



Health and Health Care of  
**Korean American  
 Older Adults**

<http://geriatrics.stanford.edu/ethnomed/korean>



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Course Director and Editor in Chief: **VJ Periyakoil, MD** Stanford University School of Medicine

✉ [periyakoil@stanford.edu](mailto:periyakoil@stanford.edu) ☎ 650-493-5000 x66209 <http://geriatrics.stanford.edu>

Author: **Linda Sohn, MD, MPH** VA Greater Los Angeles Healthcare System



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 IN THE DIVISION OF GENERAL INTERNAL MEDICINE  
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**Sohn, L, MD, MPH:** Health and health care of Korean American Older Adults <http://geriatrics.stanford.edu/ethnomed/korean/>. In Periyakoil VS, eds. eCampus Geriatrics, Stanford CA, 2010.

## DESCRIPTION

This module presents information that is available related to health status and health care of elders from Korean backgrounds in the US. It includes some background on the population and traditional health beliefs as well as important clinical considerations.

### Course Director and Editor in Chief of the Ethnogeriatrics Curriculum and Training

VJ Periyakoil, MD

Stanford University School of Medicine

### Author(s)

Linda Sohn, MD, MPH

VA Greater Los Angeles Healthcare System

## LEARNING OBJECTIVES



1. Explain major traditional health beliefs among individuals from Korean backgrounds.
2. List eight practical considerations Western providers should take into account in clinical assessment of Korean American elders.
3. Discuss appropriate approaches in dealing with advance directives and end-of-life care with Korean American elders and their families.

## 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

## INTRODUCTION & OVERVIEW

### Demographics

It has been over a hundred years since the first Koreans immigrated to the United States.

On January 13, 1903 the first group of Korean American immigrants, 56 men, 21 women and 25 children came to the island of Hawaii to work as immigrant laborers on sugar plantations (Chow 2003).

Korean Americans are one the fastest growing subgroup populations of Asian-Americans. Since 1975 Koreans have ranked in the top five of immigrants to the US, along with immigrants from the Philippines, China, and Vietnam.

**Over one million US residents (1,406,687), 0.5% of the US population, identified their “race” as Korean alone or in combination in 2005. About 25% were concentrated in the Los Angeles County area and about 16% in the New York region.** The number of Korean Americans is expected to continue to increase.

**For more information on demographics, see [www.census.gov](http://www.census.gov)**



**(INTRODUCTION & OVERVIEW CONT'D)**

In 1990 **of the 800,000 Korean Americans residing in the US, 4.4 % of were aged 65 and over.**

Characteristics of the Korean American elders in 1990 included (Young & Gu, 1995):

- 91% were foreign-born
- 19% of whom were naturalized
- 80% do not speak English well
- 53% were linguistically isolated
- 42% had less than a high school education
- 20% reported incomes under the poverty level
- 43% to 48% live alone
- 1.4% lived in nursing homes

**Background**

The legend of Korea's foundation by the god-king Tangun in 2333 B.C. embodies the self-sufficiency valued by the Korean people. In the legend a bear and tiger wished to become human. They prayed fervently to Hwanung, a king living in the heavens, to fulfill their wish. Giving each 20 cloves of garlic and a bunch of *mugwort* (a herb), he told them to take only that nourishment and to stay out of the sun for 100 days. They took the food and retired to a cave.

The tiger became impatient and hungry and abandoned the cave. The bear, however, endured and was turned into a woman. She prayed to become a mother and Hwanung gladly obliged, and the bear-woman bore Tan'gun, the first human king of the people of the peninsula, Korea, establishing his capital at Wanggom (P'yongyang) in 2333 B.C. He called his kingdom Choson meaning morning calm or morning freshness.

**Creation of North and South Korea**

Korea has experienced many invasions by its larger neighbors during its 2,000 years of recorded history. During the modern era, one key political/historical event is the division of Korea into the South and communist North. After WWII, division at the 38th

**FAST FACTS**

- National language of Korea is Hangul
- Korea has a population of 49 million with a growth rate of 0.394% in 2007
- In 2007 9.6% of the total population was 65 years and over

parallel marked the beginning of North and South Korea. On August 15, 1948 the Republic of Korea (R.O.K.) was established, with Syngman Rhee as the first President. On September 9, 1948 the Democratic People's Republic of Korea (D.P.R.K.) was established under Kim IL Sung. The history of invasions from its neighbors fosters a strong sense of nationalism in the Korean people, which is only further heightened by the division of the country.

