

AN INVESTIGATION OF OLDER KOREAN IMMIGRANTS' PERSPECTIVES ON
ACCESSING PRIMARY HEALTH CARE SERVICES

by

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ABSTRACT

Accessibility is a key tenet of the Canadian health care system. As many older persons, age 60 years and older, are managing ongoing chronic health conditions as part of their everyday lives, issues of access to health services are particularly important. Vancouver has a substantial number of older Korean immigrants, yet little is known about their experience and perceptions about accessing Primary Health Care (PHC) services. This study explored issues related to PHC access by older (aged 60 years and older) Korean immigrants. This qualitative study employed purposive sampling and interpretive description methodology. Open-ended interview data and field notes were gathered from 10 older Korean immigrants (five male and five female) recruited in Vancouver from mid-October 2006 to April 2007.

The findings revealed that older Korean immigrants have had difficulty gaining access to appropriate PHC services because of the shifts in their social positioning and other barriers which contributed to an inappropriate use of PHC services, delays in care and lack of continuity in PHC. Also, the data revealed a number of ways the PHC system is unresponsive to the health care needs of older Korean immigrants. This study offers insights that may assist health care professionals to understand the nature of the challenges older Korean immigrants face when seeking health care and how they seek to resolve them. The analysis proposes a number of interventions that respect the older Korean immigrants' values and interventions that may improve their access to PHC.

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CHAPTER ONE

INTRODUCTION

Background to the Problem

Canada continues to become an increasingly diverse society through immigration. Also, Canada receives immigrants from every part of the globe, with the largest flows coming from countries in South, East and Southeast Asia. In 1997, the top 10 countries of origin were non-European (Kessel, 1998). In 1999, 30% of all immigrants arriving in Canada were from China, Korea, the Philippines, and Taiwan, and 15% of them were from India, Pakistan, and Sri Lanka (Citizenship and Immigration Canada, 2000b). An important part of this demographic shift is an increase in the number of people from Asia who choose to resettle in Canada.

With the influx of mainly Asian immigrants, Vancouver has experienced dramatic changes in its ethnic composition. In 2001, census data revealed that about 40 % of Vancouver's population was foreign-born (Statistics Canada, 2001). Among immigrants, the number of Koreans has been growing the most rapid rate. Since 1992, South Korea has consistently been ranked within the top 10 immigrant sources to Vancouver and in 2000 was the fifth leading source (BC Stats, 2005). In 2001, the total Korean population in Canada was about 100,660, of which about 4,585 were aged 65 years and over (Statistics Canada, 2006). Although the number of older Korean Canadians remains relatively small (4.6 % of the Korean Canadian are 65 and older)¹, Vancouver now has the highest proportions of Koreans, compared to other metropolitan areas (Census of

¹ The actual number, however, is assumed to be much higher because many older Korean immigrants may not be interested in participating and may not be sufficiently fluent in English to complete Canadian census forms.

Canada, 2006). This change in population trends is beginning to be reflected in the characteristics of Korean immigrants aged 60 and older.

In the 1960s, Korean immigration to Canada began officially after the government of Canada removed discriminatory policies against people from countries outside Europe and the Commonwealth. The establishment of diplomatic relations with the Korean Government in 1963 accelerated migration from Korea (Korean Ministry of Foreign and Trade, 2004). Among Korean immigrants to Vancouver, 51.5 % were aged 40-59 years at immigration and 32.1 % were aged 60 years and over (Statistics Canada, 2001). Two different types of older Korean immigrants have settled in Canada. Among the first type, the initial reason for coming to Canada is the desire to seek a better life for themselves at the age of 40 years or more; among the second type, the reason for coming to Canada in their old age is to assist adult children in family reunification.

As a result of the growth of the Korean population, which includes a considerable number of persons over 60 years of age, the demand for health care services for older Koreans, especially within the PHC sector, has increased significantly in British Columbia (B.C.) over the last 10 years. Although the health care system has developed strategies to meet the health care needs of immigrant populations such as establishing interpretation services and providing guidelines and education to healthcare providers (B.C Ministry of Health, 2006; Health Canada, 2001), there is evidence that many immigrants still face considerable barriers when accessing health care services (Chen, Ng, & Wilkins, 1996; Elliott, Berman, & Kim, 2002; Health Canada, 1999; Lynam, Henderson, Browne, Syme, Semeniuk et al., 2003; Matuk, 1996; Miller, 1990; Nah, 1993). In order to offer appropriate health care services to immigrant populations,

particularly older Korean immigrants, it is important for us in the health care industry to first gain knowledge about the characteristics, and health and social needs of such immigrants.

Although many older immigrant adults face barriers to accessing health care in Canada, very little is known about the experiences of older Korean immigrants in the Canadian health care context. Canadian health care is a universal system that has a mandate to make health care accessible to all population (Health Canada, 2001). The point of entry to the broader system is via primary health care providers. Historically, these have been community based physicians in private practice but in recognition of the need to make a broader range of services more accessible, to enhance continuities in care and to enhance efficiencies, in recent years different models of primary care practice have been introduced. These include primary health care practice. Such practices are often interdisciplinary community (publicly funded) clinics that provide a broader range of services, from health promotion to chronic illness management. PHC emphasizes the determinants of health and strategies to advance individual health. At present both models of practice are in operation and they both provide the point of entry to the broader health care system. As this domain is integral to the health care system it is timely that we use this as a point of departure for examining elderly Korean immigrants' experiences in accessing the health care system.

During my tenure as a Korean nurse in Canada, I have noticed a number of problems related to accessing PHC services among older ethnic groups, including older Koreans. Many older Korean immigrants' have voiced their concerns about accessing PHC services in Canada to me. Many have little understanding of the health care system

in Canada. For example, they do not really know where to go to see a PHC provider. Moreover, when these people do see health care providers, many experience communication problems, possibly due to having English as their second language. Another frequently voiced concern is a feeling of discomfort with health care providers of the opposite gender, and a preference for providers of the same gender as themselves. Such barriers can result in an inappropriate use of PHC services and may contribute to delays in health care services and lack of continuity in service delivery. Each of these issues poses potential problems for older Korean immigrants and for the health care system. These are issues that gave rise to the research questions addressed in this study.

Population aging is a complex phenomenon among elderly persons, encompassing important issues for general public health, especially in the delivery and availability of services (Health Canada, 2002). As of 2004, B.C. has over 1 million persons aged over 55 years, which translates into about one-quarter of the provincial population (BC Stats, 2005). The problem of access is not unique to older Korean immigrants. Many older immigrants are unfamiliar with the Canadian health care system and as a consequence may find it difficult to understand how that system works; often they are not fully aware of their rights to service, the role of practitioners, the management of appointments, and the expectations of providers (Kinnon, 1999). A number of studies undertaken in Canada have shown that Asian immigrant groups, particularly those who do not speak English, face barriers when accessing health-information and are less likely to use preventative health services such as cancer screening (F. Ahmad, Shik, Vanza, Cheung, George, & Stewart, 2004; Bottorff, Balneaves, Grewal, Sent, & Browne, 2001; Choudhry, Srivastava, & Fitch, 1998; Goel, 1994; Gupta, Kumar, & Stewart, 2002). Studies of the

accessibility of services in multiethnic settings have reported communication problems, racial discrimination, and differences in values and expectations related to health and the health care system as barriers to access (Balis & Maiga, 1999).

When there are communication problems, clients are both fearful that their description of their health condition may not be fully understood, and worried that they themselves may not fully understand the information that is being provided. Leduc and Proulx (2004) note that in some cases, these fears are so strong that patients report repeated visits or the use of other health services for the same problem. In the United States, Sohn and Harada (2004) identify a second concern: when immigrant groups have inadequate access to PHC they experience delays in treatment. There is also evidence that because they are not connected with PHC services they may use emergency services for non-emergency situations, thereby contributing to crowding and increased wait times in emergency departments (Choudhry et al. 1998; Leduc & Proulx, 2004).

In a province like British Columbia, which receives a significant number of Asian immigrants, a better appreciation of the ways in which the broader social context influences access to PHC services is needed. I believe it is essential to investigate these problems in order to ensure that older Korean immigrants receive needed care. Hyman (2001), among others, has documented that immigrants tend to use health services less than Canadian-born citizens, and this could reflect the inadequacy of present health services in meeting the needs of certain immigrant groups. Although studies exist which focus on the issue of access (Bowen, 2001; Young, Spitzer, & Pang, 1999), gaps remain in terms of documenting perspectives, and needs of particular immigrant groups,

especially Koreans. Therefore, in this study I investigate older Korean immigrants' perspectives on accessing PHC services.

Purpose of the Study

The purpose of this study is to explore the issues related to PHC access by older (60 years and older) Korean immigrants. Expected outcomes included developing an understanding of the perspectives and experiences of older Korean immigrants when accessing PHC services. I anticipate that the results of this study will assist health care providers to plan and deliver better, more culturally responsive care.

Research Question

The main research question for this study is “What are the experiences of older Korean immigrants in accessing PHC services?” This primary question includes the following secondary questions:

- How do older Korean immigrants understand PHC in order to access the services?
- What are older Korean immigrants' knowledge and expectations with respect to PHC?

Research Design

The research design chosen for this study was interpretive description, as articulated by Thorne, Reimer Kirkham and MacDonald-Emes (1997) and Thorne, Reimer Kirkham and O'Flynn-Magee (2004). The interpretive descriptive approach is appropriate in part because it draws upon principles of the nursing profession as its philosophical underpinnings (Thorne et al., 1997; 2004), and in part because it enabled me to draw upon the perspectives and experiences of older Korean immigrants in

accessing PHC. Also, using interpretive description meant that an analytic framework was formulated from the existing knowledge available in the field. In this case, literature related to access to health care services from the fields of nursing and general health professions was critically analyzed and used to develop a preliminary analytic framework, which provided direction for the processes of data collection, analysis and interpretation. This framework is presented first in the introduction to the thesis and then explored more fully in the literature review that follows in the next chapter.

A key element of this type of design is that the preliminary analytic framework is not static, and its parameters shift as the study progresses so that the inductive process can reveal insights not included in the preliminary framework (Thorne et al. 1997). Thus, one of my goals in using this method is to maintain the exploratory nature of the study whilst still adhering to the principles of qualitative inquiry for nursing science.

Organization of the Thesis

I began this chapter by describing the key components of the problem under study. In Chapter Two, I review the existing literature that focuses on access to PHC across Canada, and on what is known about access to PHC for immigrant Canadians, particularly older immigrant Canadians. I also review the concept of cultural safety, because this focuses attention on the various sources of influence on health care needs among culturally diverse populations. In Chapter Three, I describe more fully the interpretive descriptive method and how I approached it in this study. In Chapter Four, I outline the key findings of this research, based on the analysis of the interview data. In Chapter Five, I discuss the research findings from the study. In Chapter Six, I present a

summary and conclusion, including implications and recommendations for nursing education, practice, and further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter I review both the existing literature on the Canadian health care system and the literature on the accessibility of PHC services for immigration populations. I begin with a brief overview of how the Canadian health care system functions and then provide a discussion of available knowledge on the positioning of immigrants within the health care system. Since there are multiple levels of influence on how health care is provided (policy, system and interpersonal levels), I found it necessary to introduce a concept that focuses attention on sources of influence on the health care needs of culturally diverse populations. The most appropriate concept for this study is the idea of cultural safety, which has been used to offer insights into issues of access for immigrants in the Canadian context.

The Canadian Health Care System

The Canadian health care system, as it exists today, grew out of a commitment to remove financial barriers to health care for all Canadians. The ongoing development of this system and the delivery of services take place within a political framework in which the responsibility for most health services falls under provincial or territorial jurisdiction, with additional support from the federal government. Canada's national health care system is built on five fundamental principles: accessibility, portability, universality, comprehensiveness, and public administration. These principles were introduced by the federal government in the Hospital Insurance and Diagnostic Services Act (1957), with

the stipulation that provincial governments would enact the five principles in exchange for the federal government's covering 50% of the cost of health care.

In 1984, the Canada Health Act (CHA) became a cornerstone of the Canadian health care system by reinforcing the basic principles that underpin the health care system and affirming equality of access for all Canadians. The act was developed with a focus on equalizing Canadians' health status by equalizing their access to health services. Health Canada (2003) confirms that the primary purpose of the act is to facilitate reasonable access to health care services without any barriers. The CHA establishes the criteria for insured health services in the provinces and territories, and regional governments must meet these criteria in order to receive federal funds. The act specifies that every insured resident is eligible for equal benefits from insured Canadian health services (Health Canada, 2003). In addition to the policies and principles exclusive to the health care system, other policies, such as the 1982 Canadian Charter of Rights and Freedoms, also commit the system to ensuring equal access to health services for all Canadians.

PHC has become the preferred philosophy of health services practice and is guiding the refinements to the primary care component of Canada's health care system. PHC seeks to provide both an individual's entry point of contact with the health care system and ensure continuity of care. The Alma Ata Declaration of the World Health Organization (1978) confirms PHC as the foundation of a comprehensive health system and addresses the main health problems in the community as providing health promotion, disease and injury prevention. Also PHC emphasizes the determinants of health and strategies to advance individual health. Within PHC, a distinction is made between primary care and primary health care. Primary care is the element within PHC that

focuses on basic medical services (B.C Ministry of Health, 2007). In Canada, primary care has developed through the public funding of individual doctors, primarily family physicians. At present, the majority of primary care in Canada is delivered by primarily family physicians and general medical practitioners, and more recently nurse practitioners² who focus on the diagnosis and treatment of illness and injury (B.C Ministry of Health, 2007). However, in recent years PHC has also been developed through other models such as community health centers, public health nurses, well-baby clinics, and non-medical health care professional include nurses, therapists, and dentist who focus on health promotion (Atun, 2004). There is a growing consensus that family physicians, nurses, and other professionals working as partners will result in better health, improved access to services, more efficient use of resources, and higher levels of satisfaction among both clients and providers (Atun, 2004). The key feature of PHC reform has been a shift towards teams of providers who are accountable for providing comprehensive services to their clients.

The structure and culture of the health care system are not constructed in isolation from the way in which society is organized. Anderson and Reimer Kirkham (1998) maintain that in order to understand how the health care system functions, it is necessary to gather knowledge about the social, political, and historical climate within which that system exists. I will now briefly discuss the most significant features that have an impact on positioning immigrants within society in general and the health care system in particular.

² Nurse Practitioners (NPs) have been introduced as another type of primary care provider who will be working in this capacity in many provinces.

One of the significant themes within the 'social location' of immigrant populations in Canadian society is the practice of 'othering,' whereby immigrants are defined as different and therefore often excluded from many aspects of mainstream society. With the changes in the Canadian social mosaic in recent decades, the practice of othering has rapidly expanded and been applied to immigrants of non-European ancestry (Day, 2000). Henry, Tator, Mattis and Rees (2000) suggest that the practice of othering underlies the division of Canadian society in two segments of 'we' and 'they.' 'We' means those who are part of the 'dominant' community of 'White' (Euro-Canadian) Canadians. 'They' refers to 'others' (including, for example, First Nations people, Tamils, Asians, Blacks, immigrants, and refugees of color), positioned outside the boundaries of the symbolic Canadian community and the national vision of Canada. The term 'culture' has for the most part been conflated with the term 'race,' and the most common type of racism in Canada today is not based on biological differences, but rather on cultural differences. Henry and his colleagues (2000) argue that this type of racism is also the most common type of racism occurring in health care settings. Anderson and Reimer Kirkham (1998) connect the ongoing racism and racialization that exist within the health care system to broader aspects of Canadian society, noting how perpetuating certain dominant discourses can produce marginalized, stereotypical and essentialized 'others'. These authors also point out that this "sets the stage for health care providers to relate to patients as the 'objectified other' with alien beliefs and practices" (p.256). Thus, since the largely invisible nature of racialized constructs of the 'other' in mainstream Canadian discourse are the context in which health care providers learn about and perpetuate practices that objectify some of their clients as 'other,' it is essential to

consider this larger context when addressing issues of racialization in the health care system.

Health Canada (2001) points out that the response to the health care needs of certain populations depends on the ways in which services are structured. One way to evaluate the responsiveness of the health care system to the needs of minority groups is to compare the health of immigrants with the health of the rest of the population. Research to date has shown some differences between the health of immigrants and Canadians from mainstream society (Kinnon, 1999). Health Canada (2001) notes that inequality occurs because different care may be provided based on group membership, health care provider-patient interaction may differ based on group membership, policies may not recognize the needs of certain populations, and program design may result in the needs of some groups being better served than others. It should be noted that the system links inequities in the accessibility of health services to communication barriers and cultural differences between minority groups and the mainstream.

Canadian health care services, including PHC, are based on the Western biomedical model of health and illness, which has been criticized for being unresponsive to the health care needs of culturally diverse populations (Anderson, 1986). In this model, PHC is the 'point of entry' to all levels of the health care system. It is important to gain a better understanding of issues surrounding access to the PHC system from the perspective of immigrants. In a province like British Columbia that receives a significant number of immigrants, it is necessary that we seek to understand the ways broader social context influences access to PHC services. Despite considerable research into the health care of Asian ethnic groups in Canada, very few studies have focused on older Korean

immigrants' access to PHC. Older Korean immigrants, like many other older immigrant groups, face unique challenges subsequent to resettlement and there is a need to understand the barriers they experience in attempting to access PHC services.

Access to Health Care

The literature suggests four major constraints on immigrants' access to primary care services in Canada and the United States (U.S.): 1) the immigrants' lack of information about primary care services (F. Ahmad, Shik, Vanza, Cheung, George, & Stewart, 2004; Lu, 1995; Pham & McPhee, 1992); 2) language barriers exist between health care providers and clients (F. Ahmad et al., 2004; Choudhry, 1998; Matuk, 1996); 3) cultural beliefs about health and illness (Choudhry, Srivastava, & Fitch, 1998; Jenkins, McPhee, Stewart, & Ha, 1996); and 4) assumptions about difference (Doane & Varcoe, 2005; James, 2003; Geiger, 2001; Smedley, Stith, & Nelson, 2002). In what follows I review the literature on barriers to accessing PHC services.

Lack of Information about PHC Services

Lack of knowledge is one of salient features limiting immigrants' access to PHC services. In a Canadian study of Chinese and East Indian immigrant women, F. Ahmad and his colleagues (2004) find that the loss of extended social networks, and a lack of familiarity with the environment, which led to limited knowledge of resources, seemed to be the primary reason for immigrants' experiencing difficulties in accessing PHC services. While current practice assumes that most people derive information from a number of sources, including television, newspapers, etc. F. Ahmad and colleagues (2004) report that the immigrant women involved in their research were limited in their ability to derive benefit from content of television programs, health workshops, internet, and

newspapers so that their access to health information resources was very limited. As with Chinese and East Indian immigrant women, it is my observation that when older Korean immigrants have a limited understanding of English they also rarely seek resources from English-speaking service agencies (F. Ahmad et al., 2004).

Although community organizations play a role in facilitating settlement and providing information, there is also a lack of Korean organizations and Korean-language services for older Korean immigrants. In the U.S. study on primary care services Korean immigrants, Kim, Cho, Cheon-Klessig, Gerace, and Camilleri (2002) conclude that the Korean immigrants' distrust of governmental agencies could add to their difficulties in accessing primary care services. Thus, although various resources exist to help immigrants find information on PHC, including clinics and community organizations, many immigrants do not know how to access those resources.

Language Barriers

The problem of linguistic or communication barriers has a significant impact on the health of immigrants. Such barriers increase the risk of miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased provider and patient satisfaction, malpractice injury, and death (Office of Minority Health, 1999). The response of health care organizations to the linguistic needs of immigrants has been to establish interpreter services. However, structural constraints, such as front-line health care providers' heavy workload, cost, or even lack of service in some institutions, all influence how these services are used (Anderson & Reimer Kirkham, 1998).

While a number of studies have documented the language barrier problem faced by immigrants (F. Ahmad et al., 2004; Choudhry, 1998; Elliott, Berman, & Kim, 2002; Kim et al., 2002; Matuk, 1996; Sohn & Harada, 2004), there are few studies which have examined how exactly language barriers become problematic, that is, how they impact care delivery and influence immigrants' clinical profiles. Forty-two percent of immigrants speak neither English nor French on their arrival in Canada (Statistics Canada, 2001), and a number of older Korean immigrants do not speak English well even after several years in Canada. Some immigrants are less likely to access PHC services after immigration due to language difficulties (Kim et al., 2002; Ku & Matani, 2001). Also, in a 2002 Canadian study Elliott, Berman and Kim found that Korean immigrant women experiencing menopause reported that health care professionals did not explain procedures, surgeries, and illnesses because of linguistic barriers. Clearly it is important to ensure that care is understood between health care providers and clients.

It is well documented that communication problems create barriers to access, can lead to misdiagnosis, inappropriate treatment, miscommunication of symptoms, and problematic follow-ups (Globerman, 1998; Stephenson, 1995). In a study among older Korean-American adults, Sohn and Harada (2004) reported that because of communication difficulties, some older Korean immigrants tended to wait until they were struck by serious illness to consult health care providers, bypassing PHC services. These older Koreans tended to seek Korean speaking providers and/or delay accessing health services. It is evident that for some older Koreans, the language barrier makes it difficult to access the resources of the PHC system.

Cultural Beliefs about Health and Illness

Another influence on access and its limitations may be related to a fundamental misunderstanding between immigrants and mainstream health care providers. Discrepancies between the Western biomedical framework and Korean beliefs about health and illness have been found to be the major factors influencing older Koreans' accessibility to PHC services. Canadian health care professionals' lack of knowledge regarding Korean culture often limits their ability to assess and understand older Korean immigrants' interpretations of health and illness. As a result, there is a need to develop the dual or reciprocal responsibility in the provision of care as a moral ethical imperative, in order to increase the accessibility of PHC services. We need to look at the issues related to mis-communication and lack of understanding of cultural beliefs and their influence on the interactions between health care providers and older Korean immigrants.

Assumptions about Difference

The assumption that cultural differences are the major cause of barriers to health services access has begun to be challenged by current research, which instead points to systemic bias and lack of flexibility in program delivery as the biggest barriers (Jenkins et al., 1996; Naish, Brown, & Denton, 1994; Waldram, 1990). The results of Chugh, Dillmann, Kurtz, Lockyer and Parboosingh's 1993 study indicate that, whereas community members felt that access barriers arose from racism and ethnocentrism, service providers believed barriers stemmed from a lack of cultural competence or were simply "cultural" barriers. The process of cultural categorization occurs dynamically in health care settings and in any environment in which health care providers can automatically make assumptions about the individuals in a category, and then act on the

basis of stereotyped preconceptions. With cultural categorization, health care providers, often unintentionally, create a mould for judging individuals within the same culture; they then use this mould to 'fit together' people who share the same cultural heritage (Meleis & Im, 1999).

It has been increasingly recognized that many health care decisions are informed by assumptions about clients. For example, James (2003) notes that stereotypes can be used to fill in missing information. Thus, when a health care provider is unable to gather the desired information, he/she may draw upon stereotypical images to enact the plan of care. Similarly, in a U.S. study, Norredam, Krasnik, Sorensen, Keiding, Michaelsen and Nielsen (2004) discovered that health care professionals tend to generalize and mythologize some groups of foreign-born clients. Many immigrants feel ignored and/or discouraged because of health care professionals' generalization of ethnic groups and their discriminating treatment of immigrants (James, 2003; Norredam et al., 2004).

In health care settings, the process of social categorization occurs when health care providers compare the attitudes and actions of peoples from different ethnocultural groups with those of mainstream society or other groups. For example, the results of a U.S. study by Sohn and Harada (2004) indicate that some older Korean American immigrants feel that medical professionals treat them differently because of their ethnic origin. This treatment can impact access to primary care services. Similarly, in a Canadian study, Korean immigrant women reported that their questions were ignored by doctors and as a consequence indicated that they would have preferred to seek traditional medicine from a Korean doctor with a shared language and culture (Elliott, Berman & Kim, 2002). It is important to examine the impact of such reactions in clients' use of PHC

services. For example, if the client has accessed the health care system but experienced discriminating treatment, he/she may be discouraged from continuing to seek care in the future.

Several studies in both the U.S. and Britain show how stereotyping has an impact on the provision of care for minorities (Bach, Cramer, Warren & Begg, 1999; Plaisted, 2002; Sambamoorthi, Moynihan, McSpirtt & Crystal, 2001; Todd, Samaroo & Hoffman, 1993; Van Ryn & Burke, 2000). For example, Plaisted (2002) detect perceptions of poor treatment and stereotyping by health care providers in a study of Somali women in the U.S. Similarly, in a study by Van Ryn and Burke (2000), disparaging racial stereotyping, rather than clinical data, is clearly shown to be predictive of refusal to recommend bypass surgery for many African-American clients in a number of cases. Other examples of differences in care based on stereotyping include differences in HIV treatment modalities (Sambamoorthi et al., 2001), cancer treatment (Bach et al., 1999), and analgesic prescribing patterns (Todd et al., 1993) for ethnic minorities compared with non-minorities. Racial stereotyping has also been associated with inappropriate use of treatment to deal with the presumption of danger from racial minority clients (Lewis, Croft-Jeffreys, & David, 1990; Pipe, Bhat, Matthews, & Hampstead, 1991).

From the clients' point of view, being stereotyped has been shown to have a significant impact on the health care provider-user relationship. Such relationships are often characterized by mistrust. In their research with aboriginal peoples in Manitoba, Kaufert and O'Neil (1998) explored the issue of trust in the provider-client relationship in detail. They concluded that low trust is linked to decreased patient satisfaction, lower levels of compliance, and subsequent patterns of health service access. Similarly, Ong,

Haes, Hoos and Lammes (1995) noted that delay or refusal to seek needed care could result from mistrust, perceived discrimination, and negative experiences in interactions with the health care system.

Concept of Cultural Safety

The current delivery of health care in Canada is based on a Eurocentric model that assumes common language and cultural background for both health care providers and clients. Clearly this assumption is no longer valid for the Canadian system. As a result, a new cultural concept needs to be developed to address the reality of current Canadian demographics. One of the major theoretical concepts underlying this study is “cultural safety.” Since there are multiple levels of influence on ways health care is provided (policy, system and interpersonal levels), and because such relations are historically constituted, it is necessary to adopt a concept that focuses attention on these different sources of influence on the health care needs and treatments of culturally diverse populations.

While the concept of cultural safety has become firmly established within the health care system, it is worth revisiting its specific origins. Cultural safety was developed to draw attention to intercultural relations between the Maori and the mainstream in New Zealand society, and to inform nursing education in New Zealand in 1989 (Nursing Council of New Zealand, 2002). Maori nurse leaders developed cultural safety as a theoretical construct to address inequities in power relationships and resource allocation in health care, because these issues contributed to health inequities (Ramsden 1993). This concept implies that in order to ensure good health care for all people, the structural issues that determine the social context of health care provision need to be

addressed (Polaschek, 1998). Furthermore, advocates of cultural safety suggest that changing the attitudes of nurses and health care providers can be the first step towards effecting structural and social change. Specifically, cultural safety aims to reorient the training of health providers, nurses in particular, towards a more critical understanding of colonial processes and structures, and their impact on Maori people (Kearns & Dyck, 1996).

The concept of “culture” within cultural safety is used in its broadest sense to include all elements of an individual’s being, including socioeconomic status, age, gender, sexual orientation, ethnic origin, migrant/refuge status, religious beliefs, disability (Ramsden, 1997), as well as the individual’s location in his/her interactions with health care providers. One premise for providing culturally safe care is that health care providers must reflect on their own social positioning, personal values, beliefs, understanding, and feelings toward others in all their interactions, and be aware of the ways in which their personal perspective influences the care they provide. Cultural safety is often defined in opposition to cultural risk. Cultural risk describes “a process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and the delivery systems of people from another culture” (Wood & Schwass, 1993 p.20). Culturally safe nursing practice involves actions which recognize, respect, and nurture the unique cultural identity of the Maori, and safely meet their needs, expectations and rights (Wood & Schwass, 1993), thereby minimizing or eliminating cultural risk.

In using the concept of cultural safety as a central concept for this study, I hope to gain an understanding of the conditions that might foster cultural safety for older Korean immigrants and thereby influence access to PHC. For example, cultural risk may arise

when older Korean immigrants' past experiences in the health care system are not recognized. Cultural safety may be used to guide an examination of the ways in which oppressive social, cultural, economic, and political factors intersect with race, gender, and class to generate inequities in the accessing of PHC services. Moreover we may gain an understanding of the ways in which mainstream health care providers' cultural ethnocentrism and lack of knowledge about Korean cultural values place older Korean immigrants in a culturally unsafe care situation, or what actions older Korean immigrants take to seek the provider's of cultural safety care. I conceptualize cultural safety as a means to develop effective interventions that support older Korean immigrants by sensitizing mainstream health providers to the marginalizing practices and injustices that continue to exist within the health care system.

Summary

In this chapter, I reviewed existing literature on the Canadian health care system to demonstrate how the system's fundamental structure and practices interact with the ways in which immigrants are positioned within society. In terms of both its decision-making and the strategies for making services accessible, the system has failed to recognize the needs of certain immigrant groups. After reviewing the literature that focuses on access to PHC across Canada and on access to PHC for immigrant Canadians, I found that very little was known about older Korean immigrants' access to PHC. I also reviewed the concept of cultural safety because it focused on the various influences on health care needs and treatment of culturally diverse populations. The main purpose in adopting cultural safety as central concept is as an analytical lens, and as an appropriate

tool for health care providers to develop ways of offering culturally appropriate care for older Korean immigrants.

The methodology selected for this study is an interpretive description, qualitative research approach. This methodology is appropriate when little is known about a phenomenon and further exploration is required. Using an interpretive descriptive approach to conduct this study enabled me to draw upon the perspectives of older Korean immigrants' experiences in accessing PHC. I now turn to the methodology and methods of this study in Chapter Three.

CHAPTER THREE

METHODOLOGY AND METHODS

Introduction

In this chapter, I provide a rationale for the choice of a qualitative design inspired by interpretive description, and delineate sampling strategies and data collection methods, such as interviews and field notes. I also discuss the limitations of the study. The choice of a qualitative approach is relevant when considering the exploratory nature of this research. The study is aimed at understanding older Korean immigrants' experience of accessing PHC services. The study's methodology and methods were selected to explore the issues that have an impact on older Korean immigrants' everyday lives, and examine how accessibility is embedded in multi-layered contexts where historical, economic, social, and cultural elements affect older Korean immigrants' access to PHC services.

Methodology

This qualitative study employed the methodology of interpretive description as outlined by Thorne, Reimer Kirkham and MacDonald-Emes (1997) and Thorne, Reimer Kirkham and O'Flynn-Magee (2004). This method provides guidance for the researcher attempting to interpret phenomena of interest to the discipline for the purpose of capturing themes and patterns. This method includes knowledge identifying common patterns found within experiences that represent the core of nursing practice, knowledge and practical application of principles (Thorne et al., 1997). As Gillespie (2002) emphasizes, interpretive description is suitable when examining previously unexplored experiences, allowing the researcher to move beyond participants' descriptions and engage in interpretation of the participant's experiences from their perspectives. This

approach supports the development of a description of individuals' perceptions of an experience and interpretation of that experience to uncover meaning(s) for nursing knowledge.

An interpretive description, informed by the concept of cultural safety, is used to understand older Korean immigrants' experience in accessing PHC. Interpretive description aims to understand how participants' experiences intersect with social structural factors to influence access to PHC services in the Korean immigrant community. As Thorne and colleagues (1997) emphasize, interpretive descriptive methodology is designed explicitly to assist in the development of nursing knowledge. This emphasis permits exploration of the individual's connection to their world and promotes the expression of self-interpretation (Vaughan, 1992). By employing an interpretive description, I attempted to draw upon perspectives of older Korean immigrants to then introduce their ideas and experiences related to primary care access into the professional domain; I thereby created an opportunity to explore the nature of the systemic changes needed to improve access. Through studying the participants' experiences, new knowledge is gained and this new knowledge can be used for action and change not only at the individual level but also in a broader context at the social and political levels.

Sampling

In this method the goal of the sampling is not to achieve a representative sample but rather to select participants on the basis of their ability to provide rich and detailed information about the phenomenon of interest. The sample for the study was obtained using purposive sampling techniques. Thorne and colleagues (1997) point out that the use

of purposive sampling allows selection of participants according to the needs of the study, based on the desire to obtain maximum variation in the phenomenon being studied. Also, Thorne and colleagues (1997) identify purposive sampling as important to an interpretive description meant to generate nursing knowledge as it allows the researcher to capture similarities and differences in participant accounts. Purposeful samples aim to provide an understanding of the phenomenon under study by selecting people who know about and preferably have experience of the research topic (Morse & Field, 1995; Sandelowski, 1995). In this study, sampling was aimed at finding participants to help answer researcher questions in order to understand their experience in accessing PHC, regardless of their gender. Eligible participants for this study had the following characteristics: Korean immigrants, 60 years of age and older, resident in Canada for at least 5 years, non-English speaking, residing within Greater Vancouver, willing to share their experience, and prepared to give written permission to participate. I selected five male and five female participants with the intention of examining various subgroups among the Korean elderly who were most likely to have differences in terms of lifestyles, needs and adjustment patterns.

Recruitment of Participants

As a Korean nurse in Canada, my familiarity with the health care setting, and the fact that I am known within the Korean immigrant community, provided a certain ease of entry and connection with potential participants. Recruitment commenced after I received approval from the Behavioural Research Ethic Board of the University of British Columbia. The study was advertised using flyers posted at several Korean churches, restaurants and grocery stores. I contacted participants who were interested in the study

within the Korean community and Korean churches. Upon obtaining permission to contact potential participants, I arranged a meeting at a mutually convenient time and place. At the meeting, I explained the purpose of the study and answered participants' questions; those who agreed to participate were asked to sign an informed consent form before the interviews proceeded.

A total of ten people participated in the study. Five of the participants were male and five female. Sample size was guided by the ongoing analysis of the data with a minimum sample of six participants established as being appropriate for the investigation (Sandelowski, 1995). The age range for the participants was 60 to 87 years old, with a mean age of 71.5 years. Seven participants were married and three were widowed; one had post graduate education; two had undergraduate education; four were high school graduates; and three completed elementary school. All 10 participants had resided in Canada from 5 years to 30 years, with a mean of 18.2 years. Eight participants had a chronic health condition, such as hypertension, heart disease, diabetes, osteoporosis, and chronic back pain. As many participants were managing ongoing chronic health conditions, issues of access to PHC services were important.

Purposive sampling for maximum variation will ultimately guide sampling decisions and will allow for sampling to continue until data saturation occurs. In this way, the adequacy of the sample will be ensured when no new themes or patterns emerge from the data, indicating that the information given by the sample is complete (Streubert, Speziale & Carpenter, 2002). All participants were informed of the intended use of the data and the use of a digital recorder for the interview. All participants signed a written consent form ensuring confidentiality.

Data Collection Methods and Procedures

The primary data collection method was in-depth, face to face, unstructured interviews with each participant in a location best suited to the participant. As the goal of an unstructured interview is to allow the participant to tell his/her story, I followed Field and Morse's (1995) recommendations to listen intently, minimize interruptions, and avoid use of closed-ended questions, jumping, counseling, or presenting the researcher's perspective.

The study was carried out in Greater Vancouver from mid-October 2006 to April 2007. Open-ended interviews and field notes were used to collect data. I conducted all of the interviews in Korean and transcribed each interview in Korean into an electronic file. Seven interviews occurred at the participant's home and three at a fast food restaurant. The duration of the interviews ranged from 23 minutes to one hour. Participants were encouraged to indicate when the interview was completed, and thereby to retain control of the process. The sequence of each interview included an introduction period where the study was explained, any questions were answered, informed consent was obtained, and demographic information was collected. In addition, a short period of time was spent sharing information with participants about my professional background and any relevant personal information such as occupation, marital status etc. This allowed the participant to gain contextual information about me as both a researcher and a nurse; this step was completed in accordance with the concept of cultural safety.

The interviews were audio recorded (on a digital recorder) by palm pilot machine, and open-ended trigger questions were used as needed to initiate and maintain the

dialogue. At the beginning of the interview, trigger questions were asked to get an overview of the situation or experiences. Trigger questions were utilized as a tool to facilitate the research process and as a means of refocusing the discussion. Sample trigger questions are presented in Appendix D. The interviews were conducted in the participants' native Korean language and the researcher made some written notes about the interview. During interviews, some questions had to be explained to the elderly participants using easy wording, and I always made sure that the respondents had fully understood the questions. This process helped to ensure reasonably accurate responses to questions from elderly participants.

I wrote field notes after each interview. As Morse and Field point out, field notes are "a written account of the things that the researcher hears, sees, experiences, and thinks in the course of collecting or reflecting on the data" (1995 p. 103). Field notes reflect sensitivities, meanings, and understandings that the researcher obtains from having been close to, or after having participated in, the described events (Emerson, Fretz & Shaw, 1995). At the beginning, I was focused on the participants' recruitment issues. As I became more self-reflective, I gained a richer insight into my ways of describing interview events. In this study, two types of field notes were used. First, I kept a descriptive diary in which I wrote analytic memos and ideas to be explored in subsequent interviews, or to be discussed with key informants. Second, I kept a general descriptive journal in which all interactions with the participants were recorded. I wrote a journal to develop self-reflection and reflect on my personal biases on race and gender; my committee's comments helped me to develop greater awareness about these biases. For instance, when I was transcribing the interviews, I became so involved with the

participants' narratives and I had difficulty separating my own experiences from theirs. I needed to be constantly aware of my role as a nurse, as a researcher, and most importantly my own history as a Korean Canadian. I was aware of the presence of these personal contexts throughout the study and realized my personal biases within the data collection process. For this reason I felt it crucial to document my thinking, decisions, choices, and insights throughout the entire research process. I kept a journal that I reviewed periodically attending to personal slant or any potential areas of bias. Further to this both I and my thesis committee members repeatedly reviewed and challenged the findings of the analysis to counter this risk. As well I often discussed insights with my committee members remaining open to any feedback regarding the emergence of personal biases in the study process. The transcripts became the data for analysis.

Data Analysis

The aim of the data analysis was to understand older Korean immigrants' experiences in accessing PHC, and to explore the impact of the PHC system on access to health care services in general. A thematic analysis was used to understand the influences of social and political forces in constructing access experiences. I also found it useful to examine the dominant western ideologies that are the basis for PHC services. Concepts and preliminary codes were identified by topic, and each interview was categorized according to topic. Codes identified the content of each interview, and category labels were used as descriptive names for each group of data. The interpretive description was constructed by repeated review of the transcripts and immersion in the data. Data were broken down into units of information that were inductively coded into the initial three broad idea categories, namely, 1) The position of the elderly in the family, 2) significance

of the health care relationship with providers, and 3) participant perspectives on health and illness. The properties of components of the idea categories were then identified from the data. From these categories the information was synthesized into themes that provided a coherent description of participant experiences.

Morse (1994) points out that no magic recipe exists when it comes to describing and detailing the steps involved in qualitative data analysis. Three steps of data coding were used: transcription and translation of the data from Korean to English, open coding, and coding following initial data analysis. First, I listened to the audio-recorded interviews in Korean several times to get a general sense of the whole of the participants' voices. Then, I transcribed the audio-recorder interviews verbatim in Korean (all interviews were conducted in Korean and transcribed in the same language into an electronic file). Finally, the Korean text was translated into English. In order to ensure quality in the transition between the two languages, the Korean texts were only translated into English after I made sure I fully comprehended each interview. In this translation stage, I situated myself within the participants' perspective of the word as a means of understanding their experiences. All interviews were translated into English so that my committee members could understand how the interviews were proceeding and what kind of data I was collecting.

The various steps of data analysis such as open coding were conducted in English. After shifting to English, I presented the logic behind the data analysis to my committee. For some Korean words that could not be translated directly, I searched for a core Korean concept and then interpreted it into the English language to capture subtle meanings. In this translation stage, I often returned to the audio-recorded interview to review it closely

and identify the participant's tone of voice by visualizing each participant at the time of the interview. The translated and transformed English texts and Korean transcriptions were assessed by a Korean Canadian doctoral student in English education for added accuracy. In the process of comparing transcripts with audio-recordings, recalling observations and experiences during the interview, and reading transcripts several times, I became immersed in the data. This procedure gave me an additional, overall sense of each interview.

The second step was to perform open coding, which involved reading the transcripts carefully while writing codes or questions in the margins. At this stage I eliminated redundant information and searched for core meanings; essence codes were completed using English. All interviews were read line-by-line to identify codes, and to generate new and as many codes as possible. After completing the analysis of 3 interviews, I reviewed with one of my supervisors. A few new codes emerged, through which I was able to get rich information. Data saturation is reached when no new information can add to the understanding of the phenomenon. Strauss and Corbin (1998) state that data saturation is obtained when "no new information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data" (p.136).

For the third and final step of data coding, I began my analysis of the data by examining the participant narratives in the context of the analytic framework. The narratives were broken down or inductively coded into data that were congruent with the initial three idea categories described earlier. The next step involved coding the data into in each of the broad idea categories for the presence of patterns or similarities. Thorne

and colleagues (2004) suggest that “breadth is more useful than precision in the earliest coding and organizing processes, permitting groups of data bearing similar characteristics to be examined and re-examined for a range of alternatives” (p.11). Also, Thorne and colleagues (2004) state that when analyzing data it “becomes important to move in and out of the detail in an iterative manner asking frequently, what’s happening here?” (p.14). Using these techniques of moving between microscopic and macroscopic views, the data were inductively coded into smaller and more specific subcategories. In this process data was refined from three broad categories into many categories that provided a beginning description of the experience.

This analysis produced categories that were more specific and provided a greater depth of information about the experience of accessing PHC. As the analysis progressed, decisions regarding the appropriateness of data were made; categories became increasingly clear after I reviewed the progress of the analysis with committee members (approximately 3-4 committee meetings were held for this purpose). Further analysis of the data allowed the construction of several dominant themes and sub-themes from the more specific categories developed. This provided a deeper understanding of older Korean immigrants’ experience in accessing PHC and resulted in the development of the final interpretive description. For example, the first three broad categories were refined after discussion with committee members, and four dominant themes emerged: 1) social positioning, 2) perspectives on health and illness, 3) expectations of the PHC system, and 4) navigating the PHC system. Each of these themes was supported with data from the narratives with committee members’ help. The interpretation of thematic findings

represents a coherent logic and a traceable audit trail (Thorne et al., 1997). After refining the themes several times, I found three themes grounded in the data as interpreted by me.

My own reflective analysis and continual reconsideration of participants' perspectives resulted in ongoing refinement of coding categories, concepts and themes. Exemplars from coded categories and themes were retrieved and compared within and across transcripts. Concurrently, the interview data were continually read alongside the observational data, which provided important contextualizing information. In the process, my analysis shifted to a more abstract level of conceptualization to generate broader propositions. As Thorne and colleagues (2004) state, "it is the researcher who ultimately determines what constitutes data, which data will arise to relevance, how the final conceptualizations portraying those that will be structured, and which vehicles will be used to disseminate the findings" (p.12). I approached the analysis of the narratives with an awareness of the need for reflexivity throughout the process. I was aware that at times I became so involved with the participants that I had difficulty separating my own experience from theirs.

Ideally, the analysis process includes opportunities for participants to review the researchers' interpretations, so that descriptive and interpretative validity can be checked, and participants can have input into how data are constructed and presented (Thorne et al., 1997). In this study, this step was not formally established with the participants because many of them were unable to meet with me a second time. Instead, near the end of the six-month data collection period, I discussed my evolving concepts, categories and

themes in interviews with three participants; I also reached four participants (second interview) to obtain an explanation or more details about the content of interviews³.

Since there were only ten participants, data analysis was performed in English and by hand. Data preparation was performed as follows: First, I transcribed all of the audio-recordings in Korean and then translated them into English; I placed a hard copy on file for each participant. Second, I read each English transcript several times: the first and second readings gave me a general idea of the interview, while the third and fourth readings involved writing down codes in the margins. Third, when progressing with the date coding, I was able to aggregate some codes to form categories, with my committee's help. Fourth, I underlined interview transcripts using fluorescent markers to delineate categories (to facilitate the work of cutting and pasting to regroup categories and themes), and created a second file for each participant where codes and categories appeared on each transcript.

Ethical Considerations

Potential participants were provided with a description and explanation of the study, and given opportunities to ask questions or seek clarification of the research process from the researcher. Once an individual had agreed to participate, written consent was obtained prior to the commencement of any research activity. Participants were informed that they could choose to withdraw or choose not to participate further at any time, and that any decision to withdraw would in no way affect the care they received. Participants were informed that only the researcher and members of the academic committee would have access to any consent forms, transcripts, and field notes obtained

³ Three participants were not available to participate in a second interview: One participant decided to go back to Korea and two participants visited Korea for a few months.

during the research process. Participants were offered the opportunity to review transcripts of their interviews, and to review research findings.

The methods utilized to ensure participant confidentiality included using pseudonyms, generalizing descriptions of settings, and altering any information that could be used to identify participants. Participants were assigned numbers instead of names. Participants were informed that they had the right to exclude any information from the study that they did not wish to share, including the right to have any portion of the audiotape erased at any time. Additionally, the entire audiotape will be erased upon the completion of the study. No participants requested that any part of their audiotape be erased.

Rigor

Rigor in qualitative research refers to the ability to ensure the validity and reliability of the findings (Morse & Field, 1995). The traditional criteria for rigor as stated by Lincoln and Guba (1985) refer to truth value, applicability, consistency and neutrality. Sandelowski (1986) further explicates rigor in qualitative research and provides guidance when assessing rigor, contending that the varieties of qualitative studies, with their tendency to evaluate qualitative designs against conventional criteria of rigor, and the artistic features of qualitative inquiry, can be seen as impinging on the scientific adequacy of qualitative research. It is difficult to find one truth in qualitative research, as often the data points to multiple truths; therefore the researcher must report the informants' perceptions and viewpoints accurately. The following will describe the approaches used to ensure rigor throughout the study.

Sandelowski (1986) describes truth value as credibility: a “study is credible when it presents such faithful descriptions or interpretations of a human experience that people having that experience would immediately recognize it” (p.30). “Going native” poses a major threat to truth value, and denotes a process whereby the researcher becomes so involved with participants that he/she has difficulty separating his/her experience from the experiences of the participants. Both I and the supervisory committee repeatedly reviewed and challenged the findings of the analysis to counter this risk.

The qualitative and exploratory nature of this type of inquiry limits the applicability and generalizability of the findings. Nevertheless, although these findings present in-depth descriptions and interpretations specific to the lived experience of the study participants, they may yield valuable insights that may lead to greater understanding within a larger context. Sandelowski (1986) describes applicability as “fittingness,” when “findings can fit into contexts outside the study situation and when its audience views the findings as meaningful and applicable in terms of their own experiences” (p.32). It is also important to utilize current theoretical and conceptual knowledge to support the fittingness of findings. By expanding, modifying, or explicating current theory the researcher strengthens support for fittingness and/or the applicability of findings.

Sandelowski (1986) describes consistency as auditability: “a study and its findings are auditable when another researcher can clearly follow the decision trail used by the investigator in the study” (p.33). The presence of a clear audit trail, including descriptions of how participants were chosen for inclusion in the study, bracketing or acknowledgement of the researcher’s biases or influences, and journaling of decision

making during the analysis process are all important, and were included in this study. In addition, data collection procedures, the nature of the data collection setting, and information on how categories are developed were all addressed.

Sandelowski (1986) describes neutrality as conformability, referring “to the findings themselves not to the subjective or objective stance of the researcher” (p.34). Qualitative researchers must also be aware of and document personal contexts and biases throughout the study in order to understand how these may influence the analytical process and to ensure some measure of neutrality. Although in interpretive description design acknowledges the researcher’s background and experience as an integral part of the inductive analytical process, care must be taken to ensure that the findings are derived from the participants’ descriptions and perceptions of the phenomenon being explored, rather than the study becoming a vehicle with which to present the researcher’s biases and beliefs about the topic under study.

Ensuring rigor for this study meant that I needed to be constantly aware of my role as a nurse and most importantly my own history as a Korean Canadian immigrant. I was aware of the presence of these personal contexts throughout the study and realized the potential for bias within the data collection, analysis, and interpretation processes. I completed date field notes and kept a journal that I reviewed periodically, attending to my own perceptions, hunches, possible ‘blind spots’ and any potential areas of bias. In addition I regularly discussed emerging ideas and insights with my supervisory committee, remaining open to any feedback regarding the emergence of personal biases in the study processes.

Limitations and Significance of the Study

The qualitative and exploratory nature of this inquiry limits the generalizability of the findings. The findings are limited by the selection criteria for participants, i.e. older Korean immigrants who were 60 years and older, and the small sample size (n=10). Participants were all living in the same urban area, so their experience may not represent the experiences of individuals living in other urban, rural or remote areas. Since the participants were volunteers, it is possible that I did not interview persons with unique experiences who chose not to participate in the study for whatever reason. It is also possible that, given the nature of the research, participants may have provided the answers they thought I wanted, rather than answers that accurately reflected their experience.

However, the findings have considerable importance for health care professionals and the organization of health care services. This study sought depth and detail about older Korean immigrants' experiences and therefore it offers insights to assist health care professionals in understanding not only the nature of the challenges and issues older Korean immigrants face when seeking health care, but also how they seek to resolve them. The study's description of this phenomenon may serve as the basis for proposed interventions that respect the values of older Korean immigrants and improve their access to PHC. The findings offer preliminary directions for health care professionals to provide PHC in ways that respect and support older Korean immigrants.

Summary

The method utilized for this study is based on qualitative research approach and interpretive description described by Thorne and colleagues (1997, 2004). The sample for

the study was obtained using purposive sampling techniques, based on the desire to obtain maximum variation in the phenomenon being studied (Thorne et al., 1997). In this chapter, I have presented an overview of the research approach of interpretive description and how this approach is implemented in the design of this study. Data consisted of transcribed audio recording and field notes. Data analysis occurred throughout and subsequent to data collection. The decision trail for data analysis is presented and utilized to guide the inquiry. The findings of the study will be presented in Chapter Four.

CHAPTER FOUR

FINDINGS

Introduction

In this chapter I present an interpretive description of older Korean immigrants' experiences of accessing PHC in Canada. The description was constructed from the narratives of the older Korean immigrants who participated in the study. This chapter builds from the processes of data gathering and analysis presented in Chapter three. It is organized into two sections. In section one, I begin by providing a descriptive overview of the study participants. I then provide an overview of the key concepts that characterized the participants' experiences and then proceed to illustrate the dimensions of the experience by drawing upon the data. The main dimensions of the participants' experiences are the shifting social positioning of older Koreans within families, perspectives on the PHC system, and barriers in navigating the PHC system.

Background of Participants

A total of ten participants, five male and five female were recruited through the Korean churches, Korean restaurants, and apartment buildings (subsidy housing) with a high concentration of Korean elderly in the Greater Vancouver area. All the participants had immigrated to Canada from Korea. Seven of the participants came to Canada between the late 1970s and mid 1980s. Two came to Canada in the late 1990s and one participant came to Canada in early 2000. As a result the length of time the participants have been in Canada ranges from 5 to 28 years. Four participants emigrated with the hope of achieving a better life at the age of 40 years or more as economic immigrants. Five came to Canada through the invitation by their children when they were in their early

60's as the family reunification. One came to Canada through an entrepreneur program when he was in his mid 50's. The age range for the participants was 60 to 87 years old.

All of the participants had been married. Seven lived with spouses and three women were widows and lived alone. All the participants have children in Canada and some participants had children in Korea as well. They lived separately from their adult children as they felt they had to be independent. Two male participants currently owned a small business, one male was retired (used to own a small business), and two males were employed as ministers serving in the church. The majority of women participants have never experienced any paid employment in Canada and the one employed woman had worked for 13 years, making minimum wage, with a company that recycles clothing. Six participants' source of income is predominantly a government subsidy (\$ 10-15,000 CDN per year) and they indicated they were able to manage their affairs without receiving any financial assistance from their adult children. Two business men earned income approximately \$ 40, 000 CDN. Two of the ministers received income from their church (\$ 40-45,000 CDN).

All the participants except for one were unable to speak and understand English. Their English skills are limited to several words and some greetings. According to the findings, all women participants had more language difficulties than the male participants as a majority of the women had little exposure to English. They stayed home to look after their children or grandchildren. With two exceptions, all participants had a chronic health condition, such as hypertension, heart disease, diabetes, osteoporosis, and chronic back pain.

Findings of the Study

As I undertook the interviews for this research, I was struck initially by the uniqueness of each of the participant's experiences, and was concerned with how to proceed with the analysis without negating the individual. However, as each participant conveyed his/her unique narrative, it became apparent that understanding these unique experiences with the PHC system was needed in order to understand the ways such experiences shaped how they learned to navigate the health care system. As I proceeded with a thematic analysis I realized that I could not view each narrative as a discrete entity, but as part of a multidimensional whole with each participant's story contributing to the final common interpretive description.

As interviews progressed I began to recognize similarities in the narratives which, as the analysis progressed, were synthesized into common themes that could then be applied to each individual's experiences. By highlighting the similarities and differences I hope to capture the meanings of the experience for the study participants. These common themes may then provide useful insight into the experience of accessing PHC system that may have meaning in other situation for other immigrant population.

To assist in the organization of data analysis I first identified four broad idea themes that formed the analytic framework for the narratives and assisted me in constructing the interpretive description. The initial ideas for themes were: social positioning, perspective on health and illness, expectation of PHC system, and navigating the PHC. After ongoing refinement of themes with committee members' help, the final three broad idea themes were identified: the shifting social positioning of older Koreans

within families, perspectives the PHC system, and barriers in navigating the PHC system. Three dominant themes, describing the experience of PHC, provide a description of what was salient to the experience and will be used to guide the discussion of what the experience of accessing PHC was like for the participants.

The Shifting Social Positioning of Older Koreans within Families

The theme of “the shifting social positioning of older Koreans within families” was constructed from the descriptions of the participants’ experiences as members of Korean Canadian families. The participants all noted that their status and roles had been changed in the family since they immigrated to Canada. According to Korean traditional values, the old in the family have the power, authority, and respect from the other family members, and the younger are supposed to respect their elders’ wisdom and experience (Kauh, 1999). However, the participants in this study could not hold such a position in the family in Canada for several reasons: first, many of participants could not understand English; second, they were not familiar with the Canadian way of life; third, they did not accumulate assets to leave to their children⁴. In this situation, the participants’ children may not seek advice from their parents on such topics as residential changes, job seeking, and financial matters. So the participants in this study did not represent a meaningful role for their children, nor could they exercise any power or status within the family (Kauh, 1999). As such, their change of role in family life was related to gain support from their adult children that affecting their access to PHC services. The influence of their changed role in the family was related to the following three sub-themes; independent family life, being “Elderly”, and being “Isolated”.

⁴ According to the participants, it is Korean traditional value that parents leave assets to their children in order that they inherit power and authority.

Independent Family Life

The sub-theme of “independent family life” illustrates how the change of family support affects older Koreans’ access to PHC. After living in Canada, the participants realized that they needed to maintain their residential and financial independence since their children became more independent as a result of adopting Canadian values and family norms. For example, the participants’ children may not see themselves as responsible for taking care of their aging parents due to the more individualistic values system in Canada. Also most of children had little time to care for their aged parents because of their own busy lives. Two female participants stated:

Well, they (children) are busy. They are busy raising their children (83 year old female).

I remember some friends of my husband’s. Their children are busy and they can’t help. They don’t rely on their children as well (68 year old female).

As a consequence, some participants described feeling the need to be more independent so as not to be a burden to their adult children. One female participant explained why she chose to live apart from her daughter.

I came here to look after my grandson, but he has grown up, so there is no reason for me to stay at my daughter’s house. And there is not much to do. I decided to move out to live on my own (82 years old female).

Surprisingly, no participants in this study lived with their children. Many participants lived too far away from their adult children and were not able to rely on them to help to meet their needs (e.g. assistance with their grocery shopping and visiting doctors. Although I could not locate statistics on the prevalence of intergenerational families in Korea, my observation is that the majority of elderly live with their children in Korea. As such, the study participants’ experiences are in marked contrast to this practice.

The following narratives illustrates some of the ways living alone influenced the participants' access to PHC.

One day, it was difficult to walk uphill. It was hard to walk and I felt breathless... I wanted to see a doctor, but I couldn't tell my children to come with me. I just...try to deal with the circumstances by myself (86 year old female).

They live far away so it's difficult to tell them these things (meal preparation, grocery shopping, visiting doctor's office) (83 year old female).

Living apart from their children, the participants had less expectation about their adult children's support. Interestingly, many participants expressed not attempting to seek assistance from their children as they did not want to take their time and energy. Instead of relying on their own adult children, the participants tended to ask for help from church people or friends:

The young folks (children) all work during day... they are working everyday to earn money. So it's hard for me to ask to take me to a doctor...Now the folks at my church help me out a lot (82 year old female).

They (church members) come and help me. I can't even make phone calls, so they call and take me to the doctor's office (86 year old female).

As noted above, Korean churches enabled the participants to expand their sources of support beyond the family. Nine of the participants were Christian and were actively involved in church work. The results of Kauh's (1999) study in the United States revealed that the Korean churches were valued as primary groups that offered assistance in terms of transportation, social support, and visitation. Most of participants in this study reported similar experiences with Korean churches when they were ill:

People from my church helped me a lot by taking me to the emergency room and buying medications. Sometimes, they visit me as I can't go outside by myself (83 year old female).

There was a Korean pastor who helped older Koreans by providing a ride (68 year old female).

As noted in the above findings, these participants had difficulty in seeking help within the family. However, I could not further inquire why these participants felt hesitant to ask for assistance from their children as they avoided discussing in detail⁵. It seemed clear to me that their independent family relationships made these participants not to rely on family support. Instead, they sought help or support from other members of their social network such as friends or church people.

Other participants described similar experiences where they needed to be more self-sufficient and could not rely solely on their adult children for support. The myth of family members' support was deconstructed since the results showed the participants expanded their informal network beyond family. As the participants described their different role in family life, it became apparent to me that the participants may have forced to become independent because of changing family values, and an adoption of "Canadian" values. Most of the participants were relying on their churches' support or friends, but these supports were not always available, which led them to delay or give up in seeking health care services. Consequently, changing independent family structure may have caused negative influences on their health and illness management.

Being 'Elderly'

The participants' narratives reveal that their negative perceptions of "old" had an impact on their access to health care services. While in traditional Korea society 'being elderly' was associated with respect, authority and power, in Canada this may not be the case. It seems that in North-American countries, aging is conceptualized as a devaluing

⁵ According to Kauh's (1997) study in the U.S. Koreans commonly tend to avoid talking about their family relationships to a stranger such as researchers; Koreans are reticent talk to others about negative emotions towards to their family members because of beliefs related to losing family face.

process, where aging persons are virtually excluded socially since they no longer are productive for the society. Issues related to ageism, negative stereotypes of aging were mentioned during interviews with the participants. The participants described that they recognized the need for more daily assistance as they became older. Their weakened physical conditions could not support their desire to be independent. Three participants described that 'being old' was an impediment to accessing PHC services:

Being old is a difficulty. I'm not very healthy...I feel so sorry that I have to depended on someone every time I go to see a doctor (83 year old female).

Sometimes I think, "Oh, they (health care providers) are ignoring me because I am old" Now I am awaiting my death [sigh]...stupid body...I'm in despair (86 year old female).

Old people like me, if we were living alone, we might not be able to make it to see a doctor every time because of our own handicaps (68 year old female).

