

Training and supporting GPs in providing palliative care to a Vietnamese-Australian community



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The mooted increasing role for general practitioners to provide palliative care for an aging Australian population has raised the need for improved training and support for GPs to provide 'healthcare for dying people that maximises quality of life and assists families and carers during and after death'.¹ In order to address this need, the Commonwealth Department of Health and Ageing commissioned a study into the education, training and support needs of GPs in palliative care.² This article reports one element of this national study: the needs of GPs who provide palliative care to a Vietnamese-Australian community in Sydney, New South Wales.

Many Vietnamese people arrived in Australia during and after the Vietnam War of the 1960–1970s. Many from this generation are now approaching their time of death.

Methods

In depth semistructured interviews were conducted with the GP, the specialist palliative care service and the carer of a Vietnamese person who had died in the previous 6–12 months. The format for these interviews was determined by the conceptual framework and terms of reference of the study.²

Family members who had cared for a loved one through a terminal illness in the previous year were identified through a local Vietnamese community group. One of the research team, BT (a medical student from Vietnam studying in Australia) conducted the interviews in the native language of the informant. Carers nominated the GPs and specialist palliative care service that had provided palliative care for the deceased. Interviews with these health professionals were conducted in English. This article reports the views of four GPs and two palliative care nurses who agreed to the interview.

Each GP was Vietnamese-Australian while the nurses were not.

The study was conducted in a discrete and cohesive community in western Sydney with a small group of key informants. In order to maintain their anonymity, demographic information regarding informants is not provided. For the same reason, summarising and paraphrasing of interview data is used more extensively than direct quotations.

Ethical approval was obtained from the Research Ethics Committee of The Royal Australian College of General Practitioners.

Findings

Informants stressed the importance of contextual issues. Historical legacies, cultural sensitivities, religious beliefs and socioeconomic circumstances were important determinants of the relationship between patients and carers with health professionals and ultimately, health outcomes.

All of the carers had migrated to Australia. One arrived in Australia as a refugee, the other three were sponsored by their children who were refugees. Often families have been fragmented and therefore support

during terminal illness becomes problematic.

In traditional Vietnamese culture, family and community take precedence over personal autonomy. This orientation has many implications. Age and gender often determine power relationships. Men expect to take on the decision making role. Women are raised to please and care for the husband's family, to bear their place within the social system stoically, politely and quietly. Women have limited power, indeed, even when in pain, are required to remain silent and display forbearance. Men, on the other hand, may swear and scream indiscriminately when in pain.

Tensions arise when the next generation does not observe these traditions. Where parents expect respect and obedience, many of their children aspire to financial independence and distance from the perceived constraints of family networks.

'So the parents are expecting the children to be more respectful to the parents, obey the hierarchy in the family, but the children with the financial independence, they get out and they don't live in a big family like we used to in Vietnam'.

Religion has important implications for Vietnamese-Australian communities. The Buddhist notion of karma reflects fundamental implications of reincarnation. Sins from a previous life bring pain in the present and future existences. Pain represents a payment for previous misdeeds and among believers, must be accepted. Admitting to pain reveals former indiscretions and perhaps, an attempt to avoid the inevitability of karma. Such religious beliefs provide complex challenges to health professionals attempting to monitor and relieve the pain of patients with terminal illnesses.

'Normally we ask patients directly and indirectly. So if you directly ask the patient how much pain they have, they may say, 'they feel, have pain, but it is acceptable in the religion'.

'In the culture you have to pay for the sin so you have to accept the pain from the previous life or from the past. You did something wrong so now you got the pain. You have to accept. You can't blame anyone. So sometimes they never say about the pain. They are guilty, so let them to suffer'.

'But for a doctor like myself I see different. I said that you have to fix the pain to keep the patient comfortable because you have too much pain, you won't eat'.

Palliative care nurses spoke of other challenges in the GP-Vietnamese community relationship – some that did not emerge in the interviews with doctors. In Vietnam, GPs do not make home visits. Therefore, in Australia, neither doctor nor patient readily had this expectation. Any possibility of home visits is further diminished by the onerous workload of many surgeries. In addition, there is marked variability in the training and experiences of many local doctors in palliative care.

Inadequate delivery of palliative care arises for several reasons. The limited community expectations for the palliative care services of GPs combined with the patient's reluctance to disclose symptomatology, the reliance on care provided by family members who often stand in isolation from health services and the repeated inappropriate presentations to the emergency department of local hospitals con-

stitute barriers to good coordination. In addition, the variability of roles displayed by GPs and the complexities of revealing and discussing prognoses with Vietnamese patients create difficulties for the doctor.

Doctors and nurses agreed on the intricacies of facing death with Vietnamese patients. Communities do not wish the person with an incurable disease to know of his or her prognosis. Speaking of death is believed to hasten the person's demise. One doctor explained his approach:

'We say to them that the condition is very severe. It could be fatal but we will try to do the best to save the situation. Sometimes there will be improvement but the best thing you can do is make her or him feel comfortable'.

Informants agreed that families expect they will be informed of the prognosis rather than the dying person. However, gender and inter-generational cultural issues sometimes create awkward situations when women or younger members of the family receive such confidential information about a more esteemed male.

Remuneration issues concerned the GPs. For those GPs who did provide home visits, the fact that Vietnamese patients avoid institutional care and expect family support for terminal care places added expectations for the GP. Those that perform home visits found that much time was spent counselling the family. In circumstances of low income households and the need for repeated visits, GPs felt happier for the government to pay through bulk billing rather than place an added financial burden on poor families.

Discussion

Contextual issues of history, culture, religion and socioeconomic circumstances were crucial for consumers and health professionals and operate as barriers to the provision of palliative care. Many GPs and patients shared the one Vietnamese heritage so that often the social influences remained implicit or unstated, rather than overt. The demands of palliative care will require the community and the profession to communicate, examine and address the assumptions that have generated

the barriers to the community and doctors operating harmoniously within the Australian health environment. This may be achieved at a one-on-one and community level.

More locally appropriate training for doctors is needed in the biomedical aspects of palliative care. However, there is a need for culturally specific education. As most GPs in this area are Vietnamese, then training in patient care would not be cross cultural. Doctors are aware of the cultural barriers to palliative care but require assistance in determining the solutions to provide appropriate care to this community. This will mean reducing some GPs' and the community's shared distance from the Australian health system. Doctors and the community both require engagement in and by the culture of the Australian health community.

Current support for GPs takes the form of specialist palliative care services, family and improved mechanisms for remuneration. The present problems in the delivery of care for terminally ill Vietnamese patients will require the cooperation of each sector to develop models of palliative care that engage and are culturally appropriate – for both the community and health professionals – with the backing of funding bodies.

Conflict of interest: none declared.

References

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2. Reymond L, Mitchell G, McGrath B, Welch D, Treston P, Israel F, Read T. Research study into the educational, training and support needs of general practitioners in palliative care. Canberra: Department of Health and Ageing, 2003.

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