**Korean Immigration to the US**

The first group of Korean laborers came to Hawaii in January 1903. Between 1904 and 1907 about 1,000 Koreans entered the mainland from Hawaii through San Francisco. Later a larger group of immigrants included the wives of US servicemen, and as many as 150,000 adoptees. With the passage of the Immigration and Nationality Act of 1965, Koreans became one of the fastest growing Asian groups in the United States, surpassed only by Filipinos.

In the 1980s and 1990s, Koreans were largely self-employed as small business owners such as dry cleaners and convenience stores. Their children, along with those of other Asian Americans would also be noted in headlines and magazine covers in the 1980s for their numbers in prestigious universities. A number of US states have declared January 13 as Korean American Day in order to recognize Korean Americans' impact and contributions. This has led to the painting of Asian groups such as the Koreans as a "model minority."

## PATTERNS OF HEALTH RISK

As with the aged population worldwide, people in Korea are living longer and living those later years with multiple medical co-morbidities. Estimated to have one of the most drastic increases in the elderly population, by 2050 those 60 years and older in Korea will make up 41% of the population.

### Obesity

Korean Americans have relatively low rates of obesity. In one study, only 8% of the sample was obese according to WHO body mass index criteria for Asians (Cho & Juon, 2006). However, it is notable that the probability of becoming obese increases with the length of residence in the United States.

### Alcohol and Nicotine

Alcohol and nicotine are the major substances consumed by Korean males. Korean American elders show lower rates of smoking and alcohol drinking than elders in Korea. For example, the rate of current smoking was 26% for Korean American men (Juon, Kim, Han, Ryu, & Han, 2003) and 47% for Korean men in Korea (Kim & Baik, 2004). Those who were less acculturated were more likely to smoke and drink alcohol (Juon et al., 2003).

### Diabetes and Hypertension

Studies also identified that Korean American elders have higher rates of diabetes and hypertension than White counterparts (Lee, Yeo, & Gallagher-Thompson, 1993). The risk for Hepatitis is known to be high among Korean Americans. In a study by Hann (1994), 5.2% of the females and 7.4% of the males over age 40 were carriers of Hepatitis B virus.

### Poor Nutrition

A study on nutritional status of residents of senior housing in Chicago found that the nutritional quality of the Korean American elders' diets was poorer than the other ethnic groups (Kim et al., 1993).

“Studies also identified that Korean American elders have higher rates of diabetes and hypertension than White counterparts.”

A large percentage of Korean elders had low intake of calories, calcium, Vitamins A and C and riboflavin; 25% of the Korean elderly women consumed less than 67% of the Recommended Dietary Allowance for protein.

### Mental Distress

Korean American elders are known to be at a particular risk for mental distress (Hughes, 2002; Hurh & Kim, 1990). Studies using standard depressive symptom inventories (e.g., the Center for Epidemiological Studies Depression Scale and the Geriatric Depression Scale) reportedly show that Korean American elders have higher scores than other racial/ethnic groups (e.g., Min, Moon, & Lubben, 2005).

Although the high scores may be partly attributed to cultural response patterns to symptom inventories (Jang, Kim, & Chiriboga, 2005), the findings call attention to the heightened needs for mental health services in Korean American communities. However, their utilization rate for mental health service is extremely low (Kim, 1995; Shin, 2002). Studies report that Korean American elders are subject to cultural misconceptions and stigmatism related to mental disorders (e.g., Jang, Kim, Hansen, & Chiriboga, 2007).



