

Health-seeking beliefs of cardiovascular patients: A qualitative study

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Abstract

Objectives: The study aims were to (a) describe the experiences of Chinese Australians with heart disease following discharge from hospital for an acute cardiac event; (b) identify patterns and cultural differences of Chinese Australians following discharge from hospital; and (c) illustrate the illness/health seeking behaviors and health beliefs of Chinese Australians

Design: Qualitative study

Methods: Interview data were obtained from the following sources: (a) focus groups of Chinese community participants without heart disease; (b) interviews with patients recently discharged from hospital following an admission for an acute cardiac event; and (c) interviews with Chinese-born health professionals working in Australia. Qualitative thematic analysis was undertaken.

Results: Study themes generated from the data were: (1) linking traditional values and beliefs with Western medicine; (2) reverence for health professionals and family; (3) juxtaposing traditional beliefs and self-management.

Conclusions: Considering the influence of cultural values in developing health care plans and clinical decision making is important.

Key words: Chinese Australians, health-seeking behaviors, cardiovascular disease

What is already known about the topic?

- Cardiovascular disease (CVD) is Australia's largest health problem in terms of both mortality and economic burden and it is the leading cause of death globally.
- Culture can influence perceptions of illness and health, particularly in relation to cardiovascular disease where lifestyle is a large contributor to its etiology and progression.
- Understanding cultural backgrounds is therefore imperative to improving health service provision, both in Australia and globally.

What this paper adds?

- Description of the ways in which cultural values, including a strong emphasis on collectivism and the importance of family and tradition, impact on Chinese Australians' experiences of heart disease
- Emphasis of the need for the appreciation of individuals' values, beliefs and behaviours in tailoring models of health care delivery.
- Importance of considering the influence of traditional values, attitudes and beliefs on health seeking behaviours, particular the use of Traditional Chinese Medicine.

Introduction

Cardiovascular disease (CVD) is a global health problem (Yusuf et.al. 2001). Cultural backgrounds can influence perceptions of both illness and health. This is particularly to the case in CVD where lifestyle is a large contributor to the aetiology and progression of disease (Yusuf et.al, 2001). Australia is the second most ethnically diverse nation in the world with the population comprising people from over 200 countries (Australian Institute of Health and Welfare, 2004, Davidson et al., 2003). One fifth of Australians are born overseas and many of these are from non-English speaking countries. Strict health requirements in Australia for immigration mean that the health of migrants is often superior to the Australian-born population. As the length of time living in Australia increases, the health advantage that migrants have over Australian-born people aligns with that of the general population (Young, 1992). This convergence may become more apparent in future decades as many migrants from the 1950s and 1960s become at a greater risk of ill health (Australian Institute of Health and Welfare, 2004). Increasing rates of chronic conditions and the need for self-management means that health interventions need to be culturally sensitive and appropriate, providing services that are acceptable to people who are not from the dominant culture (Davidson et al., 2004).

These patterns of cultural diversity are not confined to Australia. Internationally, countries such as the United Kingdom, United States (US) and Canada have similar patterns of cultural and societal pluralism and a need to target and tailor health care that is relevant to migrant populations. Potentially people who are not from the dominant

cultural group may be at a greater risk of poor health outcomes, particularly due to misunderstandings surrounding medication usage and not accessing health services (Bolton et al., 2002). There are diverse and complex reasons why migrants are less likely to use health services (Kliwer and Jones, 1997). Language and cultural factors commonly limit access to available health services (Hua et al., 2002). The association between low literacy and limited access suggests a need for improving knowledge of the health care system and accessible materials in migrant communities (Hua et al., 2002, Lipson and Steiger, 1996). Globally, it is important to consider that communities are rarely homogenous in their values, attitudes and beliefs (Chua and Yu, 2001). Chinese Australians also represent a range of cultural perspectives and as a consequence their cultural views are not always unified. However, culture commonly creates a backdrop against which an individual forges their own identity and is an important consideration in health care planning, delivery and evaluation.

Chinese Australians and the use of health services

Census data indicate that Chinese Australian migrants have lower levels of English proficiency compared with other groups (Rissel and Winchester, 1998). Although nearly two decades old, a National Health Survey found that there were challenges in accessing health care services and the use of doctors by ethnic Chinese was low with a tendency to access Traditional Chinese Medicine (TCM) instead (Young, 1992). In New South Wales, Australian people born in China are significantly more likely to report difficulties getting health care (Public Health Division, 2000a) and are less likely to attend hospital emergency departments (Public Health Division, 2000b) and consult general medical

practitioners (Public Health Division, 2000c). Similar problems exist in the United States (US), with Asian Americans not accessing health care services at the same rates as other groups (Ma, 2000). Chinese-Americans remain one of the least understood and most invisible and neglected minority groups in the US especially in the context of health service utilization (Ma, 2000). A study of barriers in the use of health services by Chinese Americans also found that cultural and socio-economic factors were strongly associated with access to and utilization of health services. In this study, language and communication difficulties were the major impediments to health services. Even though they had lived in the US for many years, 40% spoke Chinese only (these were elders and people with little education) (Ma, 2000, Shelley et al., 2004). Cultural factors influence health-seeking behaviors (Daly et al., 2002). Some of these factors include the individual's beliefs regarding health and illness, the role of family in health, attitudes to professional and traditional health interventions and their perceived severity, as well as susceptibility (Ma, 2000).

Chinese cultural influences on the experience of cardiovascular conditions

Although the Asian population has traditionally had a lower risk of coronary heart disease (CHD) compared with other Western nations, the increased Westernization of the Chinese culture has led to a concomitant increase in CHD (Holroyd, 2002). In Australia, rates of CHD tend to increase after their first 10 years of residence in Australia (Australian Institute of Health and Welfare, 2004). Studies to date of CHD in Chinese patients, accessible in the English language literature, have examined responses to illness, such as anxiety, depression and coping methods rather than focusing on experiences and

expectations surrounding the illness (Holroyd, 2002, Holroyd et al., 1998). Little is known about the illness and health seeking behaviors, health beliefs and knowledge of the Chinese migrant community in Australia, yet some data suggest that some aspects of the cultural tradition of Chinese migrants may impede their equity of access to health services.

As secondary prevention is a critical factor in improving health outcomes following an acute cardiac event it is important that individuals have appropriate expectations and available services are configured to meet their needs (World Health Organisation, 1993). Lui and MacKenzie (1999) studied the rehabilitation needs of Chinese stroke patients and suggested that the priorities, interpretations, and expressions of need are affected by Chinese upbringing and family values, particularly among the elderly population. A strong emphasis on collectivism is in contrast to Western populations, who focus more strongly on individual need (Bond, 1995). As a consequence, Chinese people may be less willing to express individual need unless encouraged to do so. Lui and Mackenzie (1999) also found that many Chinese elderly people are passive in expressing their health needs and this was related to their educational, social, and cultural background. The studies discussed above suggest that many Chinese patients may have unmet needs and in some instances traditional beliefs may be at odds with recommended treatment patterns. This research also highlights the need for more information on the experiences of people from diverse cultural perspectives. In spite of the rapid increase in migration described above, there is minimal Australian research investigating the health beliefs, behaviors and experiences of Chinese patients and community members. Data identifying their health

beliefs, behaviors, and experiences concerning cardiovascular conditions will likely facilitate more equitable and culturally competent health care. (Chen, 2001) When approaching investigation of any cultural group it is important to avoid stereotypical perspectives in both study design and interpretation of study data. However, health seeking behaviors and representations of health and illness are strongly influenced by social and cultural context (Gervais and Jovchelovitch, 1998). Understanding a range of cultural perspectives is crucial in effective health care planning and delivery. Following recognizing the need to tailor services to increasing numbers of Chinese patients, we considered that obtaining the perspective of care through the lens of health professionals, community members and patients may further inform culturally appropriate and competent care (Anderson et al., 2003).

Study aims:

The aims of this study were to:

- Describe the experiences of Chinese Australians with heart disease following a discharge from hospital for an acute cardiac event;
- Identify patterns and cultural differences of Chinese Australians following discharge from hospital;
- Illustrate the illness/health seeking behaviors and health beliefs of Chinese Australians

METHOD

A multi-method approach to qualitative data was undertaken. Data were obtained from three convenience samples: a) focus groups consisting of Chinese community members; b) interviews with patients recently discharged from hospital following an admission for an acute cardiac event; and c) interviews with Chinese-born health professionals currently working in Australia. This multifaceted, multi- method approach (Tashakkori and Teddlie, 2003) was undertaken to obtain a comprehensive view of the acute experience of heart disease and values, attitudes and beliefs. We were interested in obtaining the perspective of individuals not previously exposed to cardiovascular care, individuals who had recently been hospitalized, and health professionals with a Chinese background, who were considered to have a unique perspective incorporating the Chinese cultural background as well as knowledge of cultural dynamics of the health care system. Focus groups were considered an appropriate method to be used with community members as they assist in increasing understanding of perspectives of culturally and linguistically diverse groups and influence clinical practice to better meet their needs (Halcomb et al., 2007). Focus groups are useful as they allow investigation of multiple perspectives that can minimize cultural stereotyping (Halcomb et al., 2007).

Focus group participants assisted in the snowball sampling by identifying key informants for interviews who held detailed knowledge and experience of CVD. The interviews enabled key issues which arose from the focus groups to be probed and expanded upon while providing a different, more intimate medium of storytelling. Not only can a large amount of data be collected in a short time via interviews, but also participants'

perspectives are disclosed in their own words, thereby conveying rich and detailed accounts of individuals' experiences. Furthermore, the collaboration between participant and researcher inherent in this type of interviewing enables flexibility in the data collection process as meanings can be clarified throughout the interview and emerging topics discussed (Halcomb et al., 2007, Vogt et al., 2004). The method of individual interviews was considered more appropriate and practical for health professionals and individuals recently discharged from the hospital.

Setting

The study was undertaken in South Eastern Sydney, New South Wales, Australia, within an area highly populated by Chinese-Australian residents. The study settings within this suburb included a major tertiary teaching hospital, two non-residential multicultural aged care centers, and two community church groups, all of which offer health promotion/education programs.

Participants

Community Members

The research team invited community members who self-identified as Chinese and who had no previous history of cardiovascular disease to participate in focus groups regarding their values, attitudes and beliefs particularly in regards to their cardiovascular health.

While the researchers recognize language as a basis for identification to a particular culture, it is important to also recognize cultural allegiance. These community members attended multicultural and aged care centers and community church groups in the study

area and were invited via Chinese and English language fliers as well as snowball sampling techniques to participate. Key informants were identified from within and by focus group participants as individuals who would then participate in in-depth semi-structured interviews.

Health Professionals

A convenience sample of 13 Chinese-born health professionals now working in Australia participated in interviews. These health professionals were invited by the research team to discuss their perception of heart disease and values, attitudes and beliefs in this Chinese-Australian community. The sample comprised primarily staff working in the study setting and others referred by participants for interviews. It was considered, that these participants would provide a unique and valuable insight into the phenomenon of interest. As they were born in China, they had a unique understanding of cultural aspects as well as an in depth understanding of the Australian health care system. In addition, it is not uncommon for bilingual health workers to be called upon for interpreting and cultural brokerage.

Patients

Individuals admitted to the hospital diagnosed with CHD were approached by a bilingual research nurse. Of ten individuals who were approached, eight consented to participate and were interviewed prior to reaching data saturation. The two patients declining participation stated that they felt too unwell to be interviewed.

Procedure

Approval to undertake the study was granted by the Area Health Service Human Research Ethics Committee. Informed consent documents were translated into Chinese by a qualified health care interpreter. Focus groups, lasting 60-90 minutes each, were conducted by a member of the research team, multicultural health workers, and qualified health care interpreters over a period of three months. In total, a sample of 76 individuals was achieved which comprised ten focus groups consisting of eight to ten participants per session, an appropriate size within which discussion can be created with individual input generally not impeded. The focus group schedule was informed by a review of the extant literature on CVD health beliefs and behaviors of minority and immigrant populations, yet participants were free to discuss any issues that concerned them. Focus groups were primarily conducted in Chinese, with separate groups conducted in Mandarin and Cantonese. Consensus was achieved through moderation and comparing and contrasting views of participants (Halcomb et al., 2007). Proceedings were audio-taped and translated by a qualified health care interpreter. Translations were reviewed by a bilingual researcher to check the nuances of conversation and that their intrinsic meaning was not lost. Field notes were recorded by a bilingual research team member. Focus group data collection ceased once data saturation was achieved as evident by no new emerging information.

