査読付き研究ノート

Cultural beliefs, attitudes and behavior in seeking health care of Japanese-Peruvian laborer immigrants in Saitama and Gunma

− Concerning Ethic and Human Rights −

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Summary

Japanese-Peruvian laborer immigrants settled in Saitama and Gunma prefecture and their peculiarities of interaction in health care settings due to the cultural beliefs and attitudes were studied in depth. Through qualitative research, Japanese-Peruvian immigrants, the bilingual medical personnel, medical translators and volunteers for medical translation were interviewed with this purpose. We found language difficulties for translation and the lack of information on the medical translation services available through prefectural services. The lack of the other person's point of view, the haste for relief from symptoms, the use of over-the-counter medicines brought from abroad, as well as paternalism in the medical patient relationship but the need of reassurance, were found among other attitudes at the clinical settings. "Cultural Diagnosis" which is concerned about patient's indigenous meaning on sickness needs to be paid attention to medical settings.

Keywords

Culture Diagnosis, Immigrants, Health care, Japanese-Peruvian

1. Introduction

This year, the second year of the Institute of Medical Anthropology, we focus our field work again in the prefectures of Saitama and Gunma. With the purpose of getting a deeper understanding of the cultural aspects, attitudes and behavior in clinical settings of Japanese-Peruvian laborer immigrants, we conducted interviews with patients, medical translators, volunteers and health care workers. As we present the summary of the most relevant interviews, we will emphasize the peculiarities related to cultural approach and other behaviors found at the medical encounters.

2. Case studies: Patients, medical translators and health care worker`s view

a. Medical translator, volunteer, (15 years living in Japan) accredited by course given by one prefecture

- "The medical-patient relationship is cold logic, doctors give scarce explanation. Moreover, if they keep going to see the doctor, doctors may say, you are coming again, you don't have anything". In

her opinion, for Japanese doctors, Latin American patients speak too much.

- The hospitals she goes to for medical translation do not have or do not use bilingual questionnaires for consultation.
- This volunteer work is seldom required by the hospitals or by patients, because they do not know about their existence. The volunteer would receive payment from the patient but only for the transportation fee. The fee that a patient would pay to a professional translator would be much higher, around 7000 yen a day. The volunteer medical translators are not free to directly contact the patients; they must wait for the request of the hospital.
- The responsibility for the medical translation is that of the prefecture.

b. Peruvian volunteer in medical translation living in Japan for 7 years.

- "Peruvians are not patient, even if they would go to the doctor once, if they do not feel any improvement in one or two visits, they will request medicine from Peru, and make mistakes in the use of that medicine. For example, they would order medicine for productive cough and use it for dry cough. At the end, they will continue with the health problem".
- "Peruvian patients start their consultation telling their diagnosis to the doctor. That diagnosis would not be for sure a diagnosis provided by a medical doctor in Peru".
- "They don`t know how to use some Japanese medicines". For example oral powder is not used in Peru and transdermal therapy in patches is seldom prescribed in clinical settings. They link the use of powder with the appearance of small sores in the mouth. Because of misunderstandings like this, they start to dislike the use of Japanese medicine.
- Expressions of symptoms related to dyspepsia are difficult to translate from Spanish into Japanese.
- Sometimes Peruvian patients misunderstand the prescription, or they decide not to take certain medicines such as the ones for gastric protection can get symptoms for that.
- There was a case of a patient who was found with active tuberculosis, and without being told in advance she was forced to be hospitalized for two months. It made the arrangements difficult for their children alone at home during the period of the hospitalization.
- There are hