2001):907-921.

youths which causes family conflicts between the older and younger generation³⁶. The older generation has difficulty making the younger generation conform to traditional cultural values, “immigrant parents who are more oriented toward their native culture may find traditional parenting styles to be ineffective with children who are quickly adopting the host culture³⁷. Vietnamese elders “can no longer provide advice and lend their wisdom because it is derived from traditional culture, tied to the homeland, and not perceived by younger family members to be relevant to life in America³⁸. As there is a shift in cultural practices amongst the younger generation of Vietnamese Americans, the older generations “are at a great risk for having unmet [...] health needs and worse self-reported health”³⁹. This is an indication of acculturation hardship for the older generation.

Younger generations are conforming to the individualistic models and not upholding the traditional collectivistic model in the U.S., which causes generational conflict. Older generations rely on family as a means to make informed decisions, as the younger generation loses touch with their family traditional values. Older generations possibly feel that they have no one to turn to regarding important decisions. Individualism is the practice of autonomy and independence from their group of people in society⁴⁰. In America, informed consent has become essential in every aspect of health care as the primary focus of decision making⁴¹. Before 1960, health care decisions in the U.S. were based on paternalism⁴². Paternalism is where physicians would make informed health care decisions on behalf of their patients and it is used in the matter of protecting the patient from harm. It was not until the 1960s-1970s that an increased demand for patients’ right of making autonomous health care decisions emerged. U.S. medicine progressively became more advanced, providing more health care options that should be explained to patients.

³⁶ Kathryn L. Braun and Rhea Nichols, “Death and Dying in Four Asian American cultures: A Descriptive Study,” *Death Studies* 21 (August 1997): 327-359.

³⁷ Joyce Ho, “Acculturation gaps in Vietnamese immigrant families: Impact on family relationship,” *International Journal of Intercultural Relations* 34 (2010): 22-33.

³⁸ Barbara W. K. Yee, “The Social and Cultural Context of Adaptive Aging by Southeast Asian Elders,” *The Cultural Context of Aging Worldwide Perspective*. 3rd Edition. Jay Sokolorsky. Greenwood Publisher: 2009.

³⁹ Dara Sorkin, Angela L. Tan, Ron D. Hays, Carol M. Mangione and Quyen Ngo-Metzger, “Self-Reported Health Status of Vietnamese and Non-Hispanic White Older Adults in California,” *JAGS* 56 (2008):1543-1548.

⁴⁰ Harry C. Triandis, “Individualism-Collectivism and Personality,” *Journal of Personality* 69 (December 2001):907-921.

⁴¹ Marjorie Kagawa-Singer and Leslie J. Blackhall, “Negotiating Cross-Cultural Issues at the End of Life ‘You Got to Go Where He Lives,’” *American Medical Association* 286 (December 2001): 2993-3001.

⁴² Linda A. McLaughlin and Kathryn L. Braun, “Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision Making,” *Health & Social Work* 23 (May 1998): 116-126.

Due to this change, in 1973, the Patient Bill of Rights was passed; it elevated patient self-determination from an ethical concern to a legal obligation for physicians⁴³. The moral behind the patient self-determination principle allow patients to make the final decision regarding their treatment⁴⁴. Informed consent is a shared decision making process in which the health care providers communicate effectively to patients so that they are able to make an informed medical decisions regarding treatment. The concept of informed consent is important because it helps protect people from medical negligence and “even when informed consent became an ethical obligation in 1957 (as articulated in the Code of Ethics of the AMA and the AHA), physicians were still resistant to telling patients about serious illness, especially if the prognosis was terminal”⁴⁵. For that reason, informed consent provides patients the options to make informed decisions regarding their health care needs.

Major health concerns that affect Vietnamese Americans are diabetes, cardiovascular disease, obesity, tuberculosis, hepatitis B and cancer⁴⁶. Vietnamese Americans have the highest incidence and mortality rates from liver, lung, and cervical cancer⁴⁷. Although mortality rates are high within this group, a large portion of this population are not seeking help and getting appropriate care. A lack of education and knowledge about health care and illnesses had caused a delay amongst the older generation who has not or partially acculturated in seeking the help they need. The disparities that Vietnamese Americans face in health care is the lack of linguistic, culturally competent health services, lack of insurance, unaffordable health care costs, and not being able to access specialty care with language or cultural understanding⁴⁸. Although past research has proved a potential cultural shift in younger generations of Vietnamese Americans, there is a lack of research that addresses health care concerns within older generations who have

⁴³ Linda A. McLaughlin and Kathryn L. Braun, “Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision Making,” *Health & Social Work* 23 (May 1998): 116-126.

⁴⁴ Alan W. Cross and Larry R. Churchill, “Ethical and Cultural Dimensions of Informed Consent,” *Annals of Internal Medicine* 96 (1982): 110-113.

⁴⁵ Linda A. McLaughlin and Kathryn L. Braun, “Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision Making,” *Health & Social Work* 23 (May 1998): 116-126.

⁴⁶ Mai-Nhung Le and Tu-Uyen Nguyen. “Social and Cultural Influences on the Health of the Vietnamese American Population.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

⁴⁷ Melissa McCracken, Miho Olsen, Moon S. Chen Jr., Ahmedin Jemal, Michael Thun, et al, “Cancer Incidence, Mortality, and Associated Risk Factors Among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese Ethnicities,” *CA Cancer Journal Clinical* 57 (2007):190-205.

⁴⁸ C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

not or partly acculturated in the U.S.⁴⁹. Vietnamese Americans have one of the most disadvantaged health and socio-economic status⁵⁰. As mortality rates continue to grow within this population, we need to address health concerns within the group that has not fully acculturated because they are the ones that are not seeking appropriate health care needs. In order to help the Vietnamese Americans community to seek adequate health care needs, we must understand the disparities in health care that they face since their immigration to the U.S. Lack or partial acculturation could be the cultural determinant of increased morbidity and mortality among the Vietnamese American people living in America. For this reason, health care providers should never assume that Vietnamese Americans are fully acculturated and should assess every patient to maintain cultural competency which is crucial in addressing the health care needs of this group. The unacculturated Vietnamese Americans practice the collectivistic model when making informed health care decisions but the major concerns remain regarding helping those who have not fully acculturated to seek adequate health care needs. In order to do so, incorporating the individualistic model indirectly could potentially help this group be more informed about their health care needs.

In a multicultural health care setting this approach to diagnosis and prognosis can cause problems. Challenges for health care providers include, “knowing just which information to share and in how much detail, deciding in what form it should be shared, know how to ensure the prospective participants’ understand[ing] of the information, knowing when this process should occur, and the like”⁵¹. Another problem that arises with the individualistic approach of informed consent is that the current U.S. system of using advance directives, in itself, is biased and ineffective for cultural diverse groups. As other researchers have found, it appears that advance directives have more appeal to educated, insured, middle-class white people than the country’s various [racial or ethnic minorities]⁵². Although informed consent is valuable in the American culture, it is not necessarily the same for other diverse groups. An example of this is truth-telling. If someone is opposed to it and “a physician persists in telling them the direct truth [it] may be perceived as cruel, uncaring and ignorant⁵³ which could result in mistrust and losing the

⁴⁹ Mai-Nhung Le and Tu-Uyen Nguyen. “Social and Cultural Influences on the Health of the Vietnamese American Population.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

⁵⁰ Wei Zhang. “Asian Americans, Socio-Economic Status and Health: Current Findings and Future Concerns.” *Handbook of Asian American Health*, G.J Yoo et al. (eds), 87-99. Springer New York, 2012.

⁵¹ Jeffrey E. Barnett, Erica H. Wise, Doug Johnson-Greene and Steven F. Bucky, “Informed Consent: Too much of a good thing or not enough?,” *Professional Psychology: Research and Practice* 38 (April 2007): 179-186.

⁵² Emeka Nwadiora and Harriette McAdoo, “Acculturative stress among Amerasian refugees: Gender and Racial differences,” *Adolescence* 31 (1996):477-487.

patient. It is important that we reconsider informed consent ethically and legally in the U.S. so that we could provide care and respect for different cultural and ethnic groups. As follows, I give a brief analysis of a patient who may not have fully acculturated, lacking the right access to care and in turn are in dire circumstances which could have been avoided.

6. Case Study

Mr. Do is a 42-year-old Vietnamese man who came to his family doctor with a series of raised nodules on his arm. The doctor was puzzled whether these represented an obscure tropical illness and referred him to the dermatologist. Before that appointment, he developed another sore nodule in his axilla and went to the emergency room where the painful nodule was at first lanced and then biopsied. The biopsy came back metastatic squamous cell carcinoma of unknown origin. The emergency room gave some of this information to the patient, but the real delivery of the news fell to the family doctor. He told Mr. Do the prognosis was terrible. Mr. Do said, "Do not tell my family. They have enough on their minds already. They do not need to worry about this." The family doctor was uncomfortable with this secrecy and felt that it meant that the patient was "in denial". In retrospect the doctor felt that this strategy was useful for the patient to be able to carry on during this period. Mr. Do sought out a Chinese doctor in Boston for further treatment, perhaps hoping to prove the American doctors wrong. He then went to Vietnam, for a visit, and then returned here to die in the hospital⁵⁴

Mr. Do is an example of someone who has not fully acculturated in the U.S. He went to seek medical attention and retrieved information from his physician who in this case is (truth-telling) and in turned asked that his physician keeps the truth from his family which could possibly be a collectivist practice as he is trying to protect his family from pain and suffering due to his diagnosis and prognosis. Seeking a second opinion with a Chinese physician could be a sign of reassurance from someone that he trusts, who in this case, represents the Asian community, who he shares a sense of identity with. Mr. Do has a chronic illness that is leading to his death, possibly from inadequate health care education. He is 42 years old, which could possibly mean he is either a part of the second wave or third wave immigrants as these two groups of immigrants immigrated around the ages of 25-42.