These narratives reveal how the participants' negative stereotypes of aging influences their access to PHC. In addition, the participants shared that they could not expect any respect from their health care providers because Canadian society in general showed less respect towards elders compared to Korean society.

According to their narratives, they experienced enormous difficulty in using public transportation due to their weakened physical conditions related to aging. Their inability to use public transportation was one factor that influenced their desire to access PHC. Two female participants, who lived alone, expressed their hardships in seeing their family doctors:

Yes...old folks can't travel far, you know. If I want to go to my family doctor I have to take a bus...I can't go there by myself. I would walk a few steps but I would fall. So I have a cane to help me (86 year old female).

I fell and broken my leg in 1992, so I can't really go far. So it is difficult to go to see my family doctor by myself. It's very difficult (83 year old female).

All of the participants expressed an increased amount of assistance due to old age. These findings show that physical limitations related to old age could influence individuals' access to PHC.

Being 'Isolated'

Besides "independent family life" and "being elderly", another sub-theme of isolation deepened the constraints on the participants' social position, supports, and social life. The participants in this study could not take part in social or recreational activities because of their lack of language ability, and transportation difficulties. As a result their social life was far removed from mainstream society. Similarly, lack of language ability among ethnic elders is viewed as a crucial factor leading to isolation in the dominant society (Rogler & Cooney, 1991).

Kauh's (1999) study among Korean elderly living in Philadelphia revealed that some older Koreans were homebound as they could not communicate in English. Hence, this made it very difficult for them to use public transportation. Furthermore, their children were not available to take them out during day. Kauh (1999) addressed that older Koreans' lack of English proficiency and their limited access to transportation deprive them of contacts with the outside world. With the exception of one participant, all participants reported that their social interactions were limited to family, friends, and Korean church members. They also expressed having difficulties in expanding their limited social network beyond Korean-speaking people. The size of primary network is also a significant factor that influences access to PHC. A majority of the participants' networks are constrained by their language ability. Therefore, they obtain some information from informal social network such as family, friends, Korean churches rather

than seeking them directly from formal social organizations (Wong, Yoo, & Stewart, 2006). Most of them only talk to other Koreans as their limited English kept them from participating in Canadian society.

We only talk to Koreans and there are not that many opportunities to talk to anyone else. We don't have many chances to experience the Canadian society because we can not speak English well (66 year old female).

Some participants were homebound due to their physical limitations, so they only connected to their family and friends who lived close by. For example, one participant had broken legs, since then she could not walk well. Therefore, she usually stayed home:

I only hang out with older Koreans who live in the same apartment (82 year old female).

As for some participants, they did not even have connections with their own family members. One participant, who lived alone and rarely received help from her children.

I just stay home and meet friends every Sunday at church. My children rarely contact me (83 years old female).

These findings indicate that the participants were isolated from the outside world. This isolated social position with older Korean immigrants certainly generated more obstacles in accessing PHC services because they had limited opportunities to gain appropriate health information. In regards to the limitation of this approach, one participant stated that:

I don't have Korean friends who know more about the system than I do, so it is really hard to get information (65 year old male).

Another participant reported that she felt trapped and lacking connection with others.

It's not only the language, but in every way. I felt isolated from others. I am only connected to my family and friends. Sometimes, nobody visits me. How can I get any information from outside world! (82 year old female).

These narratives show that the participants' limited social connection resulted in their lack of health care information and the use of community resources. Therefore, this impoverished social connection impacts participants' health or illness management. For example, one female participant, who lived alone, took aspirin after her heart attack last year. She had noticed that she often felt dizzy since she had hematuria (blood in the urine). One night she fell at home due to dizziness.

I went into the washroom and I started bleeding again. I think I bled for almost 20 days....My friend's daughter took me to the emergency and found that the medication (aspirin) caused bleeding. I did not know this until my friend's daughter explained it to me after taking me to the emergency doctor (86 year old female).

She indicated that nobody has explained the side effects of the medication. In this case, the woman's limited social connection was related to gain information about her medication. Unfortunately, her illness had not been managed well.

Surprisingly, many older Koreans in this study focused primarily on the symptoms related to their health condition. They lacked access to information regarding illness prevention and management. In short, since participants were not well connected to their families and information sources, they seemed to face many difficulties in accessing appropriate health care information and prevention of illness.

Perspectives on the PHC System

The theme of "perspectives on the PHC system" illustrates what concerns older Korean immigrants had towards the PHC system. As I noted earlier, the majority of the participants had a chronic disease such as hypertension, diabetic, heart disease, osteoporosis, and back pain. Their concerns about PHC included the major issues of

waiting time, complicated process of PHC and their relationships with health care providers.

Not Getting Treatment in a Timely Manner

This sub-theme illustrates what older Korean immigrants had experienced in dealing with the PHC system and how it failed to meet their expectation in terms of offering an acceptable time frame. Many participants repeatedly described their experience with having to wait for extended periods to see a health care provider. They emphasized that extended waiting time for diagnostic tests, surgical and other procedures was an important reasons that shaped their negative perspectives on the Canadian PHC system. One participant shared his experience of not getting treatment in a timely manner when he was ill:

The problem is that I have to make an appointment whenever I need to see a doctor even if it is my own family doctor. Due to prolonged waiting time, I didn't get an appointment, nor did I receive the assistance from my doctor (70 year old male).

In addition, other participants shared similar experiences in that some people went back to Korea to see doctors because they could not get immediate treatment and accurate diagnosis from Canadian PHC:

I knew this person who went back to Korea to get treated because it took so long here. This person could not wait any longer here, so went to Korea to find out that he had end-stage (stage 4) of lung cancer. He died in 6 months (66 year old female).

The Korean lady was very sick, so she went to see her doctor here (Canada). The doctor could not find any problems with her. But the lady's symptoms got worse, so she went to Korea to get checked upon. You know what! The lady found that she had a cancer and it was too late to treat, so she died (70 year old male)

A person was told that he had pneumonia and was treated for the disease. But he felt a lot of pain so he went to Korea to get the test and found out that he had end-stage (stage 4) of lung cancer. People are misdiagnosed often here (Canada), so

they have to go to Korea to get the accurate diagnosis and treatment (60 year old male).

As the participants' narratives show, there are many negative experiences relating to misdiagnoses and late treatments. As a result, the older Korean immigrants generated a considerable amount of distrust towards PHC. The Korean community is relatively small compared to other ethnic communities, and for this reason, it was likely that one person's story was easily spread to others through a word of mouth. In fact, every participant in this study has already heard about the above narratives, which might have increased their distrust in Canadian health care system. In addition, their sense of distrust was also deeply intertwined with their fear of death.

When one feels sick, one would wait two or three months to get things done. During the waiting time, the sick one would die (83 year old female).

When I get a serious illness, my life is at stake and the longer I am sick, the more dangerous my state become....I wish they would take care of things more quickly (66 year old female).

These fears were so strong that they may have resulted in repeated visits or use of other health care services (Leduc & Proulx, 2004). While the majority of participants shared negative experiences, two participants had positive experiences of receiving diagnosis and treatment:

He (family doctor) would exams us well, and uses methods such as the ultrasounds, blood tests, urine tests, stool samples...This is how my family doctor found about my high blood sugar (68 year old female).

He (family doctor) refereed me to a specialist....So I had two tumors taken out. I think it was great that I received a preventive treatment from my family doctor (60 year old male).

From the participants' narratives, they considered the extended waiting time would worsen their conditions. This negative perspective on Canadian PHC system could lead to delay in treatment or the use of emergency services for non-emergency situations.

Unapproachable Specialty Care

Many participants in this study voiced their difficulty in accessing specialty care. There was considerable frustration about in terms of obtaining specialists' care. One of obstacles surely included a long wait time:

We don't get things done quickly these days. A few months ago, my eyes hurt because of diabetes...I thought I would get a surgery soon, but I found out it takes three months. I went to the family doctor who referred me to a specialist and afterwards, they wanted to get an X-ray. So I went to the hospital to get that X-ray, which was taken a month later. I went back to the specialist with all the paper work. It took another month for the paper work to go back to my family doctor (68 year old female).

Not getting treated quickly, not being referred to specialists quickly enough, this is common. If I want to see a specialist and get exams done, the waiting time is a month or two months. That has been difficult (70 year old male).

Another obstacle described by several participants was that some primary care physicians attempted to treat patients on their own without referring them to specialists.

He (family doctor) often does not refer patients to specialists. When the patients ask him to see specialists, he tells them that they do not need one (65 year old male).

My family doctor tells the patients that he would treat them himself. He asks the patients why they would ever need to see specialists. Sometimes, the patients feel threatened by his response (77 year old male).

According to the above findings, the participants had difficulty in accessing PHC, and they faced another difficulty in seeking specialty care. Although anyone can experience this sort of treatment in Canada, the participants in this study have a 'double'

disadvantage in that their language difficulties and unfamiliarity with health care system could impose more difficulties in accessing specialty care.

Working Relationships with PHC Providers

The relationships the participants had with PHC providers appeared to be another important reason for their negative perspectives on PHC. Many of the participants expressed that interpersonal communication with health care providers was very important in order to pursue continuous treatment. Some participants described that they were likely to continue to get health care services when they had a positive relationship with PHC providers. However, they rarely experienced this desired positive relationship. They stated they had many difficulties in communicating with the health care providers. Participants described situations in which their health concerns or symptoms were not taken seriously by family doctors:

Doctors are busy...so sometimes it feels like they are just following rules and they don't give the patients enough time. The patients want to be examined closely, but the doctors look at the charts and say, "it's okay, it's okay" They take your blood pressure and tell you that 'it's okay'. So you guess 'You are okay', but you don't feel completely satisfied (83 year old female).

Sometimes the doctors failed to explain participants' progress of illness, and procedures to the participants' satisfaction:

Even though he (doctor) is very kind, he doesn't explain much. I can see the doctors for a short time, so I can't talk more or I don't feel comfortable talking to them...I only go to see my family doctor if I need medications. The doctor examined me and prescribed some medication but didn't give any explanation or details regarding my illness (70 year old male).

The doctor examined me with his stethoscope very quickly then prescribed medication...that's it. The doctor didn't really speak to me and he didn't explain why I have abdominal pain (65 year old male).

These narratives indicate that communication barrier has a significant impact on the relationship with their doctors. It increases the risk of reduced patient comprehension and compliance, clinical inefficiency, and decreased patient satisfaction (Office of Minority Health, 1999). In addition, one participant felt that his health concerns or symptoms were ignored as his doctor wanted to deal with only one symptom at a time:

I wanted to share a few symptoms in different areas, but he stopped me in the middle of my explanation and told me to explain during my next visit time. So I have to make another appointment to see him... my current family doctor does not explain my illness very well (65 year old male).

This male participant shared that he did not feel comfortable to talk with his doctor because he had difficulties in communicating and viewed his doctor as being unfriendly.

The results of this study reveal that a majority of the participants focused mainly on their relationships with their doctors when describing their experience. They were not aware of health care services by other health care providers such as nurses, pharmacists, physiotherapists, dietitians, etc. However, two of the participants talked about other health care providers: nurses and laboratory technicians. They reported that they did not have any pleasant experiences in dealing with nurses and laboratory technicians as well.

When I went to see a friend of mine in the hospital, I was shocked at the way the nurses speak to my friend because she couldn't understand English well. I think they didn't act that way before... why did they become a nurse? They are not supposed to act that way ...I think it's so different from what I experienced twenty years ago (83 year old female).

One day, I went to laboratory to do the blood test. There was one older Korean lady. The blood collector asked some questions to the lady. The Korean lady stood and smiled and the blood collector ignored the lady. So I tried to help the lady even I couldn't speak English well. I knew the blood collector would send the lady home to bring a translator. Also, I saw older Korean ladies at the X-ray department...it was a shame to see... You know they couldn't understand English at all. The technician asked them not to move, but the older Korean ladies moved as they couldn't understand what the technician asked. The technician couldn't

have a good film...then the technician blames it on the Korean ladies...I have witnessed this many times (65 year old male).

Other participants described their desired in terms of what they are seeking from their family doctors as follows:

When I see him, he always asks, 'how are you?' and then I ask, 'how was the result of blood tests?' He always says, 'it's okay' then my time is up. There should be more conversation or encouragement for patients. I want to hear from him, 'your progress of illness is getting better or don't worry you will be okay with this result etc', but he never says that. There is no sense of conversation in our relationship. They (doctors) should spend more time with their patients to encourage them. For example, 'don't worry you will get better once you eat well or you take medications' Then I would feel much better about my condition. But I don't have a good relationship with my family doctor... (70 year old male).

Sometimes I wish they would tell us things in detail, not just prescribed medication. I don't feel that my family doctor listens very carefully when I describe my symptoms. He is so cold. I don't feel comfortable talking with him at all (83 year old female).

These narratives indicate that having a good relationship with their doctors meant they could receive encouragement and emotional support from their doctors. Other participants similarly expressed that their doctors should be friendly. Many participants stressed the need for "a good relationship with health care providers" that allowed for expressing their symptoms and concerns about health condition. Based on the findings, the participants indicated that their relationship with health care providers was important to ensure continuity of care.

Barriers in Navigating the PHC System

The PHC system in Canada is promoted as a "universal access" system. That is, every person residing in Canada theoretically should have equal access the PHC system. Despite the underlying principle of universality, participants had many obstacles in

navigating health care system for several reasons such as limited communication skills, lack of knowledge of PHC, and limited material resources.

Limited Communication Skills

The language barrier was identified as a major obstacle for all of the participants in this study. As most of participants have had limited English ability, they had difficulty in communicating with their health care providers. In this study, the lack of English ability resulted in being misdiagnosed, getting inappropriate treatment, and misunderstanding symptoms. The participants reported following concerns:

When we discuss matters in detail, we become worried that we may miss something because of our poor English... One day, my husband had abdominal pain, so he went to see his family doctor by himself. The doctor examined my husband and said 'it's okay'. So my husband went home. But that night his pain spread to his lower abdomen. He went to emergency with a pastor who could translate in English. He had a bladder infection (68 year old female).

I knew this person who passed away after a surgery. I think this person had a surgery for his gall bladder, but bleeding would not stop after a surgery. He had a lot of pain before a surgery, so he took many painkillers, like aspirin. And the doctor didn't ask what medication he was taking. And he didn't know that aspirin was causing the bleeding. Anyway, he never came out of the operating room (77 year old male).

Well, the first thing is language. I couldn't speak English well... One time, I thought there was a miscommunication in what I told him and how he understood me (83 year old female).

Language-based miscommunication could increase the need for more service by causing inadequate treatment during initial consultation. Health Canada (2001b) reported that language barriers, which are heavily concentrated among immigrants, restrict PHC access. Some participants reported that they could not explain their symptoms precisely in English and they did not fully understand their progress of illness due to communication barriers.

When I am in pain, I just point but I am unable to explain my condition. I want to be able to explain it precisely, but I can't. So I just say it hurts. But what I wanted to say is that I felt my heart was being gouged out with a knife. I just said it hurts and didn't know how to explain in English...so the language was the first problem (86 year old female).

I don't know about the progress of my illness. If I don't feel good, then my doctor ordered some blood test...And he told me the result of blood test. That's it. I don't know anything else regarding my health (70 year old male).

