SHAMAN INTEGRATION INTO WESTERN HEALTHCARE SERVICES

Design and Methodologies

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Research Questions and Hypotheses

This study is primarily exploratory, as very little research has been done on the topic. Research questions explored in this study are: is the introduction of Shamans into Western healthcare associated with increased service use by Hmong persons? For what situations do Hmong persons use Western healthcare services? Does age play a part in the frequency of use of Western healthcare services among Hmong persons?

Hypotheses explored in this study are: 1) the incorporation of Shamans into Western healthcare services will be associated with increased services rates by Hmong persons, and 2) a lack of Shamans will be associated with Hmong persons only using Western healthcare services for life-threatening emergencies and terminal illnesses.

Additionally, it is expected that age and English-speaking ability will be moderating factors with regards to increased service use, and increased faith among Hmong persons in the service they will receive from Western healthcare providers will be a mediating factor

Research Design

For the purposes of this experiment, a quasi-experimental design will be employed – specifically, a simple time-series design, as a control group is not needed. It is necessary to assess the dependent variables (DV) – that of increased service rates (as per hypothesis 1) and service use only for life-threatening emergencies and terminal illnesses (as per hypothesis 2) – pretest and posttest in order to determine if Western healthcare service use by Hmong persons has increased, and it would be even more useful to know how service use will change over time (a point-in-time observation before and after the test may not be truly representative of the long-term results); so a simple time-series design is therefore practical and useful.

In the simple time-series design there will be multiple observations of the DVs pre- and posttest – or, in other words, before and after the interventions – to measure the DVs over time. The interventions (i.e. the independent variables [IV]) in this case are the introduction of Shamans (as per hypothesis 1) and the lack of Shamans (as per hypothesis 2). The notation is

O1 O2 O3 X O4 O5 O6 O7 O8 O9 O10 O11 O12 O13 O14 O15

Due to the nature of the simple time-series design, the study is longitudinal.

Strengths and Weaknesses

Simple time-series designs are feasible and less expensive that other experimental or quasi-experimental designs, because they do not require a control or comparison group. Also, because they track results and observations over time, the likelihood of alternative explanations or interventions being attributed to the posttest results is reduced. For this same reason, simple time-series designs also allow for the researcher to obtain a more accurate idea of the influence of the intervention (IV) and the pattern of variability over time (Grimshaw, Campbell, Eccles, & Steen, 2000).

On the other hand, time-series designs are very time consuming, and for this reason there is a greater chance of participants dropping out of the study. It is also necessary that an appropriate and significant amount of observations be conducted in order to reach more accurate results. The design also does not provide protection of other events contributing to the posttest results and has less internal validity (Grimshaw, Campbell, Eccles, & Steen, 2000).

Sampling Strategy

Sampling method

Since this is a relatively small explorative study, nonprobability sampling methods – specifically, purposive sampling – will be utilized. By using this method, the research can target

Western healthcare facilities that are located in densely Hmong-populated areas. Since funding limits the number of facilities that we can study, random sampling is not feasible. If more facilities could be studied, probability sampling methods could be utilized for higher reliability.

Population

The sampling frame is Western healthcare service physicians in St. Paul, MN. Participants will be both male and female, ages 25 to 75, and of any racial or ethnic background and sexuality. Due to the nature of the profession, participants will likely have a higher education and a salary of at least $80,000 and speak fluent English. There will be an anticipated 50 participants.

Variables

In this study there are two IVs, two DVs, two mediating variables, and one moderating variable. In testing the first hypothesis, the IV is the introduction of Shamans and the DV is increased service rates. The IV is conceptualized as a healthcare facility employing (as a volunteer or paid employee) a Hmong Shaman to assist healthcare staff in serving Hmong patients. It is operationally defined for the purpose of this study as a healthcare facility employing (as a volunteer or paid employee) a Hmong Shaman as a consultant to physicians with job duties of, but not limited to: translating, counseling, educating physicians of Hmong cultural practices, acting as liaisons and peacekeepers, addressing patient concerns, and performing alternative traditional healing methods in addition to modern methods when appropriate. The DV is conceptualized as more Hmong persons seeking services at healthcare facilities than prior to the introduction of the IV. Operationally defined, the DV is a 10% or more increase in Hmong patients in participating healthcare facilities within one year of the

introduction of the IV. Service rates only include Hmong patients who actually saw a physician or nurse by appointment or walk-in.

In testing the second hypothesis, the IV is a lack of Shamans and the DV is service use only for life-threatening emergencies and terminal illnesses. The IV is conceptualized as Western healthcare facilities not having enough Shamans to serve the Hmong patients. It is operationally defined as having no Shamans employed (as a volunteer or paid employee) on staff at Western healthcare facilities. The DV is conceptualized as Hmong persons only going to see a Western healthcare practitioner for emergencies. The operational definition is Hmong persons only seeking service (determined by healthcare facility intake records) from Western healthcare practitioners if they (Hmong persons) are in a life-threatening emergencies or have a terminal illness and not for routine care.

Moderating variables are age and English-speaking ability. Age is both conceptually and operationally defined as how many years one has been alive; however, for the purpose of this study, age will be determined by the age listed on the patients' intake forms or by verbal statement of the patients. English-speaking ability is conceptualized as one's proficiency in the English language. For this study, English-speaking ability is operationally defined as beginning, intermediate, advanced, fluent, or native proficiency, determined by the healthcare staff's estimation through verbal communications with the Hmong patients.

A mediating variable is increased faith among Hmong persons in the service they will receive from Western healthcare providers. It is conceptualized as Hmong persons believing they are getting better service from Western healthcare providers. In this study it is operationally defined as Hmong patients feeling they are receiving more quality service from their Western healthcare providers than prior to the introduction of Shamans.

Measurement Instruments

Surveys will be used to measure service rates before and after the introduction of Shamans. Qualitative and quantitative questions in surveys will provide the research team with information regarding current service use of Western healthcare by Hmong persons, for what situations Hmong persons use Western healthcare services, and what level of faith Hmong persons put in Western physicians. Pretests can also acquire information as to what services that take into consideration cultural differences are currently being provided to Hmong patients in Western healthcare facilities. The pretest information – specifically the current rates of Western healthcare service use by Hmong persons – will set the stage for the intervention and be a comparison for the posttest results.

An individualized survey will be created for the purposes of this study. Questions will be qualitative and quantitative. Types of question asked on the survey include but are not limited to: current service rates, demographics of Hmong patients, for what reason Hmong patients are seeing practitioners, criticisms of services from Hmong patients, and perceived attitudes towards and faith in Western healthcare providers by Hmong patients. The “Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (see Appendix),” will be used in pretest surveys to assess cultural competency.

Reliability and Validity

Surveys are beneficial in research because they: are relatively inexpensive; can be administered from a distance by telephone, email, or mail; can ask qualitative and quantitative questions and multiple questions at one time; offer standardized questions; have high levels of generalizability and reliability; and are able to reach large populations. Surveys also enable the research to “analyze multiple variables simultaneously” (Rubbin & Babbie, 2010).

The downside to surveys is that: they cannot always point to a cause; they limit question response and explication and may overlook context; they are subject to random error, cultural bias, and social desirability error; they have low validity; it is sometimes hard for participants to recall memories or past events; and the researcher is forced to develop questions that are broad and general if the sampling population is large as to be applicable to multiple participants (Rubin & Babbie, 2010).

Data Collection

Three Western healthcare facilities in high Hmong population areas (determined by census statistics) in St. Paul, MN will be chosen by using purposive sampling. I will contact the facilities' Human Resources staff and Program Director and explain my desired study. I will then ask for names of physician staff in the facilities that I could reach out to and then personally call and email the physicians provided to me, describing in detail the purpose and scope of the study and asking for participation. Those who agree will participate in three pretest surveys two months apart, starting in March and ending September. In September Shamans from the Hmong community will be introduced into the facilities as consultants to physicians. Every two months thereafter for the following year the research team will conduct posttest surveys (given to the same physicians) asking the same questions given in the pretests.

Ethics

Risks in this study are minimal: anxiety and discomfort sharing responsible with new staff (i.e. Shamans) and stress from extra work during busy schedules. Our research team will offer assistance in managing data collection (should the facilities allow) to ease the burden of extra work. Confidentiality is the largest issue. The research team will make sure all terms and

conditions are understood by the physicians before obtaining written consent to maintain confidentiality.