**(PATTERNS OF HEALTH RISK CONT'D)****Elderly in Korea**

According to data from the Korea National Statistics Office, the major health problems of Korean elders in Korea include:

1. Circulatory Disease: hypertension, cerebrovascular accident, coronary heart disease
2. Cancer: stomach, liver, cervix, breast
3. Endocrine Diseases: diabetes mellitus
4. Dementia
5. Respiratory: pneumonia, chronic obstructive pulmonary disease
6. Musculoskeletal Disease: osteoporosis, arthritis, fractures

**Health Problems of Korean Americans****Access to Health Care**

Koreans, as with other immigrant populations, have difficulties accessing the US health system. The healthcare system is difficult to navigate and lack of English proficiency compounds the problems. In addition many Korean immigrants lack health insurance. Large proportions of Korean Americans are uninsured (Carrasquillo O., et al., 2000).

In Los Angeles County, the city with the largest number of Koreans outside of Korea, the proportion of the uninsured is more than 40%. (Brown, E.R., et al., 2001). Many Korean Americans in Los Angeles are self-employed or work in small businesses that commonly do not provide health insurance, which may explain the large numbers of uninsured. (Brown, E.R., et al., 2000).

In addition older recent Korean immigrants do not qualify for Medicare. Many of the older Koreans immigrate to join their adult children in the US. The high rates of uninsured persons and inability to qualify for Medicare for recent elderly Korean immigrants pose important barriers to healthcare access.

**Nutritional Status**

A study looking at the nutritional status of senior housing residents in Chicago found that the nutritional quality of the Korean American elders' diets was poorer than the other two groups, the Chinese and Japanese Americans:

Large percentage of Korean elders with diets low in calories, calcium, Vitamins A and C and riboflavin; 25% of the Korean women 60 years and older in the study consumed less than 67% of the Recommended Dietary Allowance for protein (Kim et al., 1993).

The traditional Korean diet is very high in salt. In traditional Korean meals, numerous small servings or side dishes of preserved foods are served. These foods are usually pickled in brine or have been packed in salt and lightly rinsed.

This high salt diet predisposes to hypertension, and is especially troublesome when patients with congestive heart failure are noncompliant with their dietary restrictions.

“ **Liver cancer incidence and mortality rates of Koreans in California are the highest of all Asian American groups in females and second highest in males.** ”

**Cancer**

Data from the SEER (Surveillance Epidemiology and End Results) Registry of the National Cancer Institute reported that **the top three cancers in Koreans in Los Angeles to be stomach, lung and liver.** Stomach cancer is the leading cancer in Korea. Factors such as diet consisting of salted, fermented foods, smoking and H. pylori infection are thought to be contributing factors. As compared to the white population, Koreans were found to have a five times greater prevalence of stomach cancer (Koh, 1997).

**(PATTERNS OF HEALTH RISK CONT'D)**

One study reported that in California, **about 36% of Korean men are current smokers**, which is the highest prevalence among all Asian American groups examined in the study (McCracken et.al. 2007). Lung cancer death rates are highest in Korea Americans in the same study. In a report from the US department of health and human services reporting on the health status of Asian Americans in the US from 1992-1994, reported that higher percentages of adults of Korean descent (22.5%) were current smokers. (Kuo 1997).

Liver cancer incidence and mortality rates of Koreans in California are the highest of all Asian American groups in females and second highest in males. (McCracken et al., 2007). This is thought to be the result of the high prevalence of Hepatitis B infection in the Korean population. In addition, it is reported that Koreans in California have the highest proportion who report alcohol consumption, 71.1% in men and 43.4% in women when compared to the other Asian groups. Another study of Korean American men revealed the prevalence of liver cancer to be eight times greater than the white population (Koh HK, et al., 1993).

It is important to be aware of the differences in incidence and prevalence of cancer in the different Asian groups. This enables clinicians to be aware of conditions that may be more common in certain populations thus providing tools to better care for the patient and their ethnic population.

Those taking care of ethnic populations in addition to frequency of certain cancers should be aware of low prevalence of cancer screening.

In one study of Asians in California, **Koreans had the lowest prevalence of most screening tools** such as endoscopy, fecal occult blood test, pap smears and mammograms. (McCracken 2007). The statistics of older Koreans in Los Angeles and preventive health measures are alarming. About one-half of the sample, 45% of the older Korean women had never had a mammogram and of those who had a mammogram only 24% had had one in the last year.

