



Health and Health Care of Hmong American Older Adults

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DESCRIPTION

This module presents information on the health status and health care of older Hmong Americans. The module begins by providing historical background information of the Hmong including traditional health belief systems.

We advance to a literature review on the small but growing body of work on the health status of older Hmong Americans. The module concludes with important clinical considerations for the care of elder Hmong-Americans.

Course Director & Editor in Chief of the Ethnogeriatrics Curriculum & Training

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MODULE CHARACTERISTICS



Time to Complete: 1 hr, 20 mins



Intended Audience: Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



Peer-Reviewed: Yes



The Hmong language in this curriculum is consistent with the White Hmong dialect.

LEARNING OBJECTIVES

After completing this module, learners should be able to:



1. Explain major traditional health beliefs of Hmong Americans.
2. List eight practical considerations for Western health providers in the clinical assessment of Hmong American older adults.
3. Discuss appropriate approaches in dealing with advance directives and end-of-life care with Hmong American elders and their families.

INTRODUCTION

Early History

The earliest written accounts show the Hmong living in China since 2700 B.C. However, following conflicts with the Han Dynasty, during the 19th century, some Hmong migrated in large numbers to the highlands of Vietnam, Laos, and Thailand in an effort to maintain their cultural identity (Quincy, 1995). Life in the highlands was arduous. People worked extremely hard as they cleared the jungles, built homes from hand hewn logs, and planted rice, corn, and vegetables in the fragile thin soil with few horses or water buffalo to help them.

They lived in small villages with extended patrilineal households, where revered elderly grandparents worked to contribute to the household, while caring for and providing wisdom and guidance to their children and grandchildren. The Hmong originated as a non-literate society, with grandparents passing on their rich heritage orally. Although a written language was developed in 1956, many Hmong elders have retained this oral tradition.

Vietnam War

In the 1960s, the war in Vietnam spread into Northeastern Laos, where many Hmong lived. Villagers were recruited by both the Pathet Lao communist regime under the leadership of Lo Faydang and the Central Intelligence Agency for the American cause under the leadership of General Vang Pao. Consequently, Hmong men and boys served as soldiers on both sides of the war. From the early 1960s to 1975, an estimated 18,000-20,000 men died as soldiers, while an estimated 50,000 civilians died directly from the fighting or indirectly from disrupted village and agricultural life (Robinson, 1998, p. 13).

The changing political climate within the United States (U.S.) resulted in the withdrawal of its soldiers in 1975, leaving the Hmong to face persecution or death from the communist Pathet Lao. As people fled the war and resettled in new villages or foraged in the jungles, they

were unable to raise crops to survive. From 1975 to 1997, approximately 138,000 Hmong escaped by crossing the hazardous Mekong River to refugee camps in Thailand, and an estimated 50,000-100,000 people died from fighting, diseases and starvation (Robinson, 1998, pp. 107, 294). Many elders have horrific tales about their physical and psychological traumas, suffered during the war and during the refugee flight.

The Hmong stayed in refugee camps supported by The United Nations High Commissioner for Refugees (UNHCR), the Thai government and international non-government agencies, who provided security, shelter, food, water, medical services, and limited economic opportunities (Robinson 1998). Camp officials encouraged people to resettle to other countries, as the camps were a temporary arrangement. Many people were reluctant to leave for a variety of reasons, including their not wanting to leave Asia, giving up on liberating Laos, splitting up their families, or beginning new lives in foreign countries where they didn't know the language and the customs (Hamilton-Merritt, 1993).

Resettlement

Resettlement education programs tried to allay these fears. Ultimately from 1975 to 1997, over 100,000 Hmong resettled to the U.S.; others went to France, Australia, French Guyana, or Canada (Hamilton-Merritt, 1993; Robinson, 1998). Once the last official refugee camp closed in 1997, the remaining refugees either officially returned to Laos with UNHCR support, or they illegally stayed in Thailand. Tens of thousands of Hmong people found safe haven at Wat Tham Krabok, a Buddhist monastery under the protection of head monk Luam Phaib (Nelson, 2003).

In December of 2003, the U.S. Department of State and the Thai government declared their plan to resettle 15,000 registered Hmong people at the temple as official refugees. From June 2004 to June 2006, the majority of these Hmong resettled in California, Minnesota, and Wisconsin, joining their family members (Center for Disease Control and Prevention, 2005a).

(INTRODUCTION & OVERVIEW CONT'D)

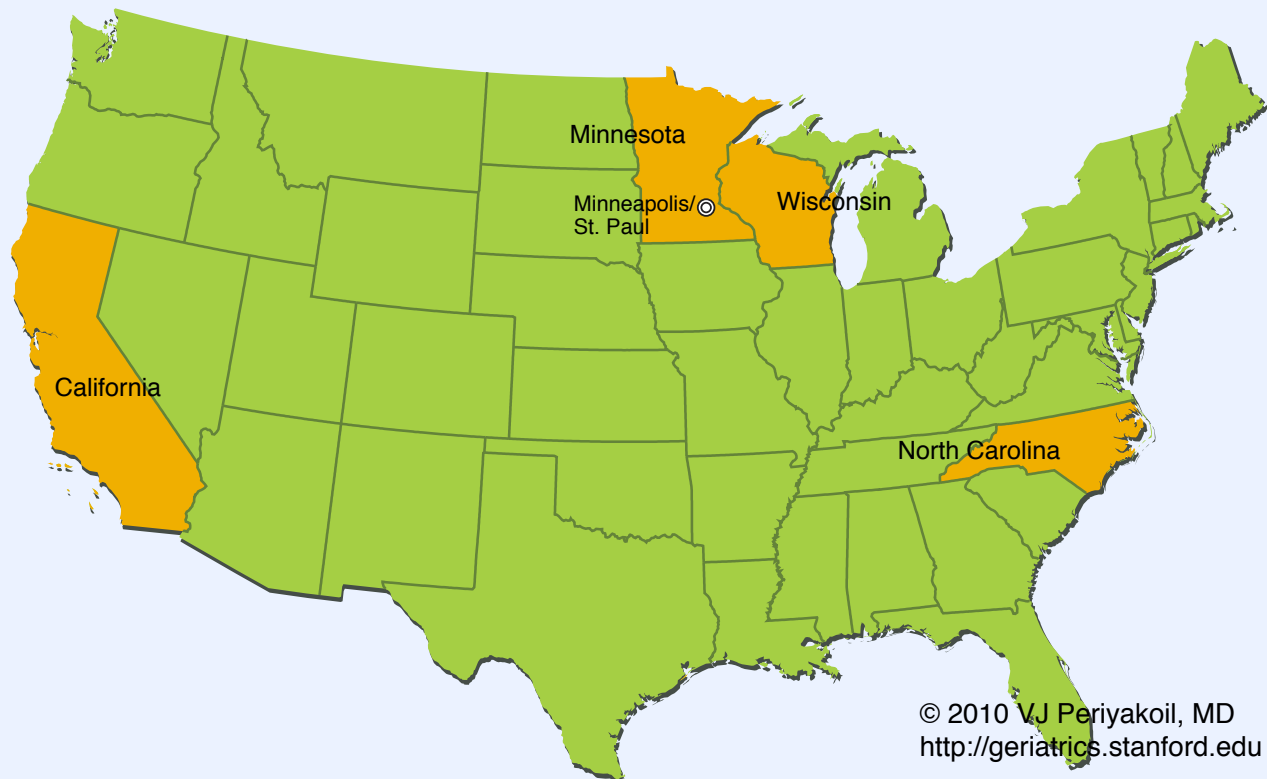
Demographics

According to the 2000 U.S. Census there are 186,310 Hmong living in the U.S., a 97% increase since 1990. States with the highest populations are California (95,000), Minnesota (70,000), Wisconsin (50,000), North Carolina (20,000), and Michigan (15,000) (See Figure 1).

Leaders within the Hmong American community believe these statistics are a 50-60% under representation, primarily due to language barriers in completing the census report (Doyle, 2001; Pfeifer, 2001).

The 2000 census reports that of the total number of Hmong Americans:

- 55.6% were foreign born with 30% of these persons being naturalized citizens
- 45.3% had no formal education
- 34.8% were “linguistically isolated”
- 38.4% were at or below the poverty level
- 2.8% were 65 years or older

Fig. 1**U.S. States with the Largest Hmong American Populations**

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(INTRODUCTION & OVERVIEW CONT'D)

Of these elders 64.1% were unable to speak English (Lee et al., 2003). It is important to note that the proportion of Hmong Americans 65 and older is considerably smaller when compared to census data for the total U.S. population for the same age cohort (12.4%). This has been attributed to the high mortality rate associated with the war in Laos (Niedzwieki, Yang, & Earm, 2003) and the high fertility rate (about 8 children per woman in 1982, and about 5 children per woman in 1987) (Kunstadter, 2003).

Background

Given the necessity of describing a culture in a prescribed number of pages, we are writing in generalities about a very diverse, complex, and heterogeneous culture.



Nurses must be cautious not to apply this general information to all patients and families, or the generalities become stereotypes, which are not true.



Rather, nurses must be familiar with the cultural generalities and then ask patients and their family members about their cultural beliefs and decision-making.

Family/Clan Structure

An understanding of the family / clan structure is critical to the care of Hmong American elders. Hmong Americans are organized into an 18-clan structure; all members of a clan recognize that they are related by a common ancestor. Clan names include the following:

- | | |
|-----------------------------|---------------------------|
| 1. Chang (Cha) | 10. Lee (Le or Ly) |
| 2. Cheng | 11. Lor (Lo) |
| 3. Chue (Chu) | 12. Moua (Mua) |
| 4. Fang | 13. Pha |
| 5. Hang | 14. Thao (Thor), |
| 6. Her (Herr or Heu) | 15. Vang (Va), |
| 7. Khang | 16. Vue (Vu) |
| 8. Kong | 17. Xiong |
| 9. Kue | 18. Yang (Ya) |

Some families add a grandfather's name to clearly identify their clan lineage. For example, the last name Saykaothao indicates that their grandfather was Say Kao Thao and the last name Mouanoutoua indicates their grandfather was Nou Toua Moua.