How would I know what the diagnosis is at that time! I don't fully understand what my doctor told me about my diagnosis. I wouldn't know because I was not informed (82 year old female).

The findings of this study show how the participants could not comprehend what is being said, and could not get answers to their questions. Many participants felt ignored and discouraged by their doctors because of their lack of language ability. This problem of communication barriers may contribute to delayed diagnosis and treatment which will eventually increase the utilization of other health care system. For example, some of these participants started to seek help elsewhere within system such as traditional Korean medicine.

Lack of Knowledge of PHC

The lack of appropriate knowledge regarding PHC is one salient features that limited older Korean immigrants' accessibility to PHC services. In addition to family doctors, PHC includes many of the other resources that are available to immigrants such as clinics, community health centers, and health care resources. These services provide disease prevention education, chronic disease management, pharmacist and dietitian service. However, most of the participants in this study were not familiar with these various resources, and as a result they had difficulty navigating them. Their principal way of accessing to health care was usually the family doctors. However, their family doctors

generally did not refer clients to other community based programs or health care resources for seniors. Some participants reported that they relied on only their family doctors in getting information of PHC system:

The family doctor ordered me to go to different places. That's how I know about health care system (83 year old female).

First of all, I only know about the family doctors and specialists...if family doctors refer me to see a specialist then I go to see... I don't know about any other places where I can get information with managing my illness (70 year old male).

We don't really know about health care information. No one is ever around to tell us these things (60 year old male).

These narratives demonstrate the ineffectiveness in the health care program which is caused by not participants' limited knowledge of PHC, but also by physicians' unawareness of other PHC resources and their limited referral service. The unfairness of primary care physician would result in irregular doctor-client relationship and consequently in more emergency room visits.

My husband always goes straight to the emergency room, even when he's just little bit sick (68 year old female).

I went to emergency several times for the chicken pox. I thought I'd better go to a place (emergency room) that gives me treatment. Those other place (clinic or physician's office) just diagnoses and don't treat (86 year old female).

Many of the participants described how little they knew about various PHC services such as clinics, community health centre and community based programs and health care resources. One female participant who once accessed these resources stated that a majority of Koreans were not aware of such programs or services:

I was lucky that I can take advantage of programs that educated me about diabetes. But many older Koreans don't know anything about that even though they (other older Koreans) have been here for a long time. Even my husband's friends have

paid a lot of money for their diabetic medication because they have not received any education (68 year old female).

As a result, most of participants could not take advantage of free health care services such as educational programs. Benefits such as the ones described above were not accessed by others.

Sometimes I hear that some people get a lot of free medication, but I don't. I spend a lot of money on medication...to be honest (86 year old female).

Other Korean seniors told me some people were receiving diabetic education. So that's when I found out...Ah...there is a program for people with diabetes. But I don't know where I can get that information (77 year old male).

There is yet another example that illustrates people's unawareness of resources. No participant in this study ever heard about the BC nurse line service, or its service in Korean language. Even though the system was in place, it sadly was not drawn upon by those who desperately needed it. The narratives relate to participant's lack of knowledge with PHC and they are not just limited to their unawareness of resources. One participant did not know how to apply for medical service plan. After 5 years' residence in BC, he still does not have a medical service plan.

No one is ever around to tell us these things. I guess it would take too much money to pay for medical service plan now. I was lucky that I haven't been to a hospital since then (60 year old male).

As participants have limited access to Canadian PHC, they tend to seek help from traditional Korean medicine to deal with their illness. Many of the participants used traditional Korean medicine for certain symptoms such as back pain and tonic medicine.

I tried traditional medicine a few times from different places and it was very effective....especially I take that traditional medication when I feel fatigued (86 year old female).

Yes, I have seen the traditional Korean doctors many times as I hurt my back. I often go to see the traditional Korean doctors for my back pain or my injured hand (65 year old male).

One participant described that he consulted with a traditional Korean medicine doctor because he was not satisfied with:

The traditional Korean doctor explained to me anatomy and how that linked to my poor health... He explained very well. I think he was very good, but my family doctor was not like this (70 year old male)

According to the above findings, all of the participants did not report making any connections to health care community resources such as the 24 hours BC nurse line, pharmacist and dietitian services, community nurse, and nurse practitioners. These participants were particularly vulnerable to lack to access to support and the associated negative impact for their health.

Limited Material Resources

This study reveals that older Korean's limited material resources restrict their access to PHC services. Six participants (out of 10) in this study had not experienced paid employment in Canada. Their source of income was predominantly from a government subsidy. The majority of the participants' income is less than \$ 800-1,500 CDN per month. This allows them to not become completely dependent on their children in terms of financial assistance. However, the majority of the participants were economically poor. Studies in the United States suggest that older Korean Americans tried to manage their finances without receiving any financial assistance from their adult children (Kauh, 1999; Kim & Kim, 1992). In this study the participants reported similar situations. However, most of participants did not have a car and potential friends and church members who

could assist with transportation for them to see doctors was limited. Some participants described their inability to pay for service fees such as the ambulance:

My husband said he would call the ambulance, and I told him that I wouldn't go if he did. ...I knew that we have to pay for that service (66 year old female).

As discussed earlier, most of participants have a lack of English ability, and as a result they were in great need of a translation service. However, as this service costs money, some participants could not use it:

I don't think older Koreans can use charge services (private translation service) as they don't have enough money to pay (65 year old male).

I don't want to spend the money, so I endure the pain sometimes even I want to see a doctor (86 year old female).

While these Korean older immigrants have more needs in terms of transportations and interpretation due to their physical constraints and language problems, they did not have much material resource that could help to meet these needs. They could not afford to pay for any private services. This seemed to be another important fact that limits their access to health care services.

Summary

In this chapter, I have presented the findings that emerged from the narratives of ten older Korean immigrants. As unique as each participant's story is, certain commonalities among the narratives emerged which are represented by the following themes: the shifting social positioning of older Koreans within families, perspectives on the PHC system, and barriers to navigating to PHC. The findings reveal that older Korean immigrants have experienced many difficulties in gaining access to appropriate PHC services because of the shifts in their social positioning and other barriers. Such barriers resulted in an inappropriate use of primary care services and reliance on the emergency

department for conditions that could be addressed elsewhere, which contributed to the delay in seeking health care services and lack of continuity in service delivery. Also, the data reveal that although there are a multitude of PHC services in place, those services are not well effective to the needs of older Korean immigrants.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

Introduction

In chapter five, I will discuss the findings presented in chapter four in relation to the published work of other authors. The purpose of this discussion is to situate the findings of this study within the current body of knowledge related to elderly Korean's experience of accessing PHC. The existing literature provided insights into the challenges immigrants face when accessing health care, but did not address the needs of immigrants with very diverse ethnic and cultural backgrounds. Therefore, my primary intent is to explore the experience of accessing PHC from the perspective of older Korean immigrants and how the findings support or refute the current understandings of this experience.

Toward this end, I have identified some key ideas from the study that warrant additional consideration in relation to some of the literature in this area. I have organized these key ideas under the three points: health care providers' limited understanding of older Koreans' lives, shifts in older Koreans' social positioning and its influence on access to health care, and relationships between older Korean clients and health care providers and their influence on health. Within the first point, health care providers' limited understanding of older Koreans' lives, I will discuss the importance of understanding older Koreans' experience in accessing PHC. Secondly, as the shifting older Koreans' social position, I will discuss how older Korean immigrants' social positioning impacts on their access to PHC system. Thirdly, I will discuss how the relationships with health care providers influence on older Koreans' health.

Health Care Providers' Limited Understanding of Older Koreans' Lives

Despite an increasing number of Korean immigrants to Canada, little is known about the lives of older Korean immigrants, specifically the change they experience as a result of immigration. In Canada, while a considerable amount of research has been done on some factors as being determinants of immigrants' health, inclusion of older Korean immigrants in research ranging from population health surveys to clinical trials has not been well documented in health research. Population health surveys also face number of limitations in assessing health access for underserved populations. Most surveys exclude people who cannot communicate in English or French, a group at highest risk for access difficulties (Woloshin, Schwartz, Katz, & Welch, 1997).

For older Koreans immigrating to Canada may experience increased difficulty in meeting their health needs as a result of having English as a second language and having a very different value system and rules of behavior. In this study, the participants who came to Canada in their late age, may have a more difficult time incorporating the language and culture of Canada into their Korean culture. They also experience the lack of the resources and relevant experiences required to legitimize their authority over the young people. The older Koreans in the new society could be disadvantaged in their intergenerational relations because of their declining control over valued resources, with results in decreasing dependence of their children on them. Wong, Yoo and Stewart (2006)'s study with older Chinese and Korean in San Francisco indicated that the older Chinese and Koreans were no longer the center of the family. In this study the participants had similar experiences in that they did not feel as if they were the center of

their family. Thus, the older Korean immigrants in this study may exercise little power, and may be granted less status in the family (Kauh, 1999).

As discussed earlier, the position of an elder in the family is ideally a respected one in the traditional Korean society (Kauh, 1999). The concept of filial piety⁶ is considered very important in East Asian countries and its practice still remains an ideal among most of Korean families in contemporary Korean society. However, the participants in this study seemed to experience less sense of filial piety from their children because of their changed role in family as a result of immigration⁷. This is consistent with recent research findings that show how immigration have affected the roles older Koreans in their families (Kauh, 1999; Wong et al., 2006). Past studies conducted in the United States found that older Koreans' authority over children has weakened, which resulted in children's treating them with less respect and sense of filial piety towards their aged parents (Kauh, 1997; 1999; Yu, Kim, Liu, & Wong, 1993).

As a result, these older Koreans chose to be independent from their adult children. Similarly, the participants in this study expected less filial piety from their children due to their changed role in family. This might have made participants feel less important or valued as an older person in family. They also might have felt the need to be independent from their children. Although most of the participants explained that they preferred to live independently from their children, in fact, their independence might have been their only option. With regards to this study, their independence, or in other words, their lack of involvement of their children has some practical implications. As they begin to modify

⁶ The historic concept of filial piety refers to the notion of respect and care for elderly family members and of family reciprocity: for example, children are obligated to provide for elderly parents (Chappell, 2007).

⁷ Kauh's study (1999) found that traditional lifestyles and values have been altered by the new society during the phases of immigration, so that the uprooted and displaced the older Koreans have lost many meaningful roles in their new host country.

their expectation of support from their adult children (Wong et al., 2006), they tend to establish more relationships with other older Koreans and try seeking help from the Korean community beyond their immediate kin. This tendency also applies to their access to health care services. As they could not gain much assistance with their chronic health condition from their adult children, they were likely to rely on other Korean acquaintances or friends' help. Unfortunately, this help was not always available, which made their chronic health condition management more difficult. This finding suggests health care providers should consider how older Koreans' changed role within the families and the children's changed concept of filial piety affect their access to health care services.

As discussed above, the changed roles of older Korean immigrants and the changed concept of filial piety in family lives have affected their access to health care services. They no longer depend on their children, who could be their linguistic or tangible resource in obtaining needed health care services. With their desire of not becoming a burden to their children, the participants in this study have figured out how to access to health care services by themselves.

This finding is noteworthy considering that the lack of family support among older Korean immigrants is not well recognized by many mainstream health care providers. With two exceptions, all participants in this study had a chronic health conditions such as hypertension, heart disease, diabetes, osteoporosis, and back pain. Their chronic health condition underscores the need for access and information of health care services and resources. The lack of family support indicates that these older Korean immigrants need support when they reach out to health care services. They need a lot of

assistance in understanding Canadian health care system, reaching out to available health care resources, and visiting their doctors. However, the findings suggest that the health care system may not be meeting their needs well. Participants' experiences imply that they do not receive the kind of support or assistance they expected from health care providers. None of the participants have experienced assistance from health care systems in terms of translation or transportation during their visits to doctors. In fact, they do not even know that they could get some help from health care providers. Without knowledge of available resources, the participants encounter a dominant health care system, one which does not recognize their needs and concerns. For example, the participants' contact with the health care system is minimal and lacks continuity of care desirable for managing ongoing health conditions. Moreover, the participants were poorly informed about additional supports and resources such as classes for illness management and activity groups for seniors.

As a result, most participants strived for basic health treatments, rarely getting any additional services related to illness prevention and management. Past studies support this finding that ethnic immigrants use fewer formal health care services including preventative care because of language and transportation barriers and lack of service awareness (Health Canada, 2001; Lee, 2000). While the service may be in place, it has not well mobilized to connect with this certain group of older Korean immigrants. These findings point out the unique needs of older Korean immigrants, the consequences of their changed role in family lives must be recognized by health care providers, and appropriate intervention needs to be developed by health care systems. To overcome this challenge, health care providers will need to be more knowledgeable, understanding, and

sensitive to the needs of older Korean immigrants. Furthermore, health care providers need to steer away from stereotypes of Asian minority preferences for family care only (Wallace, Levy-Storms, Kington, & Andersen, 1998). A better understanding of the needs of older Korean immigrants may be gained by understanding the individual's family life such as social/family network and the individual's role in the family.

Shifts in Older Koreans' Social Positioning and its Influence on Access to Health Care

Older Koreans' social positioning influences ways of accessing PHC since it explains how social isolation intersects with the process of aging to increase the isolation of those people who do not benefit from the support of kin or members of their families. In this section, I explore how social positioning of older Korean immigrants impacts their access to PHC system. The provision of health care to older Korean immigrants must be critically analyzed with a view to understanding older Korean immigrants' unique social and economic positions. The stories of participants in this study demonstrate the impact their particular social status has influenced the quality of health care services they have received.

As introduced in the preceding chapter, the social isolation of older Korean immigrants constrains their ability to access health care services and resources. The results suggest that these older Koreans' social isolation brought about their lack of understanding of PHC services and resources available to manage their health condition. As shown in the narratives, while there are many kinds of PHC services such as 24 hours BC nurse line, pharmacist and dietitian services, and nurse practitioners, the

participants in this study did not even know the availability of these services⁸. They considered physicians as the only health care providers and accessed only physicians. Furthermore, most of participants were poorly informed about programs or resources offered by community health centers. Surprisingly, many participants in this study did not even know about existence of community health centre. As a result, it is significant to understand what factors attribute to the isolated social position of Korean immigrants. How can their social isolation be explained and how does it attribute to the limited access to health care services?

The findings of this study indicate the impact of older Koreans' social isolation and lack of access to health care services is further compounded by their low socio-economic status which has an impact on their health and their access to PHC. Many participants in this study may not be in control of important material resources and they have few financial resources. More surprising is the fact that a vast majority of the participants were economically poor. Some participants in the study stated that they could not afford to pay for services such as private interpreter services, and transportation (i.e., taxi) services which eventually could jeopardize their health conditions. They also seemed to manage their affairs without receiving any financial assistance from their adult children. Yet, despite most of the participants reporting that they can barely survive on their income, they expressed gratitude towards the Canada government for its generosity. According to the Canada Health Act, every person residing in Canada should have equal access to the PHC system. Behind the principle of universality, social inequities still

⁸ As another example of evidence, I recall my workshop conducted in Korean seniors association as an effort to engage in Korean seniors, I once held a workshop for them with the topic of "heart disease prevention". Approximately 40 older Koreans participated in the workshop. No one knew about BC nurse line services (which is provided in Korean language) and they were poorly informed about PHC services and resources as well.

pertain to the people of lower economic status, and more obstacles exist in terms of their accessibility to health care services. Based on the findings in this study, older Korean immigrants may experience more negative effects on their health condition due not only social factors such as loss of social status and social isolation but also because they are of limited means. The narratives of participants in this study suggested that health care services and programs that perpetuate health and social inequities must be addressed.