Discussion

Hmong persons are currently in deep need of culturally sensitive healthcare services, as miscommunications and cultural clashes have and continue to lead to serious negative consequences in Hmong patients. Furthermore, the lack of culturally competent services has caused Hmong persons to avoid using Western healthcare services, which limits resources for care. This study aims to find a possible solution through the incorporation of traditional healers – Shamans – into Western healthcare services. The research team will survey physicians at three different healthcare facilities in St. Paul, Minnesota to determine pre-test service rates of Hmong patients, for what situations Hmong persons seek services, and current perceived levels of faith Hmong persons feel they receive among other relatable questions. Shamans will then be employed by the facilities as consultants, and posttest surveys will be administered every two months thereafter for the following year to observe changes in the survey results.

Limitations

Internal validity. This study has a high degree of internal validity; however, extraneous events may occur during the course of the study that may confound the results. This may be an outbreak of some illness in the Hmong community that may cause Hmong persons to seek help from Western clinics; or possibly many Shamans in the community may die, leaving Hmong persons fewer healthcare options. These are only two examples, but there could many more. There is no sure way to prevent extraneous events from affecting the study; however, we (the research) team will ask participating physicians to keep a sharp eye out for emerging patterns that might indicate other reasons (i.e. other than the introduction of Shamans) why there could be

a sudden influx in Hmong patients seeking services. The research team (at least two members of the research team will be Hmong) will also do their best to stay in tune with news in the Hmong communities (they will do this by reading flyers and newspapers in the Hmong communities) to identify any events that may trigger a need for Hmong persons to utilize Western healthcare services.

External validity. Unfortunately, this study has low external validity, as such as small sample is being used, both in number and geographical area. At best, the results could be applied to the Minnesota and Wisconsin states, as the two states share similar culture, weather (which can affect physical and mental health), hospitals, Hmong population, and even resources. Furthermore, due to proximity and immigration history, many Hmong persons living in Minnesota have family living in Wisconsin. This is an exploratory study with limited funding, so unfortunately, the extent to which we can generalize the findings is limited. With the development of future studies, external validity will become higher.

Other limitations. Because this study strictly focuses on incorporating Shamans into healthcare services (operationally defined in this study as strictly medical clinics and hospitals), the results cannot be generalized to social or mental health services. Also, time-series designs are very time consuming, so there is a greater chance of participants dropping out of the study.

Strengths

Design. To briefly reiterate the strengths of our design choice, it is inexpensive and feasible (in comparison to other experimental or quasi-experimental designs) because we will not be using a control or comparison group. Also, the likelihood of alternative explanations or interventions being attributed to the posttest results is reduced, because we track results and observations over time. Our chosen design also allows for our research team to obtain a more

accurate idea of the influence of the intervention (IV) and the pattern of variability over time. This will help counter the limitations previously discussed. Additionally, by using a survey as a measurement tool, we can ask qualitative and quantitative questions and analyze multiple variables at once.

Other strengths. There is a large body of literature backing the severity of the problem and the current limitations. Also, the St. Paul-Minneapolis metro area has the largest population of Hmong persons in the nation; so even by being able to generalize the results to that specific area, we are able to target a large percentage of the Hmong population in the United States. Likewise, the availability to Shamans that could be interested in participating is higher than in other areas of the United States, and more physicians may be willing to participate due to more frequent contact with Hmong persons outside of work that other physicians living in other areas of the United States. They therefore may better understand the need for such services that would be implemented in this study.

Implications for Social Work, Human Rights, and Social Justice

By refusing Hmong the use of Shamans or Shamanic healing practices, one denies them their right to free practice of religion and prevents them from achieving basic human needs, such as physical and mental health. Furthermore, by forcing clients to use only Western methods, one denies the client his or her right to self-determination and autonomy and forces a culture to assimilate.

Incorporating Shamans into Western healthcare will allow Hmong persons to access additional, valuable medical services while significantly decreasing the risk of miscommunication and culturally incompetent service. Allowing Hmong persons to use both

Shamans and Western physicians also helps Hmong persons to preserve and continue maintaining their traditional culture.

Directions for Further Research

The results of this study would lead the way for future research on incorporating traditional healing methods into Western healthcare services, Shamanistic or otherwise. If this researcher's hypothesis is correct and the results of this study indicate increased service use by Hmong persons, additional studies should be conducted spanning a larger geographical area and sampling more healthcare facilities and physicians. Recommended cities would include: Bloomington, MN; Minneapolis, MN; Eau Claire, WI; Milwaukee, WI; Wausau, WI; and Fresno, CA.