In depth interviews were conducted with both patient- and health professional participants, at mutually agreed upon times in the patient's home, outpatient clinic settings, or the hospital, as appropriate. Interviews were undertaken in Mandarin,

Cantonese, and English depending on the individual, by a research team member and accompanied by a health care interpreter, where appropriate, using an interview guide derived from the focus group schedule. These interview schedules included questions relating to participant's perception of the cause of heart disease and strategies they could undertake to improve their health outcomes, perceptions of health care providers and their capacity to take responsibility for their own health. For health professionals their views of Chinese patient's experiences were elicited. Interviews were audio-taped and transcribed verbatim, and those undertaken in Chinese were translated prior to transcription. It was considered that data saturation had occurred following eight patient and thirteen health professional interviews as no new knowledge was being generated from subsequent interviews. This process was confirmed by two investigators who were responsible for project coordination and data analysis (PMD & EA).

Data analysis

Data representing 37 hours of dialogue was available for analysis (Cavanagh, 1997, Woods et al., 2002). Data from each of the data sources were analyzed individually and then the findings combined to provide a collective perspective and also compare and contrast views (Tashakkori and Teddlie, 2003). The analysis followed the iterative mode of allowing ongoing preliminary analysis in writing up observations of focus group and interview sessions including self-assessment comments. Notes were made on a line-by-line basis throughout each transcript recording thoughts concerning participant-researcher interactional issues, topics needing further clarification, and feelings about certain parts of the interview session, as suggested by Minichiello (Minichiello et al., 1995). Data

collection and analysis occur concurrently with constant reflection on previously collected data. Early data were coded and later revised based on new information from subsequent data. The coded data were clustered into related categories and were compared with one another and linked to form a conceptual framework. For focus group data, data were categorized into key themes and a grid was used to facilitate comparison of data between groups and to demonstrate the flow of themes within the data (Miles and Huberman, 1994). The analysis was then circulated to the research team for further examination and validation. Data were synthesized with findings of the literature to identify key themes (Thurmond, 2001).

Rigour

Credibility, dependability, and confirmability were ensured throughout the undertaking of this study. The building of rapport, a method of increasing probability of producing credible findings which enables trust and facilitates disclosure was easily established with participants in the current study via involvement of multi-lingual health care interpreters and researchers (Rolfe, 2006). Secondly, regarding the information disclosed in interviews, some validation and clarification of topics by participants occurred during an interview and focus group situations. Thirdly, data sources and collection procedures were triangulated to determine congruence of findings among them (use of interviews and focus groups, use of patients, community members, and health professionals).

Independent analysis of the data by another researcher assisted in establishing credibility and ensuring value-free and confirmable analysis. Regarding dependability, constraints imposed by the data collection exercise as well as the impact on participants, meant that

follow-up focus groups and interviews were impossible. However, where specific questions or details needed clarification, the researcher was able to contact participants via telephone.

Findings

Focus group participants were English or Chinese-speaking adults of Chinese origin with a mean age of 68 ± 8 years. Both men and women participated in the focus groups.

Interview participants (those recently discharged from hospital) were 74 ± 5 years (six men and two women). The health professionals included nurses and physicians whose residence in Australia ranged from 2 to 32 years. The mean age of health professionals was 44 ± 3 years. Generating data from these discrete, yet linked perspectives of common culture, allowed a more comprehensive view of issues impacting on accessing care and views regarding heart disease. Community dwelling Chinese Australians reported their views of the etiology of heart disease, those patients recently discharged from hospital reported how they reconciled their diagnosis with their lifestyle and beliefs whilst health professionals provided valuable insight from both sides of the fence. Not only could health professionals provide reflections from their own cultural background but also ruminations on the experiences of Chinese Australians that they had cared for. Data from all sources revealed a strong emphasis on collectivism and the importance of family and tradition. Chinese culture has a strong emphasis on collectivism, which is an orientation that prioritises the needs of the group and defers individual needs, in contrast to Western cultures where there is an emphasis on individualism (Li et al., 2010). The following themes emerged from the data: (1) linking traditional values and beliefs with Western

medicine; (2) reverence for health professionals and family; (3) juxtaposing traditional beliefs and self-management.

Linking traditional values and beliefs with Western medicine

Despite the length of time in Australia all participants filtered their views and opinions through a perspective of traditional Chinese views, even though they challenged the veracity of some views, such as avoiding chilled fluids when unwell. . Views and opinions of patients and community members reflected an emphasis on traditional beliefs related to heart health and how health and illness fitted into a broader context of health and well-being. Health professionals underscored the need to have this broader perspective in caring for Chinese individuals and a failure to do so may lead to misunderstandings and poor adherence with optimal treatment recommendations.