Other sources of older Korean immigrant's isolated social position were related to their lack of English ability and lack of Korean community organizations. The findings of this study is consistent with the city of Vancouver report (2000), which was conducted as a special project to identify the Korean community's needs, the isolation of many older Koreans and their lack of access to the mainstream service organizations are significant issues among Korean community. Similar to the findings of this study, the report indicates that the isolation of the older Korean immigrants is due to their inability to speak English and the lack of Korean community based organizations.

As the findings in this study indicate, the participants' primary sources of social connections were other older Koreans who they met through their housing (apartment) and people they met at their churches. A study in the United States supports this finding that older Koreans may find more difficult to expand their social support that could lead to social isolation (Wong, Yoo, & Stewart, 2007). A considerable body of research has demonstrated the importance of ethno-cultural community based organizations as key resources in assisting immigrants to gain knowledge of their community and build connections. The churches could provide some services such as interpretation and transportation, but they are not generally comprehensive enough in their resources to

connect mainstream health care services. The narratives of participants echoed the importance of ethno-cultural community service or programs, which can provide older Korean ethnic groups with comprehensive and appropriate services in terms of their access to health care system.

The need for universal services to be enhanced or complemented by ethno-specific community services, is related to the language issue. Participants' experiences in this study indicate that their lack of fluency in English made them feel more isolated. As a way to overcome this language barrier, some participants relied on their informal networks such as churches or friends. However, social isolation still remains an issue for older Koreans. Even for those who could gain assistance with interpretation from their church or friends, help for day to day activities was not always available. As a consequence these older Korean immigrants are left alone most of time to navigate their day to day lives and the broader community.

There are several government funded cross cultural community agencies or programs in Vancouver such as MOSAIC (multilingual non-profit organization) and Immigrant services society of BC (ISS of BC). As a part of their settlement service, these organizations provide interpretation services when immigrants visit hospitals. However, most of the participants were not aware of the availability of this service as some stated that; "sometimes, I can't go to doctor's office by myself because I cannot understand English, so I just bear symptoms until it struck", or that "I just try to deal with the circumstances by myself". These narratives point out that cross-cultural community services are not well known to Korean community and that they are not mobilized by the health care professionals in the community. There is therefore a need

to build connections between these cross-cultural community programs and Korean immigrants.

One way to build the connection between cross-cultural community services and Korean immigrants could include the development of Korean ethnic community service programs. Even though some cross-cultural community services provide Korean services, their services for Korean groups are very limited, which could be one important reason why their services are not really well known to the Korean public. The results of this study suggest that limited resources and lack of support from Korean ethnic community organizations was one of the factors that contribute to older Korean's isolated position.

The findings of this study are consistent with Kawk's (2004) study on Korean immigrants in Vancouver, which indicates that the Korean community organizations have been too weak to respond to the various needs of Korean immigrants such as housing and settlement services. An update report on seniors housing by Hwang (2007) indicates that Korean seniors in British Columbia are underserved and lack of a full range of options. However, this present study suggests that the lack of Korean ethnic services is not limited to the issue of housing or general settlement services only. The lack of service is also present in the health care field. For instance, one female participant in this study who had her heart attack last year, could not walk by herself and she felt dizzy all the times after having a heart attack. Although she was eligible for assisted living service, she was not aware of the service as no one informed her of the availability of such services. She still lives an apartment (government-subsidized housing) by herself, not knowing how to receive such service options such as assistance with house cleaning and meal preparation.

Another example, is that one participant has not enrolled in the Medical Service Plan as he did not know how to apply for it upon his immigration to Canada. He stated that, “no one was around to tell us”. These examples suggest the need for Korean community organizations or organizations with a mandate to provide services to all immigrants must enhance the resources available to assist the older Koreans population. In both cases, a Korean community organization could play a vital role in connecting them to available mainstream services. One participant of this study touched upon this point stating, “well, there are available services in Chinese, but not Korean”. Korean community organization should advocate for the Korean community, and especially for older Koreans with their needs of Korean services. When these services become available and well known to Korean community, Korean elder immigrants could engage in mainstream health care services more effectively.

The Multiculturalism Act specifies that all Canadians must have equal access to their economic, social, cultural, and political entitlements (Multiculturalism and Citizenship Canada, 1990, p.1). For the health care system, this Act means ensuring equal access to health care services for all Canadians, regardless of their cultural identity. How equal is access to PHC, if older Koreans’ health and social needs are simply not considered? The findings of this study challenges the formal health care system to develop culturally safe interventions by health care providers.

As this study has shown, the participants do not receive the full range of health care resources from their health care providers. Such resources as health promotion and illness prevention programs are not accessible to them. This may be associated in part with the older Korean’s lack of familiarity with the range of services that are available

(Health Canada, 2001). Thus, it is important that health care providers should connect immigrants to these services by referring their immigrant clients to appropriate services or by working in liaison with the services. In other words, health care providers could work as advocates for older Koreans by informing the availability of programs and helping them to be benefited from the services. In order to do this, health care providers need to actively engage with Korean communities, especially the Korean senior association. They should consider the unique needs of older Korean immigrants and emphasize on the benefits of proactive prevention and health promotion activities for older Korean immigrants. In doing so, health care providers could actively reach out to Korean media such as Korean radio station, newspaper, Korean television and help the Korean public become aware of both the value and the availability of PHC services. Also, they should increase the availability of health care services by locating their service centers in the area where older Koreans could easily access to. In addition, they need to contact and work with Korean religious, commercial and social service groups in order to identify the need of older Koreans. To summarize, there is an urgent need for health care providers to be aware of social position of older Korean immigrants and to meet their unique needs related to their social isolation.

Relationships between Older Korean Clients and Health Care Providers and their Influence on Health

Several participants in this study described that their perceived distance with health care providers is one of the barriers to access to health care services. The narratives showed that most of participants experienced frustration and difficulty when they approached their health care providers. Thus, in understanding the needs of older

Korean immigrants, it is important to understand the source of their perceived distance towards their health care providers.

According to research studies (Chugh, Dillmann, Kurtz, Lockyer & Parboosingh, 1993; Reimer Kirkham, 2000), one of the barriers in building trusting relationship between mainstream health care providers and immigrants is deeply related to cultural differences. These research studies assume that mainstream health care providers are usually not sensitive enough to their clients' native culture, which brings about immigrants' a sense of distance towards the mainstream health care services. The findings of this study call for more attention to the issue of cultural difference in the context of provider-client relationship.

The findings of this study suggest that, among various cultural differences, difference in communication style is a key obstacle for older Korean population to build trusting relationship with their health care providers and to manage their health condition. The result is consistent with past findings that good client-provider communication has been shown to have lasting effective over time and directly to improve health outcome (Simpson, Buckman, & Steward, 1991; Stewart, 1995). While a number of studies have documented the language barrier problem faced by immigrants (F. Ahmad, Shik, Vanza, Cheung, George, & Stewart, 2004; Choudhry, 1998; Elliott, Berman, & Kim, 2002; Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Matuk, 1996; Sohn & Harada, 2004), few studies have explored the issue of different communication styles between health care providers and their immigrant clients. The participants in the study felt that their communication style was different from their health care providers; while they felt it important or necessary to share their emotions or concerns about their health symptoms

and conditions with health care providers, they felt that such needs of theirs were ignored by their health care providers. This created a problem in their building continual relationships with health care providers. Only when they were able to share such concerns and express their emotions freely, they were likely to receive continual care from their health care providers. Yet, the participants of this study were dissatisfied and frustrated in their relationships with health care providers, particularly about the doctor's uncaring nature, poor listening skills, lack of explanation, and limited time for visits. They also discussed their English difficulties in communicating with doctors, which may partially explain their dissatisfaction. A study support this finding that patient satisfaction is well-recognized and widely uses measure of the effectiveness of provider-client communication (Bowen, 2001). It is not difficult assume that when older Koreans experience such problem, they would avoid receiving continual care from the same health care providers, which eventually cause more limitation in relationship investment between the participants and health care providers.

From the cultural safety point of view, older Korean immigrants must feel safe in their relationship with the health care providers. The concept of cultural safety requires health care providers to recognize and respect the cultural identity of individuals. Also, it enables older Korean immigrants with the power to define their own safety. However, the participants' narratives indicate that their health care providers did not exhibit enough cultural safety to their Korean clients and that the older Korean immigrants did not possess any power to claim their safety. This study calls for health care providers to recognize and show respect for the expectation of older Korean clients in terms of communication style. Viewing health care encounters through the lens of cultural safety

would lead health care providers to examine how elderly Koreans are affected by the dominant communication culture. With this view, health care providers will be asked to examine how they manage their attitude and social-cultural positions to their older Korean immigrant clients (Ramsden, 2000). Health care providers must be able to think critically about how this Korean group is disadvantaged by a certain communication culture prevalent in health care system. Then, health care providers may make efforts to promote culturally safe environment for Korean immigrant clients. This may include their patience towards Korean clients' different communication style as well as their limited English ability. Several participants in the study described that their experience of health care providers was unfriendly. These participants described that the outcome of their interaction with health care providers could have been different if the approach of the health care providers had been more patient and sensitive to the fact that they spoke little or no English. Thus, the findings of this study suggest that the needs of older Korean immigrants would have been fulfilled if their working relationships with their health care provider were improved.

Summary

In this Chapter, I have identified some common threads running through participants' narratives and discussed them in relation to the existing body of empirical literature on elderly Korean's experiences of accessing PHC. The findings of this study, however, must be interpreted with caution, since sample size is small and may not be representative. Particularly, this study is limited by older Korean immigrants who mainly could speak Korean. The lack of understanding elderly Korean's experience of access health implies the fact that health care providers do not sufficiently recognize the needs

of their older Korean immigrant clients in relation to their changed role in family. The issue of social position intersects with lack of family support, lack of English ability, lack of Korean community organizations, and low economic status. The participants' accounts witness that their isolated social position influences their access to PHC services. In summary, this study indicates that while the health care system is in place, it has not succeeded in connecting with this certain group of older Korean immigrants. This evidence stresses the continued need to address these obstacles in order to fulfill the needs of older Koreans in regards to the health services. The needs of older Koreans must be better recognized by health care providers and more appropriate intervention needs to be developed by health care system. Thus, in the next final chapter, I will consider what implications can be drawn from this study with respect to nursing practice, research, and education.

CHAPTER SIX

SUMMARY, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSION

Introduction

The main research question guiding this study was to understand the experience of older Korean immigrants' access to PHC and to explore the issues that might impinge on older Korean immigrants' access to PHC services. The first half of the chapter provides summary of this study and in the second half of the chapter, I suggest the implications that can be drawn from the preceding analysis. I then turn to recommendations arising from this study. I consider now how nursing and other health discipline might be better positioned to develop critical consciousness that issues of access health care services from perspective of certain group of older Korean immigrants.

Summary

I designed this study to explore the issues related to PHC access by older Korean immigrants. My interest in this subject arose from experiences in my own nursing career and as a Korean woman working within the health care system. As a nurse in Vancouver, I work with culturally diverse clients, and also with the elderly population. The current body of knowledge provided insight into the challenges immigrants face when accessing health care services.

I chose interpretive description as articulated by Thorne and colleagues (1997, 2004) as the research methodology because it was appropriate to answering the research question, "what are the experiences of older Korean immigrants in accessing primary care services?" This approach directs development of a description of an individual's

perception of an experience and an interpretation of the experience to uncover meaning and contribute to nursing knowledge. Further, these individual experiences are examined to identify what persons in similar positions share and what is particular to the lived experience of each individual.

I reviewed the current body of literature to provide myself with a familiarity with the existing knowledge on challenges immigrants face when accessing health care services. Literature from a wide range of discipline including nursing, medicine, social work, psychology, gerontology were reviewed. The literature review informed the study by assisting the construction of the findings, and establishing links to existing knowledge.

The data were collected by means of in-depth semi-structured interviews with a total of ten participants. Interviews were digital recorded and transcribed verbatim in Korean. There were subsequently translated into English. Data analysis occurred concurrently with data gathering, using a process of inductive analysis. The findings informed and guided the data collection and analysis process and enabled the construction of the interpretive description.

The narratives revealed three dominant themes describing the older Korean immigrants' experience of access PHC. These were the shifting social positioning of older Koreans within families, perspectives on the PHC system, and barriers in navigating the PHC system. I discussed the findings of this study in relation to the existing body of empirical knowledge. The findings of this study generally support the view that older Koreans have a number of difficulties accessing PHC. However, certain findings of this current study indicate the need for further exploration, and suggested implications to practice, research, and education.

Implications

The findings of this study have implications for nursing practice, research and education. Although the findings from a small study such as this one cannot be generalized, when considered the context of the existing body of research related to cultural safety and nursing practice, they may provide some insights as nurses encounter the critical challenges of caring in a multicultural world.

Implications for Practice

The findings of this study suggest that the key issue for nursing practice is to develop culturally safe nursing interventions. The concept of cultural safety becomes the salient point to address and implement in their practice setting where nurse encounter people coming from a large array of ethnocultural backgrounds. Cultural safety as an analytical lens can help to examine culturalist assumptions that mistakenly reduce inequity to ethnocentrism and cultural differences (Culley, 1996). Cultural safety would prompt nurses to question their assumptions about ethnic immigrants to locate elderly persons' health concerns within a structural context, and to understand their connection with broader societal issues.

Findings from this study also highlight the problems that can arise when narrow understanding of culturalist discourse are applied to particular patient can provide a social and historically informed lens for viewing our current practices. Specifically, cultural safety would require nurses to examine their interactions with different ethnocultural groups, and consider these as being continually reinterpreted and renegotiated in relation to broader socio-political forces (Reimer Kirkham, Smye, Tang, Anderson, Bule, &

Browne et al., 2002). All of the existing definitions of cultural safety suggest that ethnocultural groups must feel safe in their relationship with nurses and other health care providers. They also compel practitioners to work to ensure clients feel safe. Nurses, from this perspective, are as much 'with culture' as are immigrants, and both groups bring their cultural perspectives into their interactions. For this reason, cultural safety requires nurses to reflect on their own attitudes towards immigrants and to consider the sociopolitical reality of immigrants' lives, and social, political, and historical influences on their interactions. Moreover, cultural safety encourages the equalization of provider-user power relations and the establishment of trust.