**Hypertension and Cardiovascular Disease**

In the San Jose, CA study, 36% reported having high blood pressure. Much lower rates of other cardiovascular-related disease risk factors were found. For example, 8% reported having elevated cholesterol (however 32% said they did not know their cholesterol levels), 8% were currently smokers, and 72% were currently exercising on a regular basis. Even though they expressed little interest in, or knowledge of, cardiovascular risk factors, 82% reported they had made changes to improve their health in the last five years. Approximately half reported each of the following: eating less salt, less red meat or eggs, or eating more fiber, fruits, and vegetables (Lee et al., 1993).

**Mental Health**

Stressors of being a Korean American immigrant may contribute to the mental health of a population. Adjustment to a new country, communication and language difficulties, problems of identity all heighten stressors that the immigrant population deal with. In addition, the portrayal of Asians as a “model minority” may result in underestimation of the problems.

Recent events covered in the media including the Virginia Tech massacre by a troubled Korean American and dual suicide/homicide by a Korean father in Los Angeles further emphasizes that Asian groups may not be the ‘model minority’ once envisioned.

Korean youths deal with the pressure of the emphasis that their parent’s place on education. Older Korean immigrants who don’t speak the language and lack social outlets deal with social isolation and depression. In addition, depression may be felt to be a sign of personal weakness. One study looking at attitudes of older Korean Americans toward mental health services found that length of time having lived in the US were more likely to have favorable perception of mental health services (Jang, 2007).

**(PATTERNS OF HEALTH RISK CONT'D)****Other Health Issues****Alcohol Abuse**

Looking at data on cancer incidences in Asian Americans in California, Koreans in California had the highest proportion of reported alcohol consumption in both men and women compared with other Asian groups. (McCracken et al., 2007).

A study looking at potential risk factors for illness explored the drinking behavior of 280 adult Korean Americans in Los Angeles, 12.5% of whom were over age 60 (Lubben, Chi, & Kitano, 1989). The older Koreans were more likely to describe themselves as abstainers than those aged 45 and under; only 20% of those 61 and over reported drinking alcohol at all. Heavy drinkers in the study were more apt to be male and frequent bars or nightclubs.

**Adjustment Problems**

Fifty Korean immigrants in the San Francisco Bay Area age 60 and over were interviewed in 1981 to identify typical adjustment problems. Ratings of stress and adaptation in five areas of functioning (social, cultural, economic, health, and emotional/cognitive) found that those in greatest risk of difficulty were those with little education, had arrived in the US recently, and lived alone (Kiefer et al., 1985).

**Diabetes Mellitus Type II**

In a San Jose, California study of 50 senior center participants and senior apartment dwellers aged 65 to 82, all of whom were born in Korea, 36% reported a history of diabetes, which is approximately four times the rate of older Americans (Lee, Yeo, & Gallagher-Thompson, 1993).

**Hepatitis B Virus**

Korean American elders are known to be at a particular risk for mental distress (Hughes, 2002; Hurh & Kim, 1990). Studies using standard depressive symptom inventories (e.g., the Center for Epidemiological Studies Depression Scale and the Geriatric Depression Scale) reportedly show that Korean American elders have

“ ...Koreans in California had the highest proportion of reported alcohol consumption in both men and women compared with other Asian groups. ”

higher scores than other racial/ethnic groups (e.g., Min, Moon, & Lubben, 2005).

Although the high scores may be partly attributed to cultural response patterns to symptom inventories (Jang, Kim, & Chiriboga, 2005), the findings call attention to the heightened needs for mental health services in Korean American communities. However, their utilization rate for mental health service is extremely low (Kim, 1995; Shin, 2002). Studies report that Korean American elders are subject to cultural misconceptions and stigmatism related to mental disorders (e.g., Jang, Kim, Hansen, & Chiriboga, 2007).

**Tuberculosis**

In Korea, tuberculosis (TB) is a public health problem with incidence rates among the highest in Asia. With regards to the older Korean American population, the rate of tuberculosis in Korean American older persons is 12 times greater than among Whites (Kitano & Daniels, 1988). Proper screening and prophylaxis is indicated for this population.



## CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

### Traditional Health Beliefs

Many Korean immigrants use Korean traditional health practices. For example the practice of traditional medicine called *Han bang*. Four common treatment methods include:

*ch'im*—acupuncture

*Hanyak*—traditional Korean herbal medication

*d'um*—moxibustion, direct or indirect burning with a stick made of the mugwort plant

*buhwang*—cupping applying heated glass cups directly to the skin, forming a vacuum

**Han bang**, derived from Chinese traditional medical practices, is based on balance between *um* (the same as yin and yang), as well as the balance of fire, earth, metal, water, and wood. Some diagnostic methods used in Han bang include observing the patient, obtaining a history of the illness, listening to a patient's voice, and taking the patient's pulse (Kim, K., et al., 2002).

Older Koreans may attribute illnesses to a failure to fulfill spiritual obligations, whether these are based on Christianity, Confucianism, animism, or shamanism. Some may feel that their illnesses are due to failure to pray, others to displeasure of ancestors with their burial place, or still others to offending folk spirits.

In one study of older Korean American women, the women attributed illnesses to *Hwabyung* (“fire illness”), caused by the inability of expressing their emotions openly. Each emotion was believed to affect a particular organ system and the flow of *Ki* (the energy that animates all living things) in different ways. The women in the study were well-educated and in most cases the emotions were related to difficult interpersonal or family relationships.

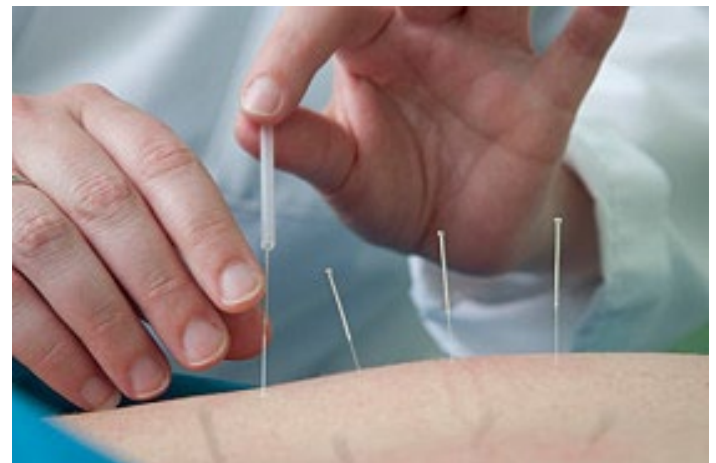
Many Korean immigrants still receive their primary health care solely from a traditional medicine practitioner, or in addition to a Western health care

provider. Older Korean Americans may alternate between seeing practitioners of Western and traditional Korean medicine. However, Koreans may not openly discuss their use of traditional Asian medicine with physicians trained in Western medicine, possibly because of a fear of ridicule or wish to avoid causing offense to the clinician.



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**Buhwang**—cupping applying heated glass cups directly to the skin, forming a vacuum



**Ch'im**—acupuncture

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## CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

### Filial Piety

Confucian teachings such as filial piety and respect for the elderly are important in Korean society.

Respectful gestures, such as bowing to those only one year older, maybe the norm. When greeting someone, good manners include that one bows slightly when shaking hands. However, older Korean Americans who are less acculturated may not be accustomed to shaking hands. Verbal communication has different levels of honorifics when talking to those older than oneself. During the medical interview with the Korean elder it is important not to forget the formality and respectfulness that is needed to be conveyed during the meeting. Appearance is emphasized, and it is also important to sit up straight in meetings and, when standing, to avoid putting one's hands into one's pockets. In conversation, extended direct eye contact can be considered rude.

In Korean American communities, religious organizations (churches and temples) play an important social role, and may greatly facilitate getting older people the help they need. It would be important for health providers to understand this relationship and to establish ties with religious organizations to serve the community.

Even when there are a number of Korean Americans living in a community, the availability of Korean-language speaking health care providers is very limited. Hospitalization may be especially undesirable because of the separation from family, preference for traditional medicine, and the unavailability of Korean food.