However, although he falls into all of these categories, potentially proving that he may not be fully acculturated, it does not necessarily mean he favors truth telling or does not want to seek the truth. As indicated prior in this article, older Vietnamese Americans with less

⁵³ Marjorie Kagawa-Singer and Leslie J. Blackhall, "Negotiating Cross-Cultural Issues at the End of Life 'You Got to Go Where He Lives,'" *American Medical Association* 286 (December 2001): 2993-3001.

⁵⁴ Lucy M. Candib, "Truth Telling and Advance Planning at the End of Life: Problems with Autonomy in a Multicultural World," *Families, Systems & Health* 20 (2002):213-226.

education are less likely to favor truth telling⁵⁵. In Mr. Do's case, health care providers should be culturally sensitive and "assuming that [he] would not want to be told [his] diagnosis because [he] is Vietnamese is stereotyping,"⁵⁶ but his right to choose not to participate in truth telling is also a form of autonomy. If Mr. Do had received the proper education and care that he needed such as that of preventative care, he may not have been in this situation. Vietnamese elders are seeking treatments in extreme circumstances or when it is too late which is causing a high mortality rate that we must try to address and resolve.

7. Recommendations and Conclusion

With the practice of acculturation dominating the younger Vietnamese American population, the older generations who are primarily from the second wave immigration group continue to face difficulties in acculturating. Older Vietnamese Americans face cultural competency barriers with the U.S. health care system and for that reason cultural competence is important. Understanding the "sex, socioeconomic class, education, immigration status, and religion interact with patients cultural backgrounds [are] important ways"⁵⁷ in determining how to help those who has not acculturated in the U.S.

RECOMMENDATION # 1: My suggestion is that using the individualistic approach such as that of truth telling in an indirect way could possibly help the older Vietnamese American to use preventative measures regarding their health concerns. The issue of truth telling is much more complex than just simply choosing between telling and not telling patients their diagnosis and prognosis. The problem that arises with truth telling is rather how, who and when to tell, "even a patient who does not want direct disclosure may wish to know the truth through other means: indirectly, euphemistically, or nonverbally"⁵⁸.

RECOMMENDATION #2: Another approach to helping those who has or are partially acculturated in the Vietnamese community to seek adequate health care could be providing more opportunities to Vietnamese Americans such as Vietnamese health educators, medical

⁵⁵ C. Tran and L. Hilton, *Health and health care of Vietnamese American older adults*, Ethno Med-Vietnamese, Stanford School of Medicine, <http://geriatrics.stanford.edu/ethnomed/Vietnamese/>. (2010).

⁵⁶ Marjorie Kagawa-Singer and Leslie J. Blackhall, "Negotiating Cross-Cultural Issues at the End of Life 'You Got to Go Where He Lives,'" *American Medical Association* 286 (December 2001): 2993-3001.

⁵⁷ LaVera M. Crawley, Patricia A. Marshall, Bernard Lo and Barbara A. Koenig, "Strategies for Culturally Effective End-of-Life Care," *Ann Intern Med* 136 (2002): 673-679.

⁵⁸ Marjorie Kagawa-Singer and Leslie J. Blackhall, "Negotiating Cross-Cultural Issues at the End of Life 'You Got to Go Where He Lives,'" *American Medical Association* 286 (December 2001): 2993-3001.

physicians, health care leaders, etc. because they are underrepresented⁵⁹ (Castillo-Page, 2012) in health care.

RECOMMENDATION #3: Lastly, retraining all physicians, most importantly, Vietnamese physicians in the U.S. because they are highly respected within the Vietnamese community. With Vietnamese physicians being able to be influential to their ethnic community, it is crucial to educate them on the importance of preventative health care measures in order to decrease the degree of Vietnamese Americans not seeking adequate health care resulting in a high mortality rate. The problem with Vietnamese physicians not playing a central role in helping Vietnamese Americans get the right health care needs are due to “Vietnamese physicians [being] less convinced of the efficacy of certain preventative care procedures, less well trained in performing them or more like[ly] to defer their patients’ reluctance to undergo them”⁶⁰.

⁵⁹ Laura Castillo-Page. Diversity in Medical Education: Facts & Figures. Association of American Medical College (2012).

⁶⁰ Christopher N. H. Jenkins, Thao Le, Stephen J. Mcphee, Susan Stewart and Ngoc The Ha, “Health Care Access and Preventive Care among Vietnamese Immigrants: Do Traditional beliefs and practices pose barriers?,” *Social Science Medicine* 43 (1996): 1049-1056.

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