

ORIGINAL RESEARCH

Vietnamese-born health professionals: negotiating work and life in rural Australia

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Submitted: 19 August 2008; Resubmitted: 5 November 2008; Published: 20 December 2008

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Rural and Remote Health 8: 1062. (Online), 2008

Available from: <http://www.rrh.org.au>

ABSTRACT

Introduction: Australia is a culturally diverse nation due to migrants from a wide variety of countries creating a multicultural society. The health professions are highly valued by the younger generation of overseas-born migrants who have acculturated into Australian society; many have chosen health care as their profession in Australia. However, most migrants settle in metropolitan areas and young health professionals may find working in rural or remote Australia culturally and professionally highly challenging. The present study of migrant health professionals examined the life experiences and acculturation strategies of Vietnamese-born health professionals working and living in rural Australia. Objectives: The two main study objectives were to: (1) examine aspects of the acculturation of overseas-born and Australian-trained health professionals in the Australian health discourse; and (2) identify key coping strategies used by them when in working in the rural context.

Methods: Six overseas-born, Australian-trained health professionals were invited to participate in this qualitative study using a snowball sampling technique. The participants were all born in Vietnam and had experienced working in rural Australia. They included three medical doctors, a dentist, a physiotherapist and a nurse. The interviews were recorded and four participants also provided additional written responses to some of the open-ended interview questions. The interview data were transcribed and later coded for thematic analysis. Topics and themes that emerged focused on the issues and strategies of acculturation to the rural health context.



Results: The study showed that the acculturation process was affected by the participants' views about and attitudes towards working in an Australian rural context. The study identified these essential strategies used by the participants in adapting to a new workplace: collaborating, distancing, adjusting, repairing, and accommodating.

Conclusion: The study provides insights into the lives of these health professionals in a rural context, and particularly their experience of cultural shock and the coping strategies they may use. A need is identified for a larger study to inform recruitment and retention of these health professionals to rural Australia, and to assist universities to prepare such students and their clinical supervisors for rural placements.

Key words: acculturation, cultural diversity, migrant health workforce, overseas-born health professionals, rural communities, rural health context, social capital.

Introduction

This study explored the experiences of six Australian-trained, overseas-born Vietnamese health professionals living and working in rural Australia. There is a considerable body of research on the experiences of overseas-trained health professionals¹⁻³, especially doctors, in rural Australia but very little about those who have previously lived and trained in Australia, particularly those with a Vietnamese background. It may be assumed that Australians who grew up in a rural area are more likely to practise rurally, but there is no evidence regarding the influence of early life experiences of overseas-born, Australian-trained health professionals on their choice of practice location.

The present exploratory qualitative study mainly aimed to examine the acculturation (or process of adaption as the result of contact with a new culture) of the participants, with a focus on the following questions:

- What difficulties do these health professionals face in their acculturation to a rural environment (such as cultural shock, difficult working conditions, family issues)?
- What factors help them adapt to the new working and living rural environment (such as social and cultural capital, local community awareness, health resources)?

- What strategies do the participants use to deal with work and life in a new rural environment?

Background

Health care has been an important Australian political issue during recent elections because it affects everyone in the community. Different governments have attempted to sell their healthcare policies on the basis of equality, efficiency and economy⁴. Because Australia is a multicultural nation, health care must accommodate a diversity of social and cultural backgrounds, and this is reflected in the terms commonly used in public communication, such as intercultural health, migrant health and Indigenous health.

Skills shortages, particularly in health care, is another current issue in Australia as the ageing 'baby boomer' generation demands increased health services and more health professionals⁵. An unmet demand for rural and remote health professionals, particularly medical doctors and dentists, is due to difficulties in recruitment. Reluctance to work in rural Australia may be due to a number of factors, such as unfamiliarity with rural life; a perceived lack of facilities and resources; cultural and distance isolation; family commitments; the lack of spouse employment opportunities; an unfamiliar lifestyle; and fear of an unknown environment⁶.



Social and cultural capital can play an important role in supporting health professionals in their transition from an urban to a rural context. Hanifan⁷, in a discussion of rural school community centres, was among the first to introduce the notion of social capital. His definition of social capital as the cultivation of goodwill, fellowship, sympathy and social intercourse among those who make up a social unit was later extensively discussed by Bourdieu⁸ and Putnam⁹.

One of the practical solutions to rural health professional shortages has been to employ overseas-trained health professionals to work in remote and rural areas. However, while their contribution is greatly valued by governments and the community, the overseas-trained doctors (OTDs) solution has its own problems^{3,10}.

Another phenomenon in Australian health care is an increasing number of overseas-born and Australian-trained health professionals (OBATs). Those in this category of migrant health professionals tend to be bicultural, or familiar with two cultures, and their unique contribution to health care is acknowledged in bicultural health research^{11,12}. In addition, being Australian raised, they may not encounter the problems of OTDs. However, there are still issues and problems concerning their acculturation to rural health that need to be understood by health professionals, policy-makers and universities. Because there is little or no research about OBATs working and living in rural Australia, this study offers some insights into their professional and social experiences in the transition to rural living and working, with a focus on those with a Vietnamese background.

Method

The six participants in this qualitative study were recruited using a snowball sampling technique. Because the term 'overseas born' encompasses a wide cultural diversity, participants were recruited from the same cultural background (Vietnamese). This avoided a cultural gap among participants too big to capture in this small study. The participants, who were born in Vietnam and trained in

Australia, all had some working experience in rural Australia, and included 3 medical doctors (2 females), one male dentist, one female physiotherapist and one female nurse. An ethics application was submitted to the Tasmanian Social Sciences Human Research Ethics Committee prior to the interviews and approved.

Data collection

A semi-structured telephone interview was conducted with each participant. The interviews were recorded with the participants' approval. A list of broad questions had been sent in advance of the interview with advice that the flexible questions could accommodate personal preferences in communicating their views and experiences. The participants were also encouraged to provide written responses and comments before or after the interview, and four participants did so after their interview. The recorded interviews were supplemented by notes.

It is acknowledged that the small sample size, the exploratory, qualitative method, and the sampling of just one migrant group all limit the generalisability of the study.

Discussion and data analysis

The interviews were transcribed as raw data and later coded for thematic analysis. Topics and themes previously identified from the literature were included and were reflected in construction of the interview questions. There was a focus on the issues and strategies of acculturation to the rural health context. Using NVivo software (QSR International; Melbourne, VIC, Australia) the data were coded using free nodes and hierarchical nodes. By integrating issues identified from the interviews and coded to the nodes and the previously identified issues represented by the interview questions, several themes common to all or most of the interviews were identified. Perhaps because the sample size was small there was not sufficient evidence of contrasting sub-themes. The identified themes were: cultural shock, social and emotional support, advantages and



disadvantages of rural practice and rural life, and adaptation/coping strategies.

Cultural shock in rural acculturation

The concept 'acculturation' describes the process by which an individual or group of people adapt as the result of contact with a new culture, which may result in some changes of behaviour, perceptions and attitudes. Cultural shocks occur when the two cultures are vastly different and there is little contact between them, for example Senegal and Australia. The acculturation becomes more difficult when the cultures have different languages. The participants observed a number of these differences between the rural communities where they were practising and their own family life in both Australia and Vietnam, and one stated:

For me, the obvious cultural shock that I experienced in the first few weeks in this rural town was what to do in the evening and particularly on the weekend. I used to hang out with friends in the city, spending a lot of time shopping, visiting friends, and our house was always filled with visitors on the weekend. We cooked together Asian foods and chatted about things. In a small rural town, there was not much for me to do after work. I felt rather lonely. Thus I spent a lot of time talking to my friends on the phone.

When migrants are from a very different culture their views on and attitudes toward health issues and health care can cause problems in the acculturation process. For instance, participants shared stories of accompanying family members who went to doctors or a health clinic only when they were very ill, not just for a regular check up or preventive health practices.

There are health issues and problems that are handled differently in Australia, such as patients' rights to health information, health privacy, use of prescription drugs, eating habits (such as sharing foods with others at a meal), overuse of monosodium glutamate (MSG) in cooking, and males smoking in the house. Many new Asian migrants hold

fatalistic beliefs (a high belief in chance) and this can result in poor initiative and inappropriate behaviours in health matters. One participant stated:

When my mother had a nasty cold or flu, she asked my father to use a coin to scratch her back to take away the bad wind from her body. After about 40 minutes of 'wind scratching', my mother's back looked horrible. It was like being tortured in a prison. When an Australian friend saw it, she's so shocked and told my mum to rush to the hospital. She's more shocked when my mother and father laughed happily about her suggestion.

The concept of acculturation normally applies when people move from one culture to another. However, it can be extended to include the process of adapting to a new discourse within a culture. Thus, for those who are brought up in a city, moving from a large city to live in a small rural town may require large changes in their views, attitudes and lifestyle. The cultural shock experienced when the participants in this study moved from a crowded Asian city to a small Australian city was difficult, and then the cultural shock experienced when living in a rural town presented quite a challenge. This represented two-layered cultural shock in their acculturation process, as one stated:

I couldn't believe it when someone in the town told me that they needed to go to a quiet place on the weekend, away from the town. To me, it's already too quiet and I wanted to spend weekends in a city, but these people want to live with nature and to run away from the town's crowded population! How ironic!

Rurality can be defined in different ways, depending on the perspective adopted. From the participants' cultural perspective, their definition of rurality was quite different from that of other Australians. At village level, people live in very close proximity and collective work and social activities are predominant. This can be experienced as a vast extended family whose members share similar values and a collective spirit. In addition, health care is a collective matter



with little assistance from government. In Australia, the unit 'village' does not exist. Farmers live far from one another and there is little daily interaction among them. At a town level, there are some similarities between Australia and the participants' home country. There is more social interaction and commercial activity and government services are present in the community. However, the participants were bewildered by the lack of interaction among the town's people across gender and age groupings. For instance, teenagers and older people did not often share social activities, and this is very different to Vietnamese social interaction. Participants noted this difference and realised it could have implications for health communication and health care.

A participant whose internship was in a rural hospital was surprised to see patients with no or few visitors. She felt disheartened to see older patients neglected or abandoned by their families and friends.

One thing that my parents were very scared when they visited a nursing home. They saw old people on wheel chairs and no one to talk to. For them, these old people were abandoned and left there to die. They wanted to go back home to live when they were at that age.

Social and emotional support in a rural context

Social capital suggests an individual or group in a structure of relationships which provides a source of support, taking place at family, community and institutional levels. The emotional support of families when they accompanied participants to a rural area was an important factor, as one stated:

I felt very lucky that my parents moved along with us to the town when I got the job. Actually we were much closer when we moved there. We spent a lot of time together. As our house was a short walk from where I worked, I occasionally came home to have a quick chat with my parents. It's a big advantage. I

couldn't do it if I lived in a big city like Melbourne or Sydney.

At *community* level in a rural town, important sources of support included the neighbourhood, social clubs, and close combined networks of colleagues and friends:

I'm not sure neighbourhood truly exists in a big city. There, everyone lives their own life. Most people do not know who their neighbours are, except saying hello and goodbye. It's wonderful in a town as most of our neighbours were our friends. We saw them when we looked through the windows, we met them at the local stores, and then at the sport oval.

At *institutional* level, working in a rural health centre can have enormous benefits not found in big cities. The concept 'collegiate' in a rural context has profound meaning, professionally and emotionally. Health professionals work closely together and the professional boundaries among differing health disciplines are not rigid. One participant explained:

There was no need for us to introduce ourselves there. We knew who we were, and knew well our personal strengths and weaknesses. In this way I felt very at home with my colleagues. I didn't have to prove how good I was!

Advantages and disadvantages working in a rural town

There were positive and negative aspects in the participants' transition from Asia to Australia, and from an urban to a rural area. Miscommunication occurred when people of different cultural and linguistic backgrounds used words with embedded cultural meanings, as was indicated by this participant's reflection:

I was rather uncomfortable when a person at work addressed me as 'love', as in 'Yes, love, a new chair



will be here shortly'. First I felt very annoyed but later I understood the casual way in their communication at work.

Communication was sometimes a problem despite the participants being fluent in English. Most town people tended to speak 'Aussie English' with a broad accent, particularly the males. For example, it can be difficult to distinguish words such as nice/noise, sure/shore, day/die. The use of local Aussie slang by some local town speakers presented a large obstacle to comprehension. Participants often had to ask them to repeat the saying many times, and this could undermine their confidence in their own English and even their professional competence.

However, positive professional aspects were strong enough to maintain participants' interest in remaining in rural practice. First, they were own bosses. Colleagues were close and worked collaboratively. There was a strong bond between staff, patients and the community. Interpersonal relationships were built on trust, support, respect and care, which are not as easy to develop in a large, crowded city. These professional aspects became valued social capital while they worked and lived in a small town.

Strategies for acculturation in rural health context

Strategy is the term to designate the carefully considered tactic to achieve one's goal. Health professionals need effective strategies to deal with challenges in their working environments. Some strategies are used as 'coping strategies' which help survival in a very challenging context. Problem-solving strategies (efforts to do something active to alleviate stressful circumstances) and emotion-focused coping strategies (efforts to regulate the emotional consequences of their circumstances) were evident¹³.

Moving to a new social and cultural environment is not a simple and easy transition, particularly for migrant health professionals whose cultural background is so different from that of the local community. For some it can be an exciting

and enjoyable experience, while for others it may be a tough battle which can result in disillusionment, despair or bitterness. However, the data from the study reveal a mixture of positive and negative aspects. For the participants, an active, problem-solving strategy means not just dwelling on cultural differences:

I think we have to learn how to confront the situation and make it work for us. I learned from my parents that life is boring if everything in life is so smooth. Thus, there are good things and bad things, wherever you go and whatever you do. We need to develop ways to deal with adverse situations as well as ways to enhance our living conditions. I mean we need to use some strategies to deal with new situations.

Strategies are necessary for effective problem-solving. Some strategies are commonsense and do not require much effort to develop, whereas there are strategies that depend heavily on the psychological and social abilities and skills of people in dealing with challenging living and working environments. The following strategies were identified by this study: collaborating, accommodating, distancing, repairing.

Collaborating: Collaboration is important when working with others or in a team, particularly when one is a new member and unfamiliar with the discourse and conditions, such as procedures, workplace communication and interpersonal relationships. For health professionals, particularly those with little rural life and work experience, collaborating is among the first problem-solving survival strategies. In addition to collaborating at work, several of the participants extended this strategy to their social lives, for example:

When I arrived at this health clinic in this rural town, I felt so hopeless. What I learned at the university didn't prepare me for this. There were only two choices: to quit and to stay. No way, quitting is not my way of dealing with life, but if I stay, I must find a way to deal with my new situation. The best way for me was to make friends with people at work and in the community. They all had something for me



to learn. I spent a lot of time socializing and working with other health workers. Gradually, I felt at home with the new place.

Accommodating: The term ‘accommodate’ is used to indicate a person’s willingness to accept a different way of life in a new social situation in order to avoid possible conflict. It is an emotion-focused coping strategy. When the Vietnamese health professionals who were trained in an urban institution moved to work in the rural context, they needed to accommodate new ways of living and working. Cultural background can have an impact on the accommodation strategies used, and this is shown by the response of a Vietnamese-background participant:

In Vietnamese, we have a popular saying: ‘The journey is difficult not because of huge mountains and wild rivers blocking the journey, but because of the fears of mountains and rivers’. Thus I had to accept the new working and living conditions and learn how to accommodate them. Otherwise I just gave up.

Distancing: The term ‘distancing’ is used to show a person’s lack of active engagement with other members of a group. It is a subtle rejection of the ideas or actions of other group members, a step back to ensure one does not join the social discourse. This is another emotion-focused coping strategy. For example, when a group of colleagues sat together and criticised other colleagues, participants sometimes found the best strategy was to distance themselves. This allowed the new health professional time to gradually enter the social network without making mistakes due to a lack of awareness. As one participant stated:

When I started working there, I was invited by many local people to participate in various social activities in the town. It was good that I was received warmly by the local community. I also made sure that I wasn’t fully committed as I needed my own space. I declined several invitations to participate in local events. It had to be done suitably.

An interesting example of using the distancing strategy is to put on the ‘foreign attitude’ so that one can be excused for being a ‘foreign’ newcomer.

Repairing: Repairing is a problem-solving strategy that was used when there was something wrong which needed ‘correction’. Problems facing migrant health professionals in a rural context vary due to their professional experience and familiarity with rural life. Mistakes can occur at any stage of their career. Participants found it was important to recognise potential problems in a new working environment and to develop repairing strategies to deal with them as they arose instead of abandoning their commitment to rural health. For example:

When a problem occurred at work, naturally I felt bad but I had to be honest with myself, reminding me that I had a lot to learn and avoiding the blame game. I wanted to sit down with my colleagues to talk openly about the problem, and how to improve.

According to one participant, a repairing strategy works better in rural health services than in hospitals in big cities. In a small rural community, staff members work and live as a metaphorical family. Thus, it is easy to share problems and seek help when this is needed.

In summary, although the participants were Australian-trained health professionals, their cultural background played an important role in their acculturation to the rural environment. The insights from the study indicate that Vietnamese-background health workers can experience complex cultural adaptation issues in their transition from Vietnamese into mainstream Australian culture, and from the Australian urban to rural contexts.

Implications

Vietnamese-background health professionals can find living and working rural areas both inspiring and challenging.



There are particular professional advantages to working in small teams and small institutions.

Although the focus of this study was Vietnamese-background health professionals, useful insights were obtained on theoretical concepts (eg social-cultural capital, cultural shock, acculturation strategy) and the issues of intercultural interaction (eg miscommunication, intercultural identity) that may be generalisable. And from the practical viewpoint, this study identified several conditions that may attract health professionals to move to and remain in a rural area. Family is very important to Vietnamese health professionals, and this is likely to be so for other cultural groups⁶. There should be sufficient flexibility to allow such health professionals to care for their families, and rural communities should consider strategies that will make families also feel at home. Social and intercultural activities and resources will encourage Vietnamese health professionals and their families to stay and accept the town as their home.

Professional development is a priority, not just for these professionals but also for their colleagues and health services. There should also be strategies in place to encourage close interaction between rural health professionals and their colleagues in other rural towns and large cities.

It is important for health services to be aware of the different strategies used by Vietnamese health professionals in their acculturation to a rural working environment. Such awareness can create sympathy and support for them in coping with the challenges of a new environment.

Conclusion

Health care has been a dominant issue in Australia. As McGrath³ points out, 'Australia has an enviable international reputation for the quality of its medical services. However, there are still many challenges as far as health is concerned'. One problem that is approaching crisis proportions is the

shortage of health professionals in rural and remote Australia. Various solutions have included increasing intakes into health courses, providing financial incentives for rural work, and the recruitment of overseas-trained professionals. Another way of addressing this issue is the recruitment of overseas-born, Australia-trained health professionals.

The study reported in this article provides some insights into the lives of such health professionals in a rural context, and particularly their experience of cultural shock and the coping strategies they may use. This can be useful information for health authorities and policy-makers concerned with maintaining these health professionals in the rural workforce. A larger study is required to inform the recruitment practices of rural health providers and to assist universities in preparing such students for rural practice.

The study highlights the importance of cross-cultural understanding at the level of health services and local communities as a way to facilitate the integration process of health professionals from different cultural and linguistic backgrounds.

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