Due to cultural values on caring for elderly Korean parents at home and other structural barriers, Korean Americans are underrepresented in nursing homes. However, the need for all family members to work, often more than one job, results in family stress around the care needed at home. When the care needs of the elder far exceed what can be safely provided at home, it may be necessary to accept institutional care. In a national survey in Korea, about 19% of older Koreans

expressed a willingness to enter a long-term care facility (Kim & Kim, 2004). In a study with Korean American elders in California (Min, 2005), 16% and 51% of the sample positively endorsed for the use of the use of nursing home under the two hypothetical conditions of hip fracture and stroke.

“Confucian teachings such as filial piety and respect for the elderly are important in Korean society.”

### Language Barrier

Communication with the health care provider is a problem for many Korean American elderly. Many Korean elders do not speak English, and may not speak English even if they had immigrated many years ago. One study revealed that 20% of the Korean American elders in LA County never spoke English and of those who did 44% felt that they spoke it poorly. They often live socially isolated from the community or live in households with limited English proficiency.

In a study of 200 older Koreans in Los Angeles most of the sample, about 95% was born in Korea and on average had immigrated to the United States about 20 years ago. Despite this, over 90% never spoke English or felt that they had fair or poor English language skills. This was also true for comprehension, writing and reading English skills. They used Korean as their primary language at home or in social settings.

Also we need to be cognizant that some Korean elders may not be literate in reading and writing especially, those with limited educational backgrounds. This is a source of embarrassment since education is very highly regarded in Korean culture. Korean elders may not be

**(ASSESSMENT CONT'D)**

forthright about their educational status or hide their illiteracy.

**Importance of Family and Kinship**

Ideas of individualism and autonomy are unfamiliar in traditional Korean culture.

Characteristics that have been found among Korean families include: a high regard for filial piety; clearly divided family roles; family collectivity and interdependence which frequently overrides individualism and independence; and importance of good education (Chin, 1993; Kitano & Daniels, 1988). Korean culture emphasizes the family unit and the individual is a part of that unit and thus decisions are made collectively. Korean elders will often involve family members in decision-making, and an important health decision will commonly involve their conferring with and relying on an eldest son, if one exists.

**Gender issues**

Traditional Korean society is patriarchal, and until recently, it was common for Korean women to stay at home to take care of the family. Korean immigrant families have had to change abruptly from having a male as the sole provider to situations where the women are also working outside of the home. This may be a source of conflict. In addition, Korean women may feel burdened if they are expected to continue to perform all the household-related work in addition to their responsibilities in the workplace.

Even highly acculturated Korean Americans may regard it as natural for adult children to be responsible for aging parents and to provide care for them at home. Women customarily are the designated primary caregivers to home-dwelling Korean American elders. Care at home can be both emotionally and financially draining and even the closest and most supportive families are at risk for caregiver stress and burnout. Although present in all cultures, such situations in the Korean American community may result in high degrees of burden when caregivers feel the traditional

pressures of providing all elder care personally and within the home setting.

**Sensitive Issues**

Korean culture is strongly influenced by Buddhism and the philosophy of Confucianism. Modesty is an important virtue especially for women in Confucianism, which may influence use of preventive health services such as pap smears and mammography. It may also be difficult to illicit intimate details such as bodily functions and sexual history when the health care provider interviews the female patient.

**Eliciting the Patient's Perspective**

- 1. What do you call the problem?** Is there a name for it in the Korean culture (i.e. Hwabyung)?
- 2. Why do you think this illness or problem has occurred?** Older Koreans may also attribute illnesses to a failure to fulfill spiritual obligations. For example, some may feel that their illnesses are due to failure to pray, others to the displeasure of ancestors with their burial place, or still others to offending folk spirits.
- 3. What do you think the illness does?** E.g., older Korean American women, may believe their illnesses is related to Hwabyung ("fire illness"), due to the inability to express their emotions openly and is believed to affect a particular organ system.
- 4. What do you think is the natural course of the illness?** What does the patient fear?
- 5. How do you think the sickness should be treated?** What alternative therapies are you using currently? How do you want us to help you?
- 6. Who do you turn to for help?** Who should be involved in decision-making? (Koreans often rely on the family unit for important decisions).

## CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

### Decision Making and Disclosure

Korean culture emphasizes the individual as a part of a family unit, and decisions are made collectively. Variation exists in decision-making between different ethnic groups. One study revealed that as opposed to 91% of white patients, 83% of the frail older Asian patients expressed their own health care wishes. Asians were more likely to name a son as an alternate decision maker. (Hornung, 1998). Korean elders will often involve family members in decision-making, and an important health decision will commonly involve conferring and relying on an eldest son, if one exists.

“Korean culture emphasizes the individual as a part of a family unit, and decisions are made collectively.”

Attitudes regarding disclosure and consent are often conflicted in the Korean population. Some believe that voicing thoughts about death and illness will precipitate death and illness. Often Koreans believe that if the ill family member is told that they are ill or have a terminal diagnosis that they will lose the will to live or become depressed. Koreans often believe that only the family, and not the patient, should be told about a terminal diagnosis.

In this family-centered model it is the sole responsibility of the family to hear bad news about the patient's diagnosis and prognosis and to make the difficult decisions regarding goals of care. This approach toward decision-making is used to protect the patient from bad news. Koreans are less likely to favor telling the truth about diagnosis and prognosis and are less likely to choose the patient as the primary decision maker.

### Advance Directive Discussions

Sensitivity is called for when having these discussions.



Ensure that you have adequate time and that patient's family is present and a professional interpreter is available.

Several prior studies regarding informing patients regarding the diagnosis of cancer with different ethnic groups have yielded similar results (Eleazer, GP et al., 1996). However, this is often a source of conflict between the family and the healthcare professionals who believe that the patient should be informed about the medical conditions. In these cases asking the patient what they would like to know about their condition would be important for disclosure and decision-making.

### Advance Directives & End-of-Life Issues

Health care providers who have discussions about advance directives and advance care planning should remember that the elders might be reluctant to participate in these discussions, as they may believe that talking about death may make it a reality.

Decisions and discussions regarding advanced directives are often difficult. Koreans, as with other ethnic groups often believe that discussing death in the presence of the ill family member will bring about sadness or depression. This often makes discussions regarding end-of-life and advanced directives difficult. However, though discussions may be difficult to bring up it is important to inquire. One study looking at the relationship between ethnicity and advanced directives in a frail older population, Asians were more likely than Whites to select less aggressive interventions but were unlikely to use written advanced directives (Eleazer, G.P., et al., 1996).

## INSTRUCTIONAL STRATEGIES

### Case Study 1

Mr. Kim is a 55-year-old Korean American male admitted to the hospital several days ago with uncontrolled pain, nausea and vomiting. On exam the patient was extremely emaciated and had a protruding mass in the mid-epigastric area. The family was at the bedside—the patient's wife and 2 daughters.

The patient's eldest daughter asked to speak to you alone. She confided in you that about one year ago her father returned to Korea for medical work-up of abdominal pain and weight loss. Her father did not want to burden the family with the health care related costs and returned to Korea and was seen by a friend who practices tradition medicine by using Han Yak.

He was diagnosed with gastric cancer and was treated with herbal remedies. Since his return the patient continued to lose weight and became very lethargic, so that he was unable to work at the family's dry cleaning store. Her mother now works at the store full-time, and the mother and the daughters attend to the father. Over the last several weeks the patient has only been able to tolerate porridge and liquids.

Over the last several days, the patient has been unable to eat anything and he has been in severe pain. The family is aware that the father is dying but does not want him to know; the family asks you not to mention anything and just treat his pain.



#### Questions for Discussion

1. Why would the patient go back to his home country for medical care?
2. How would you ascertain how much the patient knows about his illness and how much he would want to know or be involved in the decision-making?
3. How could assistance be provided to this patient and his family prior to discharge?



**(INSTRUCTIONAL STRATEGIES CONT'D)****Case Study 2**

Ms. Kim is a 79-year-old female who was brought to your office by her daughter-in-law. The daughter-in-law states that her mother-in-law has been very withdrawn, lost weight and is concerned that she is becoming demented. On history taking (provided by the daughter-in-law as translator) you find out that Ms. Kim immigrated to the US about 30 years ago with her family. Her husband owned a gas station in the local Korean-town outside the city and she worked in the small deli in the gas station.