The family is a subcomponent of the clan structure. To support the clan structure and to receive the support of the clan, the Hmong are concentrated in geographic locations throughout the country, with the largest being in the St. Paul/Minneapolis area of Minnesota. (See Figure 1)

Important for Nurses

Knowledge of the Hmong family/clan structure can help prepare and assist nurses in understanding and appreciating the family dynamics that Hmong elders may bring with them into the clinical setting. The family can influence the decisions that are made during every stage of diagnosis and treatment. Furthermore, since each clan has its own history, there are specific taboos that are distinctive to each clan.

For example, members of the Vang clan are prohibited from eating fruit or even having fruit on the table during a meal, while members of the Yang clan are not allowed to consume the liver and heart of an animal. It is traditionally believed that if these rules are violated, bad fortune, often in the form of illness, will follow. Elders often retain these traditional beliefs.

Clan Membership and Marriage Practices

Membership into a clan is acquired through birth or marriage and it is a social category as well as a spiritual designation, since the ancestral spirits watch over their family members. Hmong practice exogamy, meaning that marriage partners must be chosen from outside of their birth clan.

However, there are certain clans that are considered to have diverged from a common ancestor and therefore, they may not intermarry. This includes the Fang and Vang, Her and Hang, and Kue and Thao clans.

(INTRODUCTION & OVERVIEW CONT'D)

In addition to social repercussions, it is believed that biological implications would follow when endogamy is practiced. Upon marriage a woman leaves her clan and family and joins her husband's clan and family; although many Hmong women in the U.S. keep their birth clan name as their last name, they are considered part of their husband's clan.

Sides of the Family

There are two sides of the family:

1. **the kwv tij** (father or husband's side)
2. **neej tsa** (mother or wife's side)

Traditionally, the father's side was primarily responsible for actions and decisions in the family and the mother's side was available for emotional support, but not financial support or to take responsibility for their daughter and her children. Contemporary roles between the two sides are changing, as more daughters and sons-in-law help the wife's parents, but the main responsibility still resides with the husband's family. (For more information refer to the section on Decision-Making and Disclosure.)

The actions of individuals affect the reputation of the extended family. By tradition, the Hmong maintain strong family bonds that are based on interdependence rather than independence. As a result, it is expected that elders will rely on the extended family for assistance, and that younger family members will put other family members and the family unit before their personal desires. Adult children, in general, identify the importance of providing care to the aging parents in reciprocation for the care that was given to them as children (Gerdner, 2007; Gerdner, Tripp-Reimer, & Yang, 2008). Multiple generations frequently choose to live in the same household for reasons of social and financial support. In this way families do not have to depend on outsiders for the care of family members (i.e., elders and children).

“Traditionally, the father's side was primarily responsible for actions and decisions in the family and the mother's side was available for emotional support, but not financial support or to take responsibility for their daughter and her children.”

Aging Process

Smith (1995) proposes that Hmong elders do not fit the chronological ages that have traditionally been established in the U.S. for defining elders. This is attributed to a number of factors. For example, historically it was not uncommon for Hmong couples to begin having children at age 15 and subsequently become grandparents by 30-40 years of age. Because many Hmong endured harsh living conditions in Laos during the war, in refugee camps in Thailand, and had a difficult transition to the U.S., their traumatic life experiences have likely accelerated the aging process. Also, Hmong persons do not traditionally quantify an elder by a specific age for two primary reasons. First, without documentation people did not know their exact ages. Secondly, elders were generally defined by important life experiences and the wisdom acquired over a lifetime. There is currently no data available for the life expectancy of Hmong living in the U.S.

(INTRODUCTION & OVERVIEW CONT'D)

Perception of Elders in Laos Compared to America

Proverbs

In Laos, elders were generally viewed with respect as reflected in the following two proverbs:

1. *Cov laus lawv noj ntau diav mov lawv yeej paub dau* (Elders have eaten more spoonfuls of rice and therefore know more). The meaning of this proverb is that wisdom is the product of a long life.

2. *Rab riam ntaus tau zoo nkauj los txiav thiab hlais tsis tau nqaij. Yuav tsum muab hov ntawm lub zeb ho* (The knife made by the blacksmith, is very beautiful, but will not cut meat unless the blade is tempered and sharpened). This proverb conveys that the beauty of youth may be pleasing to the eye, but utility, like wisdom or knowledge, lies in unseen values and must be learned (Gerdner, Xiong, & Cha, 2006, p. 26).

Effect of U.S. Immigration

Traditionally, elder Hmong have provided stability and have been the “bearers and gatekeepers of culture and tradition” (Frye, 1995, p. 273). They provided wisdom and experience that was necessary for the survival of the family. However, immigration to the U.S. brought the need for knowledge and skills different than that required of an agrarian ethnic group living in the remote highlands of Laos. Consequently, the knowledge held by Hmong elders in the U.S. is viewed by some as obsolete, resulting in a deterioration of their status within the community.

Current Views on Youth

Currently, the Hmong community as a whole has focused much of its efforts on educating its youth as a means of promoting economic well-being for succeeding generations (Hutchinson & McNall, 1994). Preparing youth with advanced educational degrees (i.e., law, medicine, education) is viewed as an investment in the future which serves to empower the extended family (including the elders) and the Hmong American community as a whole.



Young Hmong Woman in Laos. © iStockphoto.com/Josef Muellek

PATTERNS OF HEALTH RISK

Introduction

Hmong older adults endured numerous losses upon their arrival to this country (lifestyle, key relationships, role identity) and threats to their cultural heritage (Parker, 1996). When compared to other refugee or immigrant groups in U.S. history, the federal Office of Refugee Resettlement has identified older Hmong as having the greatest difficulty adjusting to life in America (Hunn, n.d.). This is compounded by

- language barriers
 - low socioeconomic status
 - lack of formal education
 - insufficient means of transportation
 - social isolation
- (Thao 2002; Parker, 1996).

These factors have been linked to individuals who are at high risk for health disparities (Kue, Redo, & Yang, 1995), yet health of elder Hmong has not received the attention that it deserves.

There is a dearth of research that has focused on health issues of Hmong American elders. Gerdner (2007) conducted a three-year study using ethnographic techniques of guided interviews and participant observation to explore the perception and care of Hmong American elders with chronic illness living in selected areas of Minnesota and Wisconsin. In-depth interviews were conducted with elders (over 60 years of age), family caregivers, traditional healers, non-Hmong Western health care practitioners, Hmong Western health care practitioners, and ministers (both Hmong and non-Hmong serving the Hmong community).

Taped interviews, when transcribed, produced over 1000 pages of qualitative data. Refinement of the qualitative data analysis continues. Preliminary findings identify the following primary health concerns: hypertension, chronic pain, diabetes, depression, renal disease, chronic confusion, asthma, “heart problems,” stroke, gallstones, hepatic disease, and “colon problems.”

Older Adult Health Issues

A limited number of studies address the health issues of adults and fewer include elders in their sample. Often when elders are included, they comprise only a small portion of the total sample. For example, Cha (2003) conducted a study in Colorado that included health history surveys on 40 subjects with 13 (32.5%) elders between the ages of 60 and 86 years.

Findings identified that elders had a high incidence of:

- cerebral vascular accident
- diabetes
- hypertension
- arthritis
- muscle aches

Mob Laug

In addition, elders frequently reported *mob laug* (“old age pain”), a condition that is caused from injuries or overuse from performing heavy work at a younger age. In addition, women may eventually suffer from mob laug, which they believe resulted from insufficient rest or a noncompliance to the traditional Hmong dietary restrictions that are expected during the first 30 days post partum. Mob laug may be manifested as a generalized pain throughout the body or localized in the back, chest, arms, or legs, which becomes more severe in cold or rainy weather (Cha, 2003), and which may be difficult to cure.

Other Health Concerns

Other reported health concerns, including but not limited to elders, include a high prevalence of

- myocardial infarction
- kidney dysfunction
- bladder stones
- gout
- cancer (Cha, 2003)

(PATTERNS OF HEALTH RISK CONT'D)

Cancer

Mills and Yang 1997 report that Hmong Americans in general have increased incidents of certain types of cancer, especially:

- nasopharynx
- cervix
- stomach
- liver
- pancreas
- leukemia
- non-Hodgkin's lymphoma

Too often, the cancer has progressed to an advanced stage and grade of disease by the time it is diagnosed. Similarly, in a study of Hmong living in Minnesota, Ross and colleagues (2003) also report increased proportional incident ratios (PIRs) of cancer at the following sites: nasopharyngeal, gastric, hepatic, and cervical. In comparison to the general population Minnesota Hmong has decreased PIRs for prostate cancer, breast cancer, Hodgkin disease, and melanoma.

Mental Health

Cha (2003) also explored mental health problems, but findings were not reported by age group. Overall, subjects reported:

1. worrying too much (45%)
2. forgetfulness (40%)
3. feelings of worthlessness (32%)
4. high levels of anxiety (20%)

Dementia

There are no statistics on the prevalence of dementia within the Hmong American community. The Hmong do not have a word that directly translates to the meaning of dementia. *Tem toob* is the Hmong word that is used to describe an elder with severe memory impairment and chronic confusion. Gerdner (2001) conducted a focused ethnographic study to explore the health beliefs, behaviors, and informal/formal care structures for Hmong American elders with dementia.

RESOURCES ON DEMENTIA

Findings of Gerdner's 2001 study have launched efforts to establish resources for both family and health care providers.

Ethnicity and Dementias

A book chapter in *Ethnicity and Dementias* is devoted to assist health care providers in working with Hmong American families who have an elder with Alzheimer's disease or a related dementia (refer to Gerdner, Xiong, & Yang, 2006).

Grandfather's Story Cloth

In addition, general themes from the life experiences of family caregivers in the ethnographic study were used to create a bilingual (English/Hmong), illustrated children's book to promote understanding of Alzheimer's disease (AD) (refer to Gerdner, 2008). The book, entitled *Grandfather's Story Cloth* (Gerdner & Langford, 2008), is about a 10-year old boy named Chersheng and his grandfather, who has AD.

The storyline was created to reflect and support the values identified as being important to Hmong American family members who were caring for an elder with AD.

The book introduces the idea of using a story cloth to stimulate grandfather's remote or long-term memory as a means of enhancing communication and understanding between Chersheng and his grandfather. Two sets of author notes are included at the back of the book. The first provides background information on the Hmong and story cloths.

A second set of notes is used to inform readers about dementia and Alzheimer's disease. The educational value of this book is augmented with discussion questions and answers that support a family-based approach to learning. **This supplemental material may be obtained here:**



lgerdner@gmail.com



www.shens.com

(PATTERNS OF HEALTH RISK CONT'D)

Participants included family caregivers, traditional healers, and community liaisons living in selected cities in Minnesota and Wisconsin. The majority of interviews were conducted in the Hmong language with the assistance of an interpreter.



Community leaders identified dementia as a neglected health concern. Elders often lived in the home of either the eldest or youngest son, with the daughter-in-law providing the actual hands-on care. Conflicts with the traditional norm are emerging due to changing roles and lifestyles of Hmong living in America.

Caregiver View

The majority of caregivers viewed elder confusion as a normal aspect of aging, but sought treatment by a shaman to satisfy spiritual needs of the elder. Shaman reported treating numerous elders for chronic confusion and identified soul loss as the primary cause with advanced age as a risk factor. Some members of the Hmong community associate a negative stigma to elders with chronic confusion/dementia, referring to the elder as “crazy.”

Family Members' Perspective

Family members identified a lack of culturally sensitive information on the topic of dementia in Hmong elders that would serve to educate the community on these misconceptions. (Gerdner, Tripp-Reimer, & Yang, 2008). Adult children, who served as primary caregivers, often had young children of their own. Informants often noted that these children had difficulty adjusting to a grandparent with dementia. Ultimately, this negatively effected the interaction between child and elder and their relationship (Gerdner, 2008).

Depression

Anecdotal evidence along with initial research efforts indicates a relatively high incidence of depression in Hmong American elders. This is attributed to the losses and traumas associated with war and adjustment to life in the U.S. (Gerdner, 2007).

Two Depression Screening Instruments

Two instruments have been adapted for use in screening Hmong persons for depression:

1. The adapted version of the Beck Depression Inventory (Mouanoutaoua & Brown, 1991)
2. An adapted version of the Hopkins Symptom Checklist 25 (Mouanoutaoua & Brown, 1995).

Health Issues of Hmong American Adults

Because of the limited amount of research that has been conducted with Hmong American elders, we expanded our literature review to include research that has been conducted with adults who are 21 years and older.

Experiences with Cardio-Vascular Diseases

Hmong American adults have had difficulties understanding and responding to chronic cardio-vascular disease (CVD) [that includes diabetes mellitus (DM), hypertension (HTN), stroke, heart attacks, kidney stones and kidney disease] for several reasons, including:

1. Lack of debilitating symptoms

The lack of debilitating symptoms from DM, HTN, and renal insufficiency until they have been present for many years, makes them easy to not recognize as needing treatment.

2. Lack of traditional concepts or words

There are no traditional concepts or words that directly relate to DM, HTN, hyperlipidemia, or proteinuria, which make them difficult to comprehend.

3. Economic and social factors

The biomedical treatment recommendations for new lifestyles are difficult to implement given the lack of physical activity in American society, unsafe urban neighborhoods, economical cost of rice compared to other foods, feelings of mistrust toward Western medicines, and the low income status.

(PATTERNS OF HEALTH RISK CONT'D)

Qualitative studies of Hmong people's experiences with diabetes have confirmed the importance of imbalance in developing CVD and the need to restore balance in order to improve health (Culhane-Pera, Her & Her, 2007; Devlin, Roberts, Okaya, & Xiong, 2006; Henry 1996; Johnson 1995; Vang, 2005).

These and other studies have indicated that similar ideas are present for other CVDs (Cha, 2003; Culhane-Pera & Lee 2007; Wong, Mouanoutoua, Chen, Gray, & Tseng, 2006). Similar to the traditional Chinese concept of yin/yang, Hmong cosmology conceives of a division between light/dark, seen world/unseen world, hot/cold, female/male, wet/dry, and other dichotomies (Cha, 2000; Cha, 2003; Culhane-Pera & Xiong, 2003).

Optimal health is achieved with a balance in all of these aspects, which is unique for each person. People, who feel out of balance, whether due to a change in the weather, food, germs, chemicals, or medications, will attempt to restore health through actions that could restore the balance.

More specifically, Hmong Americans suffering from diabetes have attributed their illness to imbalances in food, chemicals, activity or mental health (Culhane-Pera, Her, & Her, 2007; Devlin, Roberts, Okaya & Xiong, 2006; Gerdner, 2007; Vang, 2005). With regard to food, the increased consumption of rice is not viewed as a problem as much as eating foods that were grown with chemicals (i.e., fertilizers and pesticides). Imbalance is also believed to occur with the ingestion of fatty pork and sweets, or simply eating foods that do not agree with the individual.

Overall, Hmong Americans view themselves as being less physically active compared to their life in Laos. Less strenuous activity has led to a decreased secretion of sweat believed to cause a poisonous build up of fats and salts in the body. In addition, weather has been viewed as a contributing factor to imbalance. For example, it is not uncommon for Hmong Americans, who have visited Southeast Asia, to report that they felt healthier in the warm climate of their homeland than in the

IMPORTANT TERM

Caiv—Hmong word for cultural prohibitions regarding foods and activities in an effort to restore balance and health.

U.S. Hmong Americans also identify a psychological component that contributes to imbalance.

Efforts to restore balance are made in an attempt to achieve optimum health. First, people must “listen” to their bodies to determine what works for them, what foods they can eat and what foods they should avoid and they must sweat, via hot weather or exercise (particularly gardening) (Culhane-Pera, Her, & Her, 2007; Henry, 1996.).

In short, they have to *caiv*, a Hmong word for cultural prohibitions regarding foods and activities in an effort to restore balance and health. While medications can help restore the balance, many people complain that Western medicines are too strong for them; rather, Asian herbal medicines are more useful because the medicines “fit” them. All people have to determine which of these activities are necessary for them, in order to restore their personal balance (Culhane-Pera, Her, & Her, 2007).

Epidemiology of Cardiovascular Diseases

There have been no longitudinal epidemiological studies about incidence rates of cardio-vascular disease (CVD) in the Hmong who arrived in 1970s-1990s. Nonetheless, some studies have shown rising rates of CVD.

CVD Mortality Rate Increase

An examination of change in diagnoses on death certificates in Fresno CA indicated that the mortality rates for CVD increased from 16% in 1980-1989 to 22% in 1990-1994 to 29% in 1995-1999 (Kunstadter & Vang, 2001) (See Figure 2).

(PATTERNS OF HEALTH RISK CONT'D)**Community-Based Studies**

Various community-based studies on volunteer samples in the 1990s revealed the incidence of:

- hypertension (HTN) = 16%–33%
- DM=16-42%
- overweight=81%
- obesity=31%
- stroke=4%
- heart attack <0.01%

(Her & Mundt, 2005; Kunstadter, 2001; Kwan & Moua 2002; Lee, Xiong, Vang, & Comerford, 2000).

One study (Lee, Xiong, Vang, & Comerford, 2000) found a direct relationship between length of time in U.S. and presence of HTN as well as obesity. Another study found high rates of CVD co-morbidities in people with type 2 diabetes (62% hyperlipidemia, 54% proteinuria, and 23% HTN) (Culhane-Pera, et al., 2005).

Study of Newly-Arrived Hmong Adults

A cross-section epidemiological study of newly arriving Hmong adults from Wat Tham Krabok Thailand to Minnesota from 2004–2005 revealed prevalence rates of:

- HTN=16%,
- pre-HTN= 36%,
- DM=3%,
- hyperglycemia=32%,
- overweight=33%, and
- obesity=15%

(Culhane-Pera, Moua, DeFor, & Desai, 2008)

Comparing with non-refugee Hmong in Thailand in the mid-1990s, rates of HTN, DM, and obesity were <0.01% (Kunstadter, 2001). It is speculated that sedentary lifestyles at the Buddhist temple refugee camp contributed to high rates of obesity and HTN. It is doubtful that people who arrived during the 1970s-1990s had similarly high rates of obesity and HTN.

Rates of Renal Disease and Renal Failure

Overall, providers have noted high rates of renal disease and renal failure within the Hmong-American population. However, there is no statistics available regarding prevalence. It is noted that at one dialysis unit in St. Paul, MN, approximately 25% of the patients are Hmong (Ann Rinehart, personal communication 2003).

At another dialysis unit in Minneapolis, MN, the average age of Hmong patients is estimated to be 10 years lower than the general population (Arkady Synhavsky, personal communication 2003).

These reports could indicate that Hmong Americans have a higher prevalence of renal disease than the general population. This may be due to a high rate of a genetic renal disease, gout, and other unknown factors.

Urologists have noted high rates of gout, uric acid stones, and complications, such as staghorn calculi and loss of kidneys in Hmong Americans (Portis, Hermans, Culhane-Pera, & Curhan, 2004). A community study of adults > 18 years of age in St. Paul revealed 4.5% had renal stones (Moua, 2004). On arrival between 2004–2005, 12% of adults > 21 years of age tested had high uric acid levels (Culhane-Pera, Moua, DeFor, & Desai, 2008).

(PATTERNS OF HEALTH RISK CONT'D)

Chronic Hepatitis B

On arrival in the 1970s-1990s, about 15% of the total Hmong refugee population carried the chronic infection, while on arrival in 2004-2006, the rate was 10% (Minnesota Department of Health, 2006a, 2006b). Well-known complications have not spared the Hmong: cirrhosis, chronic liver failure, and hepato-cellular carcinoma. Every Hmong person should know their Hepatitis B status; chronically infected people should have yearly examinations and susceptible individuals should be evaluated for anti-viral treatment.

It is our clinical impression that most patients are interested in learning about their Hepatitis B status and receiving vaccinations against Hepatitis B, and that some people who have chronic Hepatitis B are willing to be tested annually, while others are hesitant to pursue these tests, stating they feel fine and aren't concerned

about their liver. Nonetheless, as more people die from hepatocellular carcinoma or receive liver transplants from liver cirrhosis, the community is becoming more aware of the importance of surveillance.

Tuberculosis

Identification and treatment of active tuberculosis disease occur in Thai refugee camps before refugees are allowed to migrate to the U.S. In 2004-2005, 52 people were diagnosed and treated for TB in Thailand prior to departure and 37 people were diagnosed upon arrival to the U.S. (Centers for Disease Control and Prevent, 2005b). Identification and treatment of latent tuberculosis infection (LTBI) is done in this country. Approximately 12% of those arriving 2004-2006 had LTBI (Minnesota Department of Health, 2006a, 2006b).