Based on the results of the study, directions for nursing practice are delineated. Community nurses need to develop methods or tools to screen at-risk seniors among ethnic immigrants. Specifically, I urge community nurses to be aware of the risks immigrants who are at risk for losing their social position, may be living in poverty and may be isolated and therefore at risk for developing or exacerbating health problems. In the study, the impact of isolation was documented. Evaluation of immigrants' social support networks must be carefully examined since the assumption that family support is available to elderly Korean immigrants was challenged. Instead the study revealed the extent and nature of social isolation they experienced and its impact on health. Moreover, their social isolation was further compounded when health care providers overlooked their needs for support or when they allowed their decisions to be influenced by founded assumptions or processes of 'Othering'.

Nurses can increase access to care and facilitate appropriate use of health resources by providing outreach and by working to establish cultural linkages between

communities and health care delivery systems such as providing health education, health screening. Such efforts can contribute to an increased in the quality of care. Nurses also should connect immigrants to community based available services by referring their older Korean immigrant clients to appropriate services or by working in liaison with the services.

Implications for Research

The insights from this study, while interesting, cannot be considered representative of older Korean immigrants because of limitations of sample size. It is not the intention in a study of this nature to generalize to the broader population of Korean immigrants, it is rather, to offer insights on their experiences that may prompt practitioners to reflect upon their approaches to practice. As well however, linkages with the existing literature indicate that there are some insights within this study that are supported by others' research and that warrant further investigation. As I perused the literature for this study it became obvious that there was little Canadian literature in this area, with the majority of the literature having been generated in the U.S. Canadian society is considered to be unique in its multicultural context and different from American culture. For these reasons it seems to be imperative to conduct more research on PHC with older Korean immigrants located within a Canadian context.

Despite its limitations, this study has provided some insights to directions for research. First, this study points to further explore the relationships between Korean adult children with aging parents. It also points to further explore the impact of immigration on older Koreans' health and older Koreans' cultural belief on health and illness. Second, I suggest conducting research with nurses and other health care providers. In this study,

nurses and other health care providers were not interviewed since the study aims were directed at understanding older Korean immigrants' perspectives on accessing PHC. These will be promising areas for future investigation and inquiry as we attempt to increase the effectiveness of the nursing practice for population with increasingly diverse backgrounds. Furthermore, nursing cultural research must be redefined to document issues of accessing PHC that affect the health of elderly immigrants. Cultural research must be advanced in adopting new paradigms of inquiry of addressing health and social inequities of the health care system in Canada. Another important area of research is how to enable older Korean immigrants to better use the health care system. For example, conducting participant observation as to where the gaps are in navigating the system would be good.

Implications for Education

Based on the results of the study, nurses and other health care providers must be educated the concept of cultural safety. Therefore, educational institutions must emphasize the concept of cultural safety in their curricula to ensure that future nurses are knowledgeable about the concept. Health care settings, in the mean time, need to provider educational workshops for current nurses and inform them about this principle. Also training experiences should be sought out and provided to staff in health care settings in order to develop a better understanding and effectiveness when working with culturally diverse populations.

The line of analysis offered by cultural safety differs significantly from the 'culturalist' approaches typically taken in health care and nursing education, which are geared to providing nurses and other health care providers with more ethnic-specific

information. There is a need to provide education and support to professionals so that they are better positioned to work with different populations. As the analysis here demonstrates even if practitioners had cultural specific knowledge the barriers to access would not be overcome unless they adopt a perspective that challenges them to consider the client's social context and his or her circumstances as they assess, plan, and provide care.

Recommendations

This research brings insights to provide understanding of older Korean immigrants' issues to access PHC services. The findings suggest designing strategies to enhance older Korean immigrants' accessibility to PHC services. Based on the outcomes of this study, the following recommendations have been formulated. These are suggested to redirect PHC system to support older Korean immigrants.

1. These results suggest that, all older Korean immigrants do not have the benefit of extended family support and are socially isolated. Therefore practitioners must assess the supports and resources available to individual clients.
2. Programs that are funded and mandated to provide services for all immigrant groups should be challenged to ensure that there are appropriate programs for older Korean immigrants and that these programs are made accessible to them.
3. The Korean Canadian community should be assisted to develop services for older Korean immigrants. The provincial government and local community organizations could sponsor initiatives to assist the Korean Canadian community in developing health care support resources such as volunteering, interpreter services, and home care support. To this end, the provincial

government perhaps with assistance from federal funding, could consult Korean Canadian religious and community leaders to determine the Korean Canadian community needs.

4. There is a need to develop health resources in Korean related to prevention and health promotion for older Korean immigrants. For example, translating existing education materials, developing resources specific to the Korean community would help to bridge the gap in access to information that currently exists.
5. Community health programs could target programs aimed at encouraging the participation of older Koreans in the community health programs. For example, an elderly Korean support group could serve both as an avenue for social contact but also provide necessary information about programs, resources and health information. Such an initiative could increase the accessibility to services by older Koreans who do not speak English. It would also promote the notion of equality, or the rights for older Korean immigrants to be treated as equals, with regards to other Canadian cultural communities.
6. Increasing the number of Korean interpreters and staff in the community health centers located neighborhoods where older Korean immigrants live must be considered for reaching the Korean elders that could not access other health care services beside family doctors.
7. Health care providers can be advocates for the older Koreans to ensure that appropriate services are available to meet their needs (informing the availability of programs and ensuring them to be benefited from the services).

Conclusion

Through this study, I have come to conclude that the issue of access to PHC from perspective of older Korean immigrants cannot be studied outside of the social, cultural, economic context within which it unfolds. Despite the cultural diversity of Canada, there is very little research focusing on the health needs of elderly immigrants, and there is even less research on the elderly Asian senior population (Matsuoka, 1993). This study draws attention to the health of elderly Korean immigrants as an issue of inequitable access to health care programs and services. As such it is an issue of social injustice. If viewed in this way social justice could be used to inform the development of programs to assist the elderly immigrants access PHC. Moreover, this study offers insights that may assist health care providers to understand the nature of the older Korean immigrants' lives, and the processes of seeking and resolving issues related to PHC. The analysis proposes a number of interventions that respect the older Korean immigrants' values and interventions that may improve their access to PHC. This exploratory study provides preliminary direction to health care providers as they provide care that respects and supports older Korean immigrants. Thus, health care providers need to gain more information and insights about various immigrants group include older Korean immigrants. This is especially important in the Canadian context as the number of older immigrant from a variety of cultural, ethnic, and religious back grounds continues to grow.

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APPENDIX: A

Participant Information Letter

Letter of information for a study to examine
Older Korean Immigrants' perspective on accessing primary health care services
Researcher: Yu Jin Lim BSN, RN.
MSN student, UBC School of Nursing
Supervisor: Judith Lynam Ph.D, RN
Associate Professor, UBC School of Nursing

I am undertaking a study of older Korean immigrants' perspectives on accessing primary health care and am looking for volunteer participants.

I am a nurse with a background in adult medical-surgical nursing with an interest in cross-cultural nursing. I am currently enrolled in the UBC School of Nursing master program to work under Dr. Judith Lynam's supervision.

I am conducting a study to learn about older Korean immigrants' perspectives on accessing primary health care. As part of my study, I wish to interview older Korean immigrants about their experience in accessing primary health care. Interviews will be scheduled at a time and place that is both comfortable and convenient for you.

I anticipate that the results of the study will help us to understand the nature of the challenges and issues older Korean immigrants may face when seeking health care and how they resolve them. Insights from the study will be drawn upon by the researcher to propose interventions that will respect the older Korean immigrants' values and improve their access to primary health care.

As a Korean woman living and working in Canada, I am aware of the need to consider individuals' historical, social, and cultural backgrounds while carrying out this study. Issues and concerns raised by study participants will be treated with respect.

If you volunteer you will be invited to participate in two interviews. Each interview will last 45 to 60 minutes. The interviews will be tape recorded.

Any participation in this study is voluntary and will in no way affect the individual's future access to services. Furthermore, participants are free to withdraw from the study at any time, are free to refuse to answer any questions, can ask for any taped information to be erased, and can ask for sensitive information not be disclosed.

Participants names will not appear in any materials and interview materials (tapes and their transcriptions) will not be made available to any institutions. Interview materials will be kept secure in a locked filing cabinet with only myself as the researcher having access. Interview materials will be used for purpose of the thesis research, future publications and presentations and possible.

If you wish to obtain further information about the study or wish to volunteer to participate by being interviewed, please call Yujin Lim at.

Yu Jin Lim

Thank you for your attention

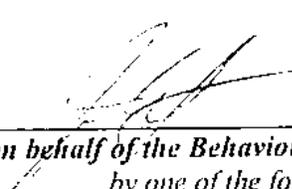
APPENDIX: B

Behavioural Research Ethics Approval, UBC



The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

<small>PRINCIPAL INVESTIGATOR</small> Lynam, M.J.	<small>DEPARTMENT</small> Nursing	<small>NUMBER</small> B06-0400
<small>INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT</small> UBC Campus .		
<small>CO-INVESTIGATORS</small> Browne, Annette, Nursing; Lim, Yu Jin, Nursing; Wong, Sabrina, Nursing		
<small>SPONSORING AGENCIES</small>		
<small>TITLE</small> An Investigation of Older Korean Immigrants' Perspectives on Accessing Primary Care Services		
<small>APPROVAL DATE</small> AUG 16 2006	<small>TERM (YEARS)</small> 1	<small>DOCUMENTS INCLUDED IN THIS APPROVAL</small> Aug. 8, 2006, Consent form / May 1, 2006. Advertisement / Contact letter / Questionnaires
<small>CERTIFICATION</small> <p style="text-align: center;">The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.</p> <div style="text-align: center; margin-top: 20px;">  <hr style="width: 80%; margin: 0 auto;"/> <p><i>Approved on behalf of the Behavioural Research Ethics Board</i> by one of the following: Dr. Peter Suedfeld, Chair. Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair</p> </div> <p style="text-align: center; margin-top: 20px;">This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures</p>		

APPENDIX: C

Participant Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA



School of Nursing

T201- 2211 Wesbrook Mall
 Vancouver, B.C. Canada V6T
 2B5
 Tel: (604) 822-7417
 Fax: (604) 822-746

Consent Form

A Master of Science in Nursing thesis research study on:
 Older Korean Immigrants' perspectives on accessing
 primary health care services

Principal Investigator: Dr. Judith Lynam
 Associate Professor and Co-Director
 Culture, Gender & Health Research Unit
 School of Nursing, University of British
 Columbia
 Telephone:
 E-mail address:

Co-Investigator: Yu Jin Lim
 Master of Science in Nursing Student
 School of Nursing, University of British
 Columbia
 Telephone:
 E-mail address:

Purpose:

The purpose of this study is to explore the issues related to primary health care access by older Korean immigrants. We are interested in knowing how to ensure primary health care is accessible. This is being undertaken to complete the requirements for a Master of Science degree in Nursing.

Study Procedures:

I would like to talk with you on one or two occasion about your experience of accessing primary health care. During these interviews a type of question I would like ask is: could you give me an example of a time when you were not feeling well and wanted to get treatment. We will then discuss where you went and why you decided to go to this

particular place for treatment or advice. We will also discuss how you learned about the particular service.

- The interviews will be conducted in either Korean or English whichever you prefer
- Each interview will likely last no more than 1-hour
- The interviews will be arranged at a time and place that is convenient for you
- The interviews will be tape recorded and I may also make some written notes about our interview
- A typist will listen to the interview tapes and type out what has been said in Korean. The typist will not know who you are.
- I will then analyse these typed interviews. During second interview you will have an opportunity to comment on the initial analysis. Any comments you may have regarding the analysis will be recorded and considered in subsequent analysis.
- You will have the opportunity to ask questions or raise any concerns at any time throughout the study.
- You may withdraw from the study at any time for any reason without affecting your future access to primary health care.

On completion of the study, you will be given a written summary of the study findings in Korean if you wish.

Potential Risks/Benefits for Participants

There are no risks associated with participating in the study. As a participant, you may not directly benefit from the being involved with this study. It is hoped, however, that by sharing your insights and experiences you will increase your understanding of accessing primary health care services.

Confidentiality:

- At the beginning of the first interview, I will identify you as participant #1, #2, etc., as a means of ensuring confidentiality and privacy. All references to you in the study will be made according to your assigned participant number.
- Tape recordings of interviews and all documents (transcripts, computer files) associated with the study will be kept in a locked filing cabinet and identified by a code number.
- At no time will any information, which identifies you, be made available to anyone other than as required by law.

Excerpts from our interviews that do not identify you, may be used as examples when writing the thesis or when developing paper presentations for professional or educational purposes.

Contact for Information about the Study:

If you have any questions or desire further information with respect to this study, please feel free to contact principal investigator, Dr. Lynam at or co-investigator, Yu Jin Lim at

Contact for Information about the Rights of Research Subjects:

If you have any concerns about your treatment or rights as a researcher participant, please feel free to contact the Research Subject Information Line in the UBC Office of Research Services at 604 822-8598.

Consent:

Your participant in the study is entirely voluntary and you may refuse to participate, or withdraw from the study at any time without prejudice or jeopardy to your future access to primary health care services. You may also decline to answer any questions at any time. All of your rights remain protected during this research process.

Your signature below indicates that you consent to participate in this study and that you have received a copy of the consent form for your records.

Participant Signature

Participant Name (printed)

Date

Or:

This consent letter has been read by the investigator, questions invited and the verbal consenting process has been audio taped. A copy of the consent form has been given to the participant.

Investigator Signature: _____

On occasion researchers undertake follow-up studies. It is therefore useful to know if people are interested in hearing about other research studies. If you are interested in being contacted for potential participation in research at a future date please provide your name and contact information below.

Yes, you may contact me at a future date about participation in other research studies.

Name: _____

Mailing Address: _____

Telephone # _____

APPENDIX: D

Interview Guide

Sample Interview Questions

These interview questions are ‘trigger questions’ that I will use to explore the topics of interest. These questions will be followed up with more specific clarifying questions depending on how people respond.

1. Could you tell me about a time when you were not feeling well and describe what you did?
 - What steps did you take to get assistance in managing your illness?
 - Who did you involve in your decisions? (eg. family, friends, went directly to a health care professional).
 - How was this situation resolved?
 - Did you get the assistance you needed?
 - Is this experience typical for you? (Here I am interested in exploring the range of resources a particular person draws upon)
2. How have you learned about the Canadian health care system?
 - What similarities and differences do you observe from health care in Korea?
3. Have you faced any barriers and good experience in seeking health care since you have been in Canada?
 - If so, what are they?
 - What have you done to overcome these barriers?
4. Could you tell me about your experience when you want to get treatment?
5. Do you have regular health care providers?
6. Tell me about how did you learn about the particular services (not diagnostic)?
7. Do you use any private health care services in addition to those of the Medical Services Plan?
8. If you could give advice to health care professionals about how to best care for you, what would you tell them?
9. Is there anything that you would like to comment on or ask for me?

APPENDIX: E

Participant Demographic Questionnaires

Demographic Data

Participant # _____

Name _____

Date of Birth: _____

Gender: _____

Marital Status: _____

Place of Birth: _____

Ethnic Background _____

Language: _____

First Language Spoken at Home: _____

Currently Living in: _____

Length of Time in BC; Canada _____

Formal Education: _____

Previous or Current Employment (income) _____ \

How many children _____

Chronic Health Condition _____