Two year ago her husband died after suffering a major stroke, so her eldest son took over the family business. Last year Ms. Kim stopped working at the insistence of her son. Ms. Kim moved in with her eldest son after the death of her husband.

Initially, Ms. Kim was reluctant to move in with her son. She had her own social contacts/circle in the apartment complex she lived in, where there were other older Koreans. Every Sunday her husband would drive them 30 miles to the nearest Korean church they had been attending ever since they immigrated to the US.

Ms. Kim is no longer able to meet with her friends and attend the Korean church because her son lives in another county and is not religious. During the day Ms. Kim is alone. Her son works at the gas station and daughter-in-law at a mortgage company.

Ms. Kim rarely sees her two grandchildren. Both grandchildren are busy with school and after school tutorials. In addition, they don't speak any Korean and so she has difficulties communicating with them.

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**Topics for Discussion**

1. Recent stressors in Ms. Kim's life i.e. death of husband, moving in with son, loss of social contact, adjustment difficulties.
2. Social isolation.
3. Adult Day Health Centers in the community.

## STUDENT EVALUATION

### Objective Questions

*For answer key, see page 16*

1. You meet Mr. Kim for the first time today. When asking about OTC or 'other' medications he looks away from you and says quickly that he takes some other supplements that were given to him as a gift. You should: (choose ONE correct answer)
- A. Go onto the next question not to be too inquisitive.
  - B. State as his doctor you need to know all the medications that he takes or you will be unable to provide medical care to him.
  - C. You state you understand many Koreans believe in Korean traditional medicine practices. State that it is really important to know everything that you take because some medications may interact with each other.
  - D. Tell him that he should stop taking the supplements because they are of no help to him.
2. Mrs. Kim, a 65-year-old female, comes to your clinic with a complaint of a mass on her chest. Further questioning reveals that she has never had a pap smear or mammogram. You should: (choose ONE correct answer):
- A. Chastise her in her lack of preventive care practices.
  - B. Tell her you would like to perform an extensive physical examination. You ask if an examination could be performed with a female nurse or if she would prefer a female physician.
  - C. Tell her to get undressed and proceed with a breast examination.
  - D. None of the above.
3. You are taking care of Mr. Lee, an 80-year-old male. Work-up reveals he has metastatic liver cancer. The family insists that he should not be told of the diagnosis. You should: (choose ONE correct answer):
- A. Listen to the family and tell the patient he has gastroenteritis.
  - B. Tell the patient to follow-up with his primary care provider.
  - C. Tell the patient he has metastatic liver cancer and that he has 3 months to live.
  - D. Ask the patient what does he know about his health currently and how much would he like to be told.

**(STUDENT EVALUATION CONT'D)**

4. Mr. Kim is a 60-year-old male who you diagnosed with diabetes 2 months ago. Upon questioning it is revealed he has not started any of the diabetes medications. You should: (choose ONE correct answer)
- A. Tell him if he does not start taking the medications you can not continue to see him.
  - B. Continue to stress that it is important to take the medications.
  - C. Ask him if he has any reservations/concerns about taking the medicine.
  - D. Refer him to an endocrinologist.
5. Ms. Kim comes to clinic today after a long-absence. You notice she has lost weight, appears fatigued and is teary-eyed during the meeting. Since you last saw her, her mother-in-law has moved in because she is no longer able to take care of herself. Ms. Kim states that in addition to her job, taking care of her husband and children now she has to change the mother-in-law's diapers and feed her. You should: (choose ONE correct answer)
- A. Tell her that you understand that this is the role of a Korean woman in the family and continue with the physical exam.
  - B. Arrange for closer follow-up appointment.
  - C. Refer her to community based organizations or support groups such as caregiver support groups.
  - D. Tell her that there is nothing she can do.

**Answer Key**

1. (c) It is important to understand the prevalence of reliance on traditional health care practices.
2. (b) It is important to understand the importance of modesty.
3. (d) It is important to understand what the patient's wishes are with regarding to disclosure.
4. (c) Concerns may include costs of medications, fear of side effects. Fear of needles.
5. (c) Caregiver burden is a problem in many ethnic populations. Caregivers need the support and understanding of others and information to help them.

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