“It is our clinical impression that most patients are interested in learning about their Hepatitis B status and receiving vaccinations against Hepatitis B, and that some people who have chronic Hepatitis B are willing to be tested annually, while others are hesitant to pursue these tests, stating they feel fine and aren't concerned about their liver.”

CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

Traditional Health Beliefs

Hmong elders understand health as a harmonious balance of forces in the natural world, the supernatural world, and between the two worlds (Cha, 2000; Culhane-Pera, & Xiong, 2003). Similarly, illness is an imbalance of these forces. To understand the concepts of health and illness in the Hmong culture, providers must understand the interlocking connections between the spiritual world and the physical world. The natural and the spiritual worlds affect and reinforce each other, so illnesses may have both biological and spiritual causes, although during the course of an illness the perceived etiologies may change.

Natural causes include imbalances of metaphysical forces (similar to the Chinese concept of yin/yang), change in weather, bad food, heredity, aging, and germs. Indeed, Hmong ideas of germs (called *kab* in White Hmong, *kaab* in Green Hmong and *phav nyaj* in Laotian, a common term used by Hmong elders) are closely aligned with Western concepts.

Hmong elders are beginning to understand chronic illnesses such as diabetes, hypertension, and coronary disease that result from changes in lifestyle. Illnesses believed to be derived from natural causes are often treated with Western medicine and traditional techniques ranging from massage, acupuncture, and dermabrasion, to the application or ingestion of a variety of herbal preparations or other organic substances (Bliatout, 1991). People often use these techniques and remedies in conjunction with shamanic healing ceremonies, for illnesses that also have supernatural etiologies.

Traditional Healing Modalities

Many elders prefer being treated with traditional home remedies for physical symptoms of either natural or spiritual illness. Headaches, muscle aches, swelling, tingling, back pains, chest pains, and abdominal pains

are often interpreted as being caused by a build-up of pressure that must be released. Techniques used to *dim pa* (release the pressure) include cupping, coining, and massage. Residual marks (i.e., linear petechiae and eccymotic lesions) appear on the skin surface at the site of the procedure (i.e., back, neck, temporal areas, nasal bridge, and chest) and usually resolve within a few days.

Txhuav or Nqus (cupping)

Refers to a glass cup, bamboo jar, or water buffalo horn that is placed on the location of the pain, and then a vacuum is applied to the skin by heat or mouth suction, which causes a bruise. Cups are often cleaned with alcohol and fire before being placed on the skin.

Kav (coining or spooning)

Involves rubbing the skin with a flat edged object such as a silver coin or spoon. In advance of this treatment, medicated oil or Tiger Balm is applied to soothe the skin and increase circulation.

Zuaj ib ce (massage)

A vigorous body massage that may be done alone, or followed by cupping or coining. The purpose of the massage is to loosen the body (muscles/tendons/veins) and to promote better circulation.

Hno (pricking the skin with a needle)

Can be done alone, after massage, or in conjunction with cupping and coining. Pricking often occurs at the bruised skin site after cupping or coining or at the fingertips after massage. Pricking is conducted both to release pressure and toxins causing the illness, as well as to determine the severity of the illness by examining the released drop of blood. The color and consistency of the blood are visually analyzed; the darker and thicker the blood, the more severe the illness.

(FUND OF KNOWLEDGE CONT'D)

Elders often use these remedies before seeking medical care, but they may also use them during or after medical care. It is important for health care providers to be aware of these modalities since some cause bruising of the skin and should not be misinterpreted as elder abuse. These traditional methods are perceived to have healing properties by those who continue to use them. One effective way of asking whether these methods are used, is to first inform the Hmong elder that you are aware of these methods of treatment, and then ask what the patient does to alleviate pain.

Herbal Medicines

Most elderly Hmong have a basic knowledge of medicinal herbs and grow the more common varieties in their backyards. During the cold winter months, some plants are repotted and placed indoors. *Kws tshuaj* (herbal medicine experts) who sell *tshuaj ntsuab* (fresh herbs), *tshuaj qhuav* (dried roots or bark), and other organic substances (i.e., rhinoceros bones/skin/ dried blood, dried bear and snake gall bladders, etc) are a common site at Hmong American festivals and weekend markets. These rare organic substances are believed to be beneficial for a variety of ailments.

Pharmacological Value

A study conducted in the late 1980's in St. Paul/ Minneapolis, Minnesota identified 37 medicinal plants used by Hmong Americans (Spring, 1989). The phytochemical components of these plants were identified and found to have the potential pharmacological activities correlated with their intended use. Ninety-two percent of the plants were found to be efficacious when Western biomedical criteria were applied. These medicinal herbs were used for a variety of purposes such as: swollen or painful joints, "weak kidneys", stomach ache, diarrhea, leg weakness, difficult and painful urination.

Harmful Effects

Hmong Americans also import medications, herbs, and other organic substances used for healing from

TERMINOLOGY

Kws tshuaj—herbal medicine experts

tshuaj ntsuab—fresh herbs

tshuaj qhuav—dried roots or bark

Laos, Thailand, and China, which can also be harmful. The Marathon County Health Department and the Wisconsin Division of Public health evaluated imported drugs and folk remedies used by two Hmong families (Werner, Knobeloch, Erbach, & Anderson, 2001).

A reddish-brown powder purchased in California for treatment of chicken pox, flu-like symptoms and nasal decongestion was found to consist of 36% arsenic and trace amounts of barium, cadmium, iron and lead. The second family had 5 packets of pharmaceutical preparations manufactured in Thailand, one of which contained chloramphenicol, an antibiotic that is not commonly used today because of the potentially serious side-effects (Werner, Knobeloch, Erbach, & Anderson, 2001).

Recommendations for Health Providers

We recommend that health care providers ask Hmong elders and their families about the use of herbs, organic remedies, and imported pharmaceutical agents and advise their cautious use, since these substances pose potential health hazards by themselves and in combination with prescribed medications. As specific substances are identified as toxic, then health care providers should educate the elders and their families about them.

Spiritual Illnesses

Illness attributed to supernatural forces may be due to soul loss, ancestral spirits, tame household spirits, wild forest spirits, malevolent spirits, or shaman spirits, but can also be attributed to magical interferences by humans in the form of curses. Illnesses

(FUND OF KNOWLEDGE CONT'D)

caused by ancestral spirits are commonly a form of communication, as ancestors may be made unhappy by actions performed or not performed by humans. These actions must be corrected by spiritual interventions or the illnesses may continue and result in death. Even tragic accidents and bad luck can be attributed to spirits.

Spiritual illnesses may occur when one or more souls separate from the physical body. Separation may occur in a number of ways. For example, a soul may be “frightened away,” abducted by a malevolent spirit, disturbed by an ancestral spirit, or simply become dissatisfied with the physical body and leave to become reincarnated. The seriousness of the illness depends on the number of souls that are lost, the length of absence from the body, the distance of the soul from the body, the firmness of the spirit’s control over the soul and the exact circumstances surrounding soul loss. Traditional healers, including soul callers and shaman are called upon to treat spiritual illnesses, often after natural home remedies failed to correct the problem.

Shaman

There are several types of shaman with various levels of knowledge and skills. When family members suspect that an elder has a supernatural illness they will seek the expertise of a shaman. The selection of a shaman involves family members discussing the abilities and reputations of available shaman and/or communicating with the spirits through divination.

There are a variety of divination procedures that can be used to select a shaman. The procedures involve a variety of objects such as eggs, rice, incense, silver coins, water or chopsticks. While there are many types of shamanic rituals, the two main types are: *ua neeb saib* (diagnostic ceremonies) and *ua neeb kho* (healing ceremonies). As the shaman enters into trance, his soul

accompanies his *dab neeb* (helping spirits) into the spiritual realm to discover the spiritual cause of the illness, battles evil spirits or ancestral spirits, locates the wayward or detached soul, and wins the spiritual battle for the elder’s health.

Upon his return, he will describe the spiritual causes, the obstacles he encountered, and the necessary ensuing steps. If he has been successful, he announces that the person will be better in a few days. If the person shows no signs of improvement within that period of time, it is generally believed that there were other spiritual or natural problems that ensued after his ceremony, which need to be addressed.

Pinzon-Perez and colleagues interviewed 115 Hmong Americans to explore participant satisfaction with shamanic practices in a rural county of California. Of the total sample, 40.5% were 45 and older. Forty-nine percent of the informants (generally those in the age range of 18-44) sought out the services of their primary care physician when they became ill. In comparison, 54% reported consulting a shaman or other traditional healer (i.e., herbalist). Over half (54%) were very satisfied with the services received from the shaman.

Ritual Healers

Tus ua khawv koob (ritual healers) are primarily men who have learned their ritual or magical craft from other healers. By burning incense, blowing water, and chanting, they direct the healing power of *khawv koob* spirits to relieve both physical illnesses such as *ua qoob* (fevers with rashes), burns, broken bones, and eye problems, as well as to relieve *ceeb* (spiritual distress such as fright). So they heal both physical and spiritual ailments, but their magical healing doesn’t return wayward souls like soul callers do, or soothe angry ancestral spirits like shaman do.

CULTURALLY APPROPRIATE GERIATRIC CARE: PROMOTING CROSS-CULTURAL UNDERSTANDING

Nine Aspects that Promote Cross-Cultural Understanding

Assessing and providing culturally competent care is challenging and rewarding.