Patients and community dwelling Chinese described the heart as the primary organ of the body and as influencing physiological and psychological functions. The importance placed on the heart was seen to influence how individuals coped and adjusted to a diagnosis of heart disease.

Participants described a whole of person perspective in relation to health and well being.

One of the community members stated:

“ .. a lot of our Chinese culture think that the heart affects a lot of our emotion as well as part of the main organ of the body.”

Therefore having a diagnosis of heart disease signaled a disruption of equilibrium and harmony in life balance. Despite the emphasis that individuals place on the heart as a

significant organ, participants still viewed a cancer diagnosis as being more serious than heart disease.

For participants who had a recent heart attack, their process of recovery and adjustment was influenced by the need to access traditional therapies and restoring balance.

Interviews with health professionals and patients revealed that older participants were reluctant to exercise and preferred resting in bed in accordance with traditional beliefs.

Participants who had resided in Australia for short or extended periods also discussed their reliance on TCM and related beliefs to achieve inner balance and harmony.

“..when my blood is cold I drink herbal tea, when I feel hot, my blood is hot, I don’t drink herbal tea anymore.”

Participants spoke of the value that they attributed to TCM and for patients access to these treatments provided a sense of coherence with their past and adherence with their traditional values and beliefs. Despite the continued influence of TCM, participants described a respect for Western medicine and practitioners. For many individuals, their general practitioner was Chinese and assisted them in brokering the two cultures and treatment modalities.

“Last year I went to Beijing to a place famous for treating people with a stroke. The doctor looked at my tongue and said there was a possibility I may have a stroke and he gave me some medicine to drink for three months and after that I walked better- so maybe the medicine was good.....After all this when I came back from holiday I went to check up with my GP... I was always on medication, like Tenormin, Imdur and aspirin and this time my father had a heart attack and he died...my GP referred me to a cardiologist so I had those stress tests and echo and all of those things.”

A Chinese nurse participant working in the area of coronary care expressed concerned over some patients’ apparent reliance on TCM for symptomatic benefit:

“I worry that using Chinese medicine may result in a delay in seeking medical attention, particularly if they have chest pain”

Several of the health professionals, spoke that the emphasis place on longer term, integrated approaches to treatment may influence the individuals need to seek treatment acutely and adhere to medical advice. They also mentioned that in some instances individuals may feel conflicted when Western treatment recommendations differed significantly from traditional views.

Reverence for health professionals and family

Participants talked about the importance of family, not just in terms of support but also for assistance in brokering the health care system. Often patients relied on family members for not only interpreting, transport and access to the health care system but also for making decisions.

“Of course the children will take us there and come along.”

“Yes, when I am sick I usually don’t do much. I let the children do the cooking and cleaning for me.”

Health professionals also commented on the importance of including family members in decision making and respecting traditional hierarchical methods of decision making, even when this is at odds to traditional views of autonomy present in Western cultures. Both community members and patients expressed respect for both Western and TCM health professionals, particularly valuing bilingual health professionals.

One participant spoke of a Mandarin-speaking physiotherapist who helped explain aspects related to a physical activity program:

“(She) was very good. She taught me how to do the exercise... After the health talk I asked (her) questions and she would explain to me...she has been very good.”

This reflects that there is a need not only for interpreting health information but also filtering and distilling this within a context of traditional views and beliefs. Another participant talked about clarifying treatment decisions with a Chinese speaking general practitioner:

“I am 74 years of age. The first time the doctor told me I should have an operation (coronary artery bypass grafting), I said no but after I talked to Doctor X and he said I should have it done and I went back (to the hospital) and had the operation.”

Juxtaposing traditional beliefs and self-management

Self-care practices such as dietary modification and undertaking physical activity are critical issues in the self-management of heart disease and other chronic conditions.

One participant declared:

“I also take tablets for high blood pressure, for diabetes for my thyroid problem.”

When questioned about the use of herbal medication with prescription agents the female participant stated:

“Well I don’t care – It makes me feel good so I will drink it”.

Participants found some dietary recommendations, such as salt reduction, challenging.

“Really, so that means I should not use soy sauce?”

Some participants also found that attending a formal cardiac rehabilitation program not to be congruent with their traditional views which promoted rest and relaxation, not exercise.

“Most Chinese people prefer to do gentle exercise- like Tai Chi and walking.”

These findings have shown that many of the participants found that recommendations for treatment juxtaposed their traditional views. Further, family members and bilingual health care workers were integral to brokering the system and assist them in making decisions.

Discussion

Data revealed that many of these Chinese Australians are balancing a range of values and beliefs, sharing both a trust in TCM and knowledge of Western medicine. This is to be expected but this process of deliberation should be recognized and considered by health professionals. Several studies have found ‘doctor shopping’ to be common in Chinese migrants (Hsu-Hage et al., 2001, Tang and Easthope, 2000) particularly when TCM has failed, suggesting that as a group Chinese migrants are grappling with the choice of two approaches to health care. Hsu-Hage et al (Hsu-Hage et al., 2001) also found that participants used both TCM practitioners as well as Western medical practitioners. Chinese Australians had a lower use of hospital services than other cultural groups, thus supporting other Australian data (Kliewer and Jones, 1997, Public Health Division, 2000a, Public Health Division, 2000b, Public Health Division, 2000c). Apart from suggesting inequitable access to health care services, this finding may reflect Chinese cultural attitudes of adopting a ‘wait and see’ approach to illness.

Hsu-Hage et al (2001) found that Chinese Australian participants would not seek professional care if they did not perceive the illness as severe, and reported that delays in

seeking care were common in Chinese culture. Ma (2000, 2002) found that the majority of Chinese Americans kept their use of health services to a minimum because of fear of and lack of trust in the system. However, participants did not report this to be the case in this study, as they had a high respect for health professionals. The tendency for Chinese patients, particularly the elderly, to be passive in their illness behavior, may be at odds with recommendations of promoting physical activity to enhance the recovery process and reduce subsequent cardiovascular risk. Thus, there may be a conflict between traditional beliefs and self-care recommendations in Chinese Australians, particularly in respect to exercise. In this study setting, the participation rate in cardiac rehabilitation was only 22% for Chinese, compared with 58% in the Greek population and 62% in the Arabic population (Anderson et al., 2004).

Participants described a high level of respect for health professionals and inferred a level of deference associated with a more passive interaction and less challenging of recommendations. According to Chinese beliefs, strong personal feelings should be suppressed in order to promote harmony. These participants considered that challenging an expert would not be considered appropriate. Thus, if a Chinese patient has doubts about a prescribed regimen, expression of concern may likely be concealed and may instead manifest in non-adherence to prescribed treatment (Chen, 2001). These findings concur with those of Lui and Mackenzie (1999) who found that most Chinese elderly people tend to take a passive role in expressing their needs. Participants described the importance of the family doctor in negotiating the health system. Hua et al (2002) also found that the majority of Chinese Australian respondents in their study reported the

family doctor as their main source of health care service information. The family doctor (general practitioner) has an important role in providing information on health care services and in promoting access to appropriate services. Participants derived support and comfort when being cared for by Chinese Australian health professionals. This is consistent with the findings of Chan and Quine (1997) who found that Chinese Australians preferred to use Chinese-speaking general practitioners. This is not surprising given the language barriers that often prevent Chinese Australians from gaining equitable access to health care. It is reasonable that a person would presumably feel more confident that his or her health needs were understood with no language or cultural barrier present.

Participants reported that priorities, interpretations and expressions of need are strongly influenced by their Chinese upbringing and family values. This was particularly the case among elderly participants. This study revealed a strong emphasis on collectivism and the importance of family and tradition, unlike the Western culture which places greater emphasis on the needs of the individual. Traditionally, Chinese families feel strongly obliged to look after one another and are compelled to meet the needs of an ill family member. Hsu-Hage et al (2001) found that friends and families were important sources of health information, along with general practitioners. Caring for a sick person is considered a family duty, so obligation to the family is of utmost importance (Holroyd et al., 1998). Data also revealed the importance of family members in assisting in making decisions about treatments.

The Confucian ethos is of reciprocity and loyalty, benevolence and righteousness, self-respect, self-reliance and self-control (Holroyd et al., 1998). In spite of the knowledge of Western medicine, many participants classified food, illness and medications according to the perceived effects on the body, as “hot” or “cold”, reflecting belief in the Yin-yang principle. Foods are often prescribed as therapeutic interventions in addition to medicines, as a way of improving health functions, preventing or curing illnesses, or adjusting to climatic changes (Ma, 2000). In their qualitative study of the health behaviors of Chinese people in Taiwan with chronic illness, Hwu et al (2001) found that all eight participants considered there to be a strong relationship between food and disease. Yin conditions were treated with Yang or hot foods, and Yang conditions were treated with Yin or cold foods to restore balance and health. This is an example of how Chinese health beliefs are grounded in culture heritage and the contexts in which they live. This underscores the importance of health professionals including Chinese cultural beliefs and values in care planning. For people with heart disease considering views relating to timeliness in seeking health advice, diet and exercise are particularly important.