The Healing by Heart Model of Culturally Responsive Care describes nine aspects for providers to learn in order to promote cross-cultural understanding and maximize quality health care (Vawter, Culhane-Pera, Xiong, Babbitt, & Solberg, 2003). In the model, health care professionals are guided to—

- 1. Be aware of the influence of culture on health status, beliefs, practices, and values.** This is a basic but critical step toward the concept of culturally responsive care.
- 2. Increase self-awareness about your own health beliefs, practices, and values.** It is essential that providers recognize the cultural influences that shape their own views of the world, health, illness, and treatment, as these will influence how they respond to other people's cultural worldviews about health and illness.
- 3. Learn about the prevailing health beliefs, practices, and values of the cultural groups you serve.** Before providers listen to their patients' needs, they need to understand the cultural group's background, including their history, social structure, cosmology, and traditional healing practices.
- 4. Identify potential areas of congruity and difference between your personal health beliefs, practices, and values and those of the cultural groups you serve.** Once these areas are identified, providers can accentuate similarities, find common ground to compromise, and deflect arguments, in order to maximize care.
- 5. Increase self-awareness about your cross-cultural health care ethics.** Providers' cross-cultural health care ethics reside on a continuum, from valuing the Western system over traditional healing to valuing patients' choice of traditional healing for all patients regardless of the Western options. Many providers feel most comfortable in a middle ground, where adults can choose traditional healing over Western healing regardless of consequences, but where families cannot choose traditional healing over Western healing for minors if minors have life-threatening conditions. Just as providers need to be aware of their cultural beliefs, practices, and values, they need to be aware of their cross-cultural ethical orientation.
- 6. Learn skills to identify, evaluate, and respond to cross-cultural ethical conflicts, with special attention to issues that challenge professional integrity.** When providers are uncomfortable with a patient's demands, it may be that their personal preference, moral beliefs, or professional integrity is challenged. Challenges to professional integrity may be the most difficult to address, requiring specialized assistance (i.e., an ethics committee consultation).
- 7. Develop attitudes that are culturally responsive to the groups you serve.** While understanding other people's cultural perspectives is important, attitudes of trust, respect, and accommodation are essential to quality cross-cultural health care.
- 8. Learn communication skills that are culturally responsive to the groups you serve.** The skills of asking open-ended questions to elicit patients' cultural needs; active listening and reflecting; and cross-cultural non-verbal communication are tools used for the improvement of cross-cultural health care.
- 9. Develop culturally responsive knowledge, skills, and attitudes that can be applied to specific clinical relationships.** This final step integrates the previous steps of self-knowledge, general cultural knowledge, culturally-responsive attitudes, and communication skills allowing providers to ask, listen, and respond to patients' cultural needs in a way that maximizes quality health care for patients of all cultural backgrounds.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Tips for Clinicians

In this section, we will highlight several aspects that can help clinicians promote culturally-responsive care in working with Hmong American elders.

Communication

Since the majority of Hmong American elders (64%) are “unable to speak English” (Lee et al., 2003), a professional health care interpreter is important. The interpreter must be able to speak the elders and families’ dialect (White Hmong or Green Hmong), and ideally should be of the same sex as the person who is the focus of communication. There are numerous challenges associated with the interpreter’s work. First, the Hmong language does not include words that directly correspond to most medical words (Johnson, 2002). In addition, the Hmong language includes words that are not easily translated into English.

This becomes even more complicated when Hmong elder’s concepts of human anatomy are different from Western medicine (Culhane-Pera & Xiong, 2003) or when there is a lack of understanding for basic human anatomy and physiology (Gerdner, Xiong, & Yang, 2006). The national Council on Interpreting in Health Care has developed a web site (www.ncihc.org) to discuss this topic further.

Nonverbal Communication

Nonverbal communication becomes critical, especially during interactions between a non-Hmong speaking person and a non-English speaking Hmong individual. When a person is unable to understand the spoken words, body language and tone of voice become the focus. Therefore, it is important to use a soft gentle voice, make indirect eye contact or brief direct eye contact, and convey a sense of patience (Vawter, Culhane-Pera, Babbitt, Xiong, & Solberg, 2003).

COMMUNICATION RESOURCES**Interpretation Issues**

The National Council on Interpreting in Health Care has developed a website to further discuss issues with Hmong to English interpretation.



www.ncihc.org

**Establishing Rapport and Trust**

“By investing yourself in creating the trust of one Hmong person, you will build the trust of many. The loss of trust of one will lose the trust of many.”

—Gervais, 1996, p. 50

The above quotation reflects the systemic implications for the establishment of trust.

Respect and Dignity

As a first step, members of the Hmong community (particularly elders) must be treated with respect and dignity. A sincere, open-minded, non-judgmental attitude is imperative in the effort to establish a trusting relationship. Also, listening to patients’ beliefs, desires for treatment, and reactions to recommended biomedical treatments can form a basis from which a trusting relationship can develop. Traditional beliefs should be accommodated whenever possible, whether as an adjunct to or as an alternative to Western medicine.

Preconceived Notions

Furthermore, it is important to view “trust through the lens of those whose trust we seek” (Kumanyika, 2005, p.84). Establishing a trusting relationship with Hmong elders is often challenging due to preconceived notions either created through personal experiences or those experienced and shared by others.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Therefore, the issue of trust is very complicated. As an insider within the Hmong American community, the second author, **Lhee Vang, MA** provides insight into some of the perceptions that promote mistrust toward Western medicine.

Distrust of Western Medicine

Too often, Western medicine is perceived as an experimental system. This view is reinforced by the evolving foundation of medical knowledge (i.e., clinical trials) to guide practice. Elders have also heard stories of teaching hospitals where medical students “learn and practice” on the patients who are entrusted in their care. Equally as alarming are the stories of cadavers being used to teach anatomy to medical students.

In addition, stories about unsuccessful medical treatments are repeated to members of the Hmong American community to serve as cautionary tales. Over time these tales become part of the Hmong lore regarding Western medicine. Consequently some Hmong Americans are fearful that medical treatment in and of itself may cause the person to become sicker than they were prior to treatment. This preconceived notion may prevent some elders from taking prescribed medications.

In general, Hmong people believe that accountability must be shared by all. Hmong American elders have expressed concern regarding the “lack of guarantee” associated with treatment outcomes in Western medicine. This is generally viewed as a lack of accountability. Elders are often fearful that clinicians will do whatever is convenient without genuinely caring about the patient’s welfare. Consequently, this strengthens the elders’ need to have family present to aid in the decision-making process. Therefore, accountability is shared within the family.

Traditional Healers vs. Western Health Practitioners

It is also important to explore the various perceptions held by elder Hmong Americans of traditional healers compared to Western health care practitioners. Often, traditional healers are viewed as integral members of the Hmong American community whose skills are highly respected. Traditional healers generally have a socioeconomic status that is equivalent to their patients. In contrast, physicians are often viewed as being at a higher socioeconomic status, whose primary motivation for their chosen profession is monetary profit. In addition, physicians are often viewed as taking a mechanistic approach to health care compared to the holistic approach of the traditional healer.

Many Hmong elders believe that, within the Western medical health care system, mainstream American patients, particularly those of a high socioeconomic status, receive better care and treatment (i.e. medications) than themselves, of lower status. Elders often perceive an imbalance in power between themselves and the Western health care providers.

As a result, they may feel the need to be obsequious to clinicians or the need to continue to seek opinions from multiple providers in an effort to receive better care and medications. The pretense of being subservient to clinicians and the option of making their own determinations at home, without communicating those decisions to providers, may be the elders’ routes to asserting their own power.

Eliciting the Patient’s Perspective

Eliciting the patient’s perspective is a key aspect to cross-cultural understanding. Without asking, providers are only guided by their assumptions. Since assumptions are based on generalities and stereotypes, they invariably will be incorrect.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)**Asking and Listening**

Asking questions and listening to responses requires patient-centered communication skills.

Examples of questions that can be used to elicit patient's thoughts, beliefs, desires and reactions to health care providers' recommendations include (Kleinman, Eisenberg & Good, 1978):



1. What do you think is wrong?
2. What do you think has caused the problem?
3. What are you afraid this might be?
4. What have you done to relieve the problem? Have you tried traditional Hmong treatments?
5. Have you seen other health care professionals?
6. What do you think would help you? How can I help you?
7. What do you think about what I have recommended? Do you think it will help? What problems do you see in doing it?
8. Who will help you make a decision? Do you want me to talk with those people?

An increased understanding of the patient's perception can facilitate communication for the establishment of a plan of care. These interactions may be straightforward or they may become complex. In the latter, nurses may need negotiation skills to identify the key points of disagreement, find common ground, propose alternative approaches, and identify a plan that both parties can agree to.

Decision-Making and Disclosure

In general, Hmong recognize that any life event or decision that affects one family member will have a direct or indirect impact on all of its members. Consequently, health care decisions are considered within the realm of the family as a whole rather than the individual alone. Traditionally, decisions were made

as a group by *kwv tij* (the husband's side of the family) under the supervision and guidance of the eldest male, with minimal input from the ill person. For elders, this often involved the eldest son or a male sibling.

Contemporary practice is expanding participation to include the ill person, wife, daughter-in-law (who often serves as the caregiver) and children with advanced education who contribute economically to the household. It is now becoming more prevalent that the eldest son takes into consideration the wishes of the elder who is ill, along with other family members. Individuals that contribute financially to the elder in question and their extended families tend to have more power in making decisions regardless of gender. For example an employed female may have more say in the funeral arrangements of her parents than her unemployed older brother.

The power that women hold in Hmong families is usually unseen by the public eye, but felt by the family nonetheless. While traditional power holders (men) are most often the official spokespeople for the family, women, must also be consulted in important decisions.

The ultimate goal of discussing medical decisions and treatment plans with the patient and his/her family is to obtain a consensus of opinion. Conflicts about treatment options are ideally settled through continued family discussions until a resolution is reached. A dispute may be resolved by consensus, but the final decision may be made by the individual of greatest power (i.e., an elder brother, a woman's husband, or a couple's eldest son).

It is important to recognize that there are a variety of family-based decision-making practices. Some elders will appear passive in family discussion and will defer to family members, such as spouses, older sons, or the family's male leader. Others will actively participate in discussions about medical pros and cons and may express an opinion that is contrary to the family's desires. Health care providers must find out who the appropriate people are to include when making critical decisions.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Patient and Family Education

It is important to provide culturally and linguistically appropriate information (Allen et al., 2004).

Many elders have retained the oral tradition of communication. This is evidenced by the number of elder Hmong who remain in contact with family members back in Laos and Thailand by sending audiotaped messages in lieu of written letters. The audio and video method of communication has been transferred to health education (Gerdner, Xiong, & Yang, 2006).

Health care programs should not focus on individual health in isolation of the family (Frye, 1995). It is recommended that education programs support the interdependence of the family unit.

Frye (1995) suggests cultural imagery as a meaningful approach to health education for Hmong elders who are not be able to read either English or Hmong. There are a number of oral folk tales that feature a tiger to symbolize treachery. The cultural response is for the family to demonstrate solidarity against the treachery. Frye (1995) adapted this imagery for a Hmong man faced with “overwhelming stress” but was ashamed to seek social support. And “when the stress was symbolized as the treacherous tiger that he could not face alone, he was culturally able to ask for help from his clan family and his network of friends” (Frye, 1995, p. 278).

End-of-Life Care

“Every culture surrounds death with specific rituals to assist the dying and the bereaved through this final life transition.”

—Kagawa-Singer, 1998

Health care professionals need to understand the cultural meaning and rituals associated with dying, death, and the bereavement process of Hmong Americans.

FAMILY, PATIENT & CAREGIVER EDUCATION RESOURCES**The Wausau Area Hmong Mutual Assistance Association**

Hmong Health Illustrations labeled in English and Hmong.



<http://www.hmonghealth.org/illustration/>

Glossary of Medical Terminology

Downloadable PDF on the **Refugee Health Information Network** site that displays terms in English, White Hmong, and Green Hmong.



<http://rhin.georgetown.edu/desktopdefault.aspx?tabid=26&DocumentID=1362>

Relaying a Terminal Illness

Traditionally, it is believed that discussing death will “unlock the gate of the evil spirits,” causing the person to die prematurely (Gerdner, Xiong, & Yang, 2006), or that speaking the words can cause death because words have power, or that telling the truth directly will cause *poob siab* or soul loss (Bliatout, 1993; Culhane-Pera and Xiong, 2007). Hence, talking about death directly can be considered a taboo, while talking about death indirectly is culturally acceptable. It is imperative that nurses find respectful and appropriate ways to tell an elderly person that they have a terminal illness.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Recommended Steps to Avoid Pitfalls

We recommend that you use the following generalities, while asking patients and their family members about their preferences, in order to avoid pitfalls.

1. Talking about the possibility of a terminal diagnosis

When you are contemplating that a diagnostic test may result in a terminal diagnosis, you could say:

"I am not sure what this test will show. I am concerned that it could be a serious illness. If it is not serious, we will all be happy for you. But if it is serious, who do you want me to talk with? We could have a family conference; which family members would you want to be present? If we had to discuss invasive options, who do you want to make those decisions?"

2. Talking about death and dying

Prior to death, **it is inappropriate for practitioners to directly say**

- To the patient: "You will die"
- To the family, "Your mother only has two weeks to live"

Although providers find it common practice to explain to families about the life expectancy of a loved one, it is experienced as a curse and disrespectful to give an approximate time frame unless specifically asked. To convey that a person will not have long to live, a Hmong person might say :

- "Nws txoj sia tsis ntev" ("Her/ his thread of life is not long, or s/he will not have long to live");
- "Tej zaum nws nyob tsis taus ntev" ("Probably s/he does not have long to live")
- "Nws nyob tsis taus txog 120 xyoo" ("She cannot live to be 120 years old.")

This phrase is derived from a Hmong folk tale that identifies 120 years as the ideal age before the soul begins its journey to *yeeb ceeb* (the spirit world) for reincarnation (Gerdner, Cha, Yang, & Tripp-Reimer, 2007).

ADVANCE DIRECTIVE RESOURCES FOR HEALTH CARE PROVIDERS**Health Care Proxy / Power of Attorney**

Affinity Health System (2007) has developed a web site to facilitate the explanation of health care proxy/power of attorney, advance directives, and patient rights. This web site includes downloadable information that has been translated into the Hmong language.



<http://www.affinityhealth.org/page/patients-proxy>

Health Care Directives

Another important online resource was developed by Allina Hospitals and Clinics and includes downloadable health care directive forms that have been translated into Hmong.



www.allina.com/ac/hearthealth.nsf/page/hcd

To convey that medical and nursing actions can no longer keep patients alive, providers can say, "*The sky is getting darker and darker and the sun seems to be setting more and more.*" All of these expressions can convey the same meaning as talking about death directly without making patients and families feel that providers want death to occur.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Advance Directives

The strength of beliefs in the above mentioned taboo is likely to affect the willingness to plan advance directives and to disclose a terminal diagnosis (Brotzman & Butlet, 1991). However, the findings of one study (Reid, 2007) indicate that some Hmong American elders are receptive to discussing advance directives.

The findings should be viewed with caution since only five elders consented to be interviewed, but are consistent with our understanding of how Hmong family and community members speak about death with each other. Findings indicated that elders did think about death, dying, and their funerals; were willing to discuss these issues with providers and family members, and preferred end-of-life options that had the least amount of pain and suffering.

Finally, Reid recommended that because Hmong elders came from an oral culture, it may be more appropriate and meaningful for the elder to record his/her wishes regarding advance directives using an audiotape recorder. Reid concludes that a tape-recorded voice has more veracity to Hmong elders than a written document. However, the use of audio taped messages may not meet the legal requirements in all states.

When discussing advance directives, we recommend that the most culturally responsive approach is to arrange a care conference with family members and a cultural interpreter who can act as a cultural broker. It may be helpful to acknowledge the sensitive nature of the topic and explain the obligation that health care providers have in understanding elder's wishes (Gerdner, Cha, Yang, & Tripp-Reimer, 2007).

In addition, it may be helpful for providers to explain that they're trying to empower the family by converting their family-based decision-making process into an American medical and legal document, which will insure that family's desires are respected when the time arises.

TERMINOLOGY: DYING AT HOME

dab qhuas—household spirits

dab xwm kab—house spirit altar

khaub ncaws laus—ancestral clothes, a euphemism for burial clothes

Care of the Dying Person**Dying at Home**

Dying at home may be particularly important for Hmong-American elders who retain traditional beliefs of animism/ancestor worship (Bliatout, 1993). This preference is primarily due to the presence of the household *dab qhuas* (spirits) particularly the *dab xwm kab* (house spirit altar) which is maintained by the eldest male. The altar is intended to serve and appease the household spirits charged with the welfare of the home and its residents (Cha, 2000).

Hmong American elders who have converted to Christianity may also prefer to die at home, surrounded by family. The home to which an elder has died is considered to acquire good fortune for its inhabitants (although some families are concerned about the resale value of their house, if a new buyer finds that someone has died there).

Nonetheless, the gathering of family and friends provides support for both the dying person and their family. In addition, it is believed that the dying person will impart “wisdom and blessings”, especially during their last words, to those who listen (Bliatout, 1993; Culhane-Pera, 2003a).

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

Hospice

Hospice care may be an option for Hmong Americans with terminal illness, but some hospice philosophies have been a source of conflict. For example, the hospice practice of requiring patients to refuse life-prolonging interventions have been experienced by some family members as being disrespectful and the underlying hospice value of helping people face and accept death has been viewed as antithetical to healthy family relationships (Culhane-Pera, 2003b; Vawter & Babbitt, 1997).

Hospice care is reported to be an underused resource in the Hmong-American community. This has been attributed to a lack of understanding and communication between both the consumer and the health care provider (Benson, 2004).

Ancestral Attire

Traditionally as death approaches, the elder is dressed in *khaub ncaws laus* (ancestral clothes, a euphemism for burial clothes, as one is going to join their ancestors in the land of the spirits). The details of the ancestral clothes vary depending upon the person's gender, age, social status, family, clan, White or Green Hmong, and geographic area or origin in Laos, but generally are in a style that their ancestors wore.

For some Hmong, the attire is a loose-fitting robe made of black or natural hemp or cotton. The man's robe may be designed with a narrow stand-up collar, whereas the woman's robe has a *dab tsho* (elaborate collar) hanging from the posterior neckline (Gerdner, Cha, Yang, Tripp-Reimer, 2005). For others, men wear shirts with a *dab tsho* and women wear multiple layers of White or Green Hmong hemp skirts, which they, their mothers or their daughters made (Morgan & Culhane-Pera, 1993).

“Hospice care is reported to be an underused resource in the Hmong American community. This has been attributed to a lack of understanding and communication between both the consumer and the health care provider (Benson, 2004) ”

Conflicting Views. There are conflicting views within the Christian Hmong American community as to whether ancestral attire is appropriate for Christians. Differing opinion are also held by leaders within the various denominations. Some Christians choose to adhere to this practice, believing the funeral attire is symbolic of culture rather than specific spiritual beliefs.

For example, some Catholic families have adopted the traditional White Hmong robe by trimming it with embroidered religious symbols (e.g., cross). Others may prefer to be dressed in newly purchased Western clothing (i.e., a new suit for a Hmong man) at the time of death (Gerdner, Cha, Yang, Tripp-Reimer, 2005). It has become increasingly common for the Hmong to layer their dead in both traditional and Western attire.

(PROMOTING CROSS-CULTURAL UNDERSTANDING CONT'D)

**TERMINOLOGY:
POST-MORTEM CARE**

Upon death, we recommend a few phrases that practitioners may be used to convey to the family that their loved one has died:

“Ib pas nqus tsis tuaj” (“One [more] breath doesn’t come”). Conceptually, this phrase means that the last breath was taken.

Alternative phrases that can be used are:

- **“Nws puv ib puas nees nkaum xyoo”** (“S/he has reached the 120th year of life”)
- **“Tas sim neej lawm”** (“S/he has reached the end of life”);
- **“Nws tsis nyob nrog peb lawm.”** (“S/he is no longer with us”)
- **“Nws xiam lawm.”** (“S/he is lost or gone”)

Following the elder’s death, family members must be allowed the privacy and time to express their grief. Customarily both males and females express their grief by *nyiaiv* (wailing loudly) and caressing the deceased by stroking the hair, face, and arms (Gerdner, Cha, Yang, & Tripp-Reimer, 2007).

In addition, they may continue to talk to the deceased, in the belief that the person’s soul remains present and is able to see and hear their words.

“It is imperative that health care professionals understand and respect the cultural heritage of the family and their response to death and the dying process.”

It is often believed that cutting or dismembering the body will delay reincarnation and result in negative consequences to the soul and physical body in the next life. Consequently, autopsies and organ donations are generally not accepted.

However, it is believed that the body should be free of metal pieces following death and prior to burial. This includes silver fillings, metal staples, and metal prosthetic devices. Traditional beliefs require that these items be surgically removed postmortem. Metal objects are believed to weigh down the soul, delaying or preventing reincarnation (Bliatout 1993; Culhane-Pera & Xiong, 2003; Vawter & Babbitt, 1997).

It is imperative that health care professionals understand and respect the cultural heritage of the family and their response to death and the dying process. For in-depth information of end-of-life nursing care and death rituals for Hmong American elders refer to Gerdner, Cha, Yang, & Tripp-Reimer (2007).

INSTRUCTIONAL STRATEGIES

Case Study: Chronic Obstructive Pulmonary Disease (COPD)

Part I

Mr. Cha Yer Moua was a 67-year-old man with emphysema who was admitted from clinic to the adult hospital ward with exacerbation of chronic obstructive pulmonary disease (COPD). His admitting nurse, Ms. Sara Jones, met him and five people as they arrived on the unit. She greeted the man in English, but he seemed to ignore her, apparently focused on his breathing. She then greeted the elderly woman at his side, which smiled but didn't answer in English. Ms. Jones then turned to a middle-aged woman, and asked how Mr. Moua was feeling. A middle-aged man standing next to her replied, "My father is very sick. His doctor said he needs a private room, medicine, and oxygen." The nurse acknowledged his need, and escorted them to a private room. She started oxygen, took his vital signs ($O_2\text{ Sat}=92\%$, $RR=20$, $HR=100$) and then looked at the written orders that the son had brought with him. She called Respiratory Therapy for a STAT nebulizer treatment, and ordered his medications.

Once Mr. Moua's breathing had improved, Ms. Jones went into the room and asked what language he spoke so she could get an interpreter. Finding out that he spoke White Hmong, she called the telephone interpreter service and waited two hours for an interpreter to answer the call. She proceeded to ask the necessary questions to obtain a medical and socio-cultural history.

Even though she directed her questions to Mr. Moua and passed the phone to him, he refused to respond, saying he was too short of breath to talk. Hence, his wife and son answered the majority of questions for him. Ms. Jones learned that he was born in Laos, had been in the U.S. for 2 decades, had had 2 wives (one of whom was living), had 12 sons and one daughter, had smoked two packs of cigarettes a day for 40 years, and was a respected shaman in the community.

When Ms. Jones asked about an advanced directive, the son intervened and said, "Don't ask my father those questions. We want him to live, that's why we brought him here. We want everything to be done as much as possible." Concerned that she couldn't get Mr. Moua's personal opinion, she explained that it was hospital policy to ask each patient the questions, and not accept family members' responses, so she had to ask him.

The son thought about it, and said, "I suggest then that you rephrase the questions using a quiet tone of voice. 'Mr. Moua, I am glad you're feeling a little bit better. We at the hospital can do lots of things to make you better so you can go home to be with your family and live to be 120 years old. Your doctor ordered many good medicines that will help you. Excuse me, sir, but it is hospital policy to ask each person two questions, even for those people who are strong and getting better like yourself. If I am not disturbing you, please may I ask you two questions?'"

Ms. Jones agreed to try this approach, and when she had repeated these words, Mr. Moua replied, "Yes, you may. I understand that the hospital has its own way of doing things."

"Thank you, sir. If your heart should stop, do you want us to push on your chest to get it going again?"

He replied, "Yes, but don't worry about that, as my heart is strong."

"Thank you sir; I am glad to hear it. The second question: if you should stop breathing, do you want us to put a tube down your throat and put you on a machine to breathe for you?"

Mr. Moua paused, as though focusing on his breath. He replied, "No, I do not want that. I have seen that terrible machine on other people, and I do not want that."

(CASE STUDY CONT'D)

Ms. Jones answered, “Thank you for allowing me to ask you these questions.”

After Ms. Jones left, the wife, son and daughter-in-law came out to the desk to tell her that the family disagreed with what Mr. Moua had said. They asserted that he had not understood what Ms. Jones had asked, because his dyspnea and hypoxia were impeding his ability to make this decision.

Also, his fear of hospitals had kept him at home for three days, despite his needing help to breath, so he was speaking from his fear. However, as his family, they had finally brought him to the hospital where they wanted everything done for him, including the “breathing machine.”

Questions for Discussion

1. What do you think about the words that the son told the nurse to use? How are those words similar to or different from the words you have used in similar situations?
2. What dilemma is the nurse facing?
3. What cultural information do you want to know in order to better understand Mr. Moua's response and his family's assertions?
4. What would you do to resolve the dilemma?
5. Do you think that Mr. Moua's assertions for Do Not Intubate (DNI) should be followed, regardless of the family members' opinions? Or do you think that you should follow the family's recommendations for a full code?

Part II

Ms. Jones didn't know what to do, and decided to discuss this with the admitting physician and her nursing supervisor, and also considered the possibility of discussing it with the chair of the hospital ethics committee. She had heard the patient refuse, and yet the family clearly wanted everything done, and they had good reasons to make her doubt the decision she had heard Mr. Moua make.

When his Hmong family physician Dr. Michael Khang arrived, she asked him. He replied that Mr. Moua had always been afraid of hospitals with particular fears that the hospital doctors and nurses would do things to him that he didn't want. So, while he had needed hospital care these past 3-4 days, he had refused it out of fear. Dr. Khang said that he would speak to him in White Hmong and try to resolve this uncertainty about DNI.

Ms. Jones accompanied Dr. Khang into the room. She watched as Dr. Khang pulled up a chair and sat next to Mr. Moua, and talked with him in low seemingly caring tones. She noticed that Dr. Khang didn't stare at Mr. Moua during their conversation, but rather looked away from him, and then periodically looked at him directly. Also, Dr. Khang talked with the son, who then talked to his father. When finished, **Dr. Khang explained to her several things:**

1. Mr. Moua was a shaman and was confident he would recover, as his shaman helping spirits had told him that he wouldn't die from respiratory problems. So, he didn't think he would need the ventilator.
2. However, he wasn't ready to die, and so after much discussion back and forth, including with his son, Mr. Moua seemed to relent, saying that if the machine would help him live, he would accept it, however, he didn't think he would need it, so he didn't think the discussion was necessary.
3. Mr. Moua's son was instrumental in helping his father decide to accept intubation and ventilation. Dr. Khang felt that Mr. Moua listened to his eldest son more than Mr. Moua listened to him. Perhaps Mr. Moua wanted to please his son, but he seemed to respect his son's opinion and seemed to be more reassured by his son's opinion about intubation/ventilation than about Dr. Khang's opinion.
4. However, Dr. Khang felt Mr. Moua's fears and concerns were not completely addressed. Dr. Khang knew that Mr. Moua was afraid that the doctors and nurses would take advantage of him, and harm him, rather than help him with the ventilator.

(CASE STUDY CONT'D)

Questions for Discussion

1. What do you think Dr. Khang did that helped facilitate this discussion? What knowledge and skills did he possess that Ms. Jones didn't have?
2. What role do you think Mr. Moua's eldest son had? Do you think that Mr. Moua's final decision was an independent decision, or was he overly swayed by his son?
3. What would you have done if Mr. Moua and his son had different opinions?
4. What do you think about Mr. Moua's apparent agreement when he still seems to disagree? And why is his fear of the hospital harming him seem to be paramount?

Reset the Case

Let's reset the case to before Dr. Khang arrived, before the difference of opinion was settled (if not completely resolved), and before Mr. Moua had signed a DNI paper, and Ms. Jones was at lunch.

Mr. Moua became extremely dyspneic and frantic, while he had a prolonged coughing spell. All of a sudden, he started hemorrhaging blood from his mouth, spewing blood onto his chest and all over his sheets. The wife screamed in terror and the son ran out of the room to get help. Several nurses ran into the room, saw his respiratory difficulty, and proceeded to call a code and give assistance.

Ms. Jones tried to tell the whirling mass of people that Mr. Moua didn't want to be intubated. When they heard that news, they froze, but the wife screamed at them: "Help! Help!" and the son said, "Help my father breathe. Put the tube down if needed. Start the breathing machine now!"

The people responded to his words, and to the frantic energy of other people arriving, and the code proceeded. Ultimately, the anesthesiologist sedated and intubated him before they moved him to Intensive Care Unit for a ventilator.

Questions for Discussion

1. Do you think that Mr. Moua's interests were best served? Do you think the team should have stopped the code or continued it?
2. How do you think Mr. Moua will feel when he wakes up and finds that he is intubated and on a ventilator? What consequences might there be for his family members and his health care providers?

Subsequent Care

Ultimately, Mr. Moua was on a ventilator for almost two weeks and was in ICU for almost one month. It was determined that his pulmonary hemorrhage had been caused by pulmonary tuberculosis, and so was given anti-TB therapies. Once discharged from ICU, he thanked the nurses and doctors for saving his life, and commended the value of the ventilator, oxygen, and medications. He acknowledged to Dr. Khang that his fear of nurses and doctors harming him was unfounded, but still, throughout his ICU experience, he was afraid every day of the invasive procedures that occurred without his control.

The day after he arrived home, Ms. Richardson and Ms. Yang greeted Mr. Moua at his home. Ms. Richardson introduced herself as a public health nurse who was going to monitor his tuberculosis therapy every day and introduced Ms. Yang as the Hmong interpreter.

Mr. Moua smiled politely, offered them a seat, told his wife to get them something to drink, and then whispered to his youngest son so that the interpreter couldn't hear him, "Monitor? Watch me? What do they mean, 'watch me'? Can't I take my medicines myself without being watched? Americans call this country 'freedom country', I don't know. Where is freedom, when a nurse comes to my house every day to watch me take medicines?"

(CASE STUDY CONT'D)

Ms. Richardson, with Ms. Yang's translations, talked about TB and the TB medicines for 30 minutes, and then offered Mr. Moua three TB pills and told him to swallow them in front of her and then open his mouth so she could see that the pills were swallowed.

Mr. Moua felt indignant and insulted. Smiling, without anger in his voice, Mr. Moua said, "I am glad for your care and assistance, as I have been very sick in the hospital and appreciate any help you can give me. But I am an elderly wise man who can take his medicines without being watched. Thank you very much." And he stood to show Ms. Richardson the door.

Questions for Discussion

1. What do you think is causing Mr. Moua to feel insulted? Why do you think he has chosen to express his discomfort in this manner (i.e., whispering to the son, and then politely telling the nurse to leave) rather than directly confronting the nurse?
2. What do you think Ms. Yang's role is, as an interpreter? Does it include being a cultural broker? If not, what can Ms. Richardson do to help? If yes, how do you think that she could help improve cultural understanding and resolve a negotiated mutually agreeable decision?

Subsequent Care

Ms. Richardson was confused and asked Mr. Moua, "Sir, I am sorry you have been very sick; I am glad you are now better; and I am glad that you want to take your medicines. I agree that you are an elderly man who can take your medicines without my supervision. If it were up to me, I wouldn't insist on this. The problem is that the state requires everyone with TB to have a nurse come to the house and watch them take their medicine. How do you think we can work together, so that we can follow the law and help you feel better?"

Mr. Moua's wife offered, "I am willing to help my husband take his medicine every day. Would that be acceptable?"

Ms. Richardson, "That would be fine, as long as I am here."

Mr. Moua, "Even if my wife gives me the medicine, I refuse to open my mouth afterwards for inspection, as if I am a baby or an animal."

Ms. Yang turned to Ms. Richardson and said, "In Hmong culture, opening the mouth and showing your tongue or teeth is embarrassing, particularly for elders. Perhaps this is his main objection."

Ms. Richardson, "If that is objectionable to you, then I am willing to forgo it."

Mr. Moua, "And I would prefer it if you would not come every day."

Ms. Richardson, "For now, I need to come every day, as those are the doctors' orders. However, I am willing to talk with the TB doctor, and ask him to decrease your medicines to twice a week. This may mean that you would have to take more pills every day, however. Is that acceptable?"

Mr. Moua, "Yes, please talk with the doctor; it would be good to decrease the pills to twice a week."

Questions for Discussion

1. What essential elements of negotiation can you identify in this exchange? How do you think each party felt about the negotiation process? Were their needs and desires met or not?
2. What elements of cultural respect and building a trusting relationship did Ms. Richardson display in this exchange? Were there other things she could have done?

Subsequent Care

After 9 months of twice a week directly observed TB treatment, Mr. Moua slowly improved, although he continued to suffer from COPD. For five years Ms. Friedman, a home health nurse, made routine visits to his home, helping him obtain medicines, oxygen, bath supports, a cane and then a wheelchair, as he

(CASE STUDY CONT'D)

became less ambulatory. She came to know him and his family well. She called him “*Txiv Ntxawg*” or “Father’s Youngest Brother” and he called her, “Daughter”.

She learned when Mr. Moua did traditional Hmong treatments, such as herbal medicines and shaman’s ceremonies, in addition to his breathing medicines. During this time, he slowly lost energy and strength; although he continued to be head of his family, he had less influence over his children and grandchildren. He became depressed at the loss of his vitality: physical, sexually, and social. Periodically she asked him about whether he was willing to discuss an advanced directive, but he always refused, stating that his shaman helping spirits would take care of him. One day, Ms. Friedman visited him and found him to be dyspneic and tachycardic, although not more hypoxic than usual. He explained, “Two days ago my wheezing returned and my coughing and breathing became worse, so I saw the doctor. She said my X-ray was good, my blood was good, but my “azma” was worse, so she gave me three small white pills again (Prednisone), but I am not any better.”

Ms. Friedman, “Uncle, perhaps you should go back to see the doctor then. Maybe something else is wrong or you need other medicine.”

Mr. Moua, “I could in a few days, if I am not better.”

Ms. Friedman, “What do you think is wrong? Is there anything you’re particularly concerned about?”

Mr. Moua, “This could be a spiritual problem. Tonight my youngest son has arranged for a shaman to do a shaman ceremony for me. Whenever the doctor says that nothing is wrong, then I know a spirit could be bothering me.”

Ms. Friedman, “Is there anything else that makes you think this could be a spirit problem?”

Mr. Moua laughed, “You are always good at asking me questions!! Yes, ever since last month I have been more short of breath. Last month I attended a funeral for my daughter’s husband’s mother, and I stumbled and fell,

even though I had my cane. So, perhaps my soul fell and did not rise again, so my soul is gone, and that is making me sick.”

Ms. Friedman, “I am sorry to hear that you fell. I can understand your concern; falling at a funeral is dangerous. May I return tomorrow to see how you’re doing?”

Mr. Moua, “Yes, Daughter, that would be fine.”

The next day, Ms. Friedman found Mr. Moua sitting up in bed, with his oxygen on, focusing on his breathing. She asked, “Uncle, how are you doing? Are you any better? What did the shaman find out?”

Mr. Moua, “It was worse than we thought. Initially the shaman threw the goats’ horns, and found out that the problem was not that my soul had fallen at the funeral, but something else was wrong. So then he shook so that his soul and his helping spirits could travel to the spirit world. They discovered that my dead father wants me to join him in the Land of the Ancestors. Back when I was in the ICU, I had died, and my soul had traveled to the Land of the Ancestors.

“I met my father’s ghost and he had given me a choice: either be reborn as an infant in a new strong healthy body or stay in this world as an old man with a failing body and be a father to my children. I chose the latter, so that is why I survived the ICU. Now my father says he needs me and wants me to join him in the Land of the Ancestors.”

Ms. Friedman, “Oh, dear, that sounds dreadful. What can be done?”

Mr. Moua, “The shaman fought with the spirits and won. He says that I will be better in 7 days, and when I am better, we can do another ceremony to pay my father’s ghost, so he won’t take me now, but will wait for me.”

Ms. Friedman, “It seems to me like you’re worse today, though. Let me examine you.” After she did, she said, “Your lungs sound worse. What do you think about

(CASE STUDY CONT'D)

going to the hospital and seeing if some other medicine could help?”

Mr. Moua, “Do you think so? Well, maybe; Let me talk with my youngest son and decide.”

Ms. Friedman, “Yes, I do think so. As you have told me before, combining medicine with the spiritual treatment can be helpful. Now may be the best time to combine both of them.”

Questions for Discussion

1. How would you evaluate Ms. Friedman's general interactions with Mr. Moua? What has contributed to their successful relationship?
2. How would you evaluate Ms. Friedman's interactions about this worsening period of dyspnea? What elements of cultural respect and negotiation did she display?
3. What do you think about combining biomedicine and modern nursing elements with traditional healing processes, such as the shaman ceremony?

Subsequent Care

Later, Mr. Moua did go to the ER, and was admitted for intravenous antibiotics for a bacterial pneumonia. The admitting unit nurse, Ms. Jones, greeted him, his wife, three sons and 2 daughters-in-law, on the floor.

“Hello again, Mr. Moua. I remember you from 5 years ago. I am sorry that you're having a hard time breathing, but with these antibiotics you're going to feel great again in 1-2 days,” replied Ms. Jones.

After she got him settled into bed with oxygen, an IV and medications, she asked a daytime Hmong interpreter to join her. Sitting in a chair beside the bed, she said, “Mr. Moua, can we talk about your preferences for treatment while you're here at the hospital? We want to please you, and help you get better as fast as you can. What kinds of treatment do you want, and don't want?”

Mr. Moua, “I appreciate everything you're doing for

me. I want the oxygen, IV fluids, and IV medicines. But this time, I really don't want to be on a ventilator. I did that before, and I have had five good years with my children and grandchildren, but I no longer have the strength that I used to have. I can't go anywhere without my oxygen and without someone pushing me in the wheelchair. I have had a long and good life. If my lungs can't sustain my life, then I don't want to be on the ventilator. A ventilator would just be punishing me needlessly, like prolonging my death, and I don't want that. Last night I already told my family how I feel, and they understand. They told me they will not make any decisions that disagree with my wishes.”

Ms. Jones, “Thank you for expressing yourself so clear to me. I understand and will make sure that other hospital caregivers understand also. I am optimistic that you will get better, go home, and live to be 120 years of age, so you can still be with your family for a long time. We do have an Advance Directive, with a list of items that you and your family can consider together in order to clarify all of your wishes.

“We have a Hmong language videotape with written materials in Hmong and English. Perhaps you and your family could look at it together.”

Mr. Moua, “Thank you. Not today, as I am too tired, but maybe we could do that before I go home.”

(CASE STUDY CONT'D)**Conclusion**

Three days later his pneumonia had improved, and before he was discharged, they held a family conference with Mr. Moua, his wife, and 3 of his 7 sons. They watched the Hmong videotape about Advance Directives, and went through the options in the written notebook, making each decision. Most of the written replies were, “I will defer to my family”, but Mr. Moua had the opportunity to tell his family how he felt about each option.

However, with the question about intubation and ventilation, Mr. Moua clearly chose “DNI” as he had before. When he returned home, he set up a videocamera and made a tape, which his family could listen to after his death.

He told his family how much he loved them, and how he wanted them to live together in peace and harmony. Finally, he admonished them to love and help each other throughout their entire lives.

Questions for Discussion

1. How did this discussion of DNI/DNR in the hospital contrast with the initial hospitalization? Why do you think it was different?
2. Why do you think the discussion of the Advance Directive seemed to be easier in the hospital than when the home care nurse had addressed it at home?
3. What emotional reactions do you have to the videotape that Mr. Moua made for his family?

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LINKS AND INTERNET RESOURCES

Grandfather's Story Cloth

Children's book about a 10-year old boy named Chersheng and his grandfather, who has Alzheimer's Disease

www.shens.com/grandfathers_story_cloth/

Interpretation Issues

The National Council on Interpreting in Health Care has developed a website to further discuss issues with Hmong to English interpretation.

www.ncihc.org

The Wausau Area Hmong Mutual Assistance Association

Hmong Health Illustrations labeled in English and Hmong.

<http://www.hmonghealth.org/illustration/>

Glossary of Medical Terminology

Downloadable PDF on the Refugee Health Information Network site that displays terms in English, White Hmong, and Green Hmong.

<http://rhin.georgetown.edu/desktopdefault.aspx?tabid=26&DocumentID=1362>

Health Care Proxy/Power of Attorney

Affinity Health System (2007) has developed a web site to facilitate the explanation of health care proxy/power of attorney, advance directives, and patient rights. This web site includes downloadable information that has been translated into the Hmong language.

<http://www.affinityhealth.org/page/patients-proxy>

Health Care Directives

Important online resource developed by Allina Hospitals and Clinics and includes downloadable health care directive forms that have been translated into Hmong.

www.allina.com/ac/hearthealth.nsf/page/hcd