Strengths and limitations

The convenience sampling methods and qualitative study design, limits the ability to generalise study findings. There is also a danger in attributing stereotypes to cultural groups (Meleis and Lipson, 2003). Yet, obtaining insight into cultural beliefs and health seeking behaviors in different cultural groups can be useful in planning, implementing and providing clinical services (Davidson et al., 2007). The multifaceted view of the

experience of Chinese Australian view of heart disease and health seeking behaviors from the stance of those with and without heart disease as well as Chinese Australian health professionals has provided elucidation of a complex socio-cultural phenomenon.

Approaching this problem from a range of perspectives has provided a comprehensive view of issues for migrants brokering a value laden health care system in a different country. Data from this study confirm and extend data from other studies in this population. Further studies that examine potential differences in levels of acculturation, age, gender and socioeconomic status would be useful.

Implications of findings for health care services

This study suggests that health professionals need to recognise that Chinese Australians may have values and beliefs that may be perceived as contrary to those of health professionals, who are normally trained in Western medicine (Davidson et al., 2003). In agreement with other studies, this is a complex process whereby individuals balance their cultural heritage with the needs and demands of the host environment (Chua and Yu, 2001). Specifically, during secondary prevention initiatives, such as cardiac rehabilitation, these beliefs may interfere with risk factor modification. For example, it is recommended that exercise programs, including Tai Chi, for older Chinese patients be encouraged and provided. This is a way of fostering exercise while at the same time preserving cultural beliefs.

The observation that the general practitioner and family members have an important role in the health seeking behaviors of Chinese Australians suggests that the inclusion of

family members and the general practitioner in program development and negotiation of care plans is important. The language barrier to accessing health services that was apparent in this study indicates that Chinese Australians may benefit from access to interpreters and translated materials. It is also important to recognise that Chinese Australians may have dietary preferences that reflect their philosophy of Yin-Yang harmony in order to restore health. Furthermore, the concomitant use of TCM has significant potential for drug interactions and should be considered in patient assessment and management (Davidson et al., 2003). It is also of concern that individuals saw cancer as being more life threatening than heart disease. This may then impact on how individuals engage in risk factor modification.

These data likely have implications for Chinese populations living in other Western societies. There are large populations of Chinese people in many Western countries where there is a balancing of traditional cultures with mainstream treatments. There is also an increasing recognition of the use of TCM both in Chinese and non-Chinese populations. Balancing traditional and non-traditional therapies is an important consideration for health professionals. These data also potentially have some salience for the increasing burden of heart disease in China. The forces of Westernisation and globalisation have change the epidemiologic and health profile of contemporary China and are also influencing development of the health care system. As China strives to address the increasing burden of CVD it is likely that health care messages will have to reconcile both traditional and Western approaches (Cao et al., 2009).

Conclusions

The study data suggest that the priorities, interpretations and health seeking views of Chinese people are strongly influenced by traditional upbringing and family values, particularly among the elderly. These values do not mean that there is a dismissal of Western Medicine, rather a balancing and blending of sometimes opposing views. As heart disease is increasing among Chinese people considering strategies to reconcile evidence based strategies for preventing and managing cardiovascular disease is important. It is also important that both primary and secondary prevention health messages carefully communicate the risks of cardiovascular disease and strategies that need to be adopted to optimize health outcomes (Cao et. al 2009). Placing an emphasis on the importance of seeking health advice and not ignoring symptoms is of particular importance. Health professionals need to preserve cultural orientation for Chinese patients brought about by two health paradigms that may at times be opposing (Chua and Yu, 2001, Gervais and Jovchelovitch, 1998). Holdroyd et al (1998) suggest that adopting a middle path to maintain harmonious interpersonal relationships and to restore individuals to health is the recommended option. Eliciting consumer views and those of health professionals is crucial in achieving this position of integration to facilitate culturally appropriate and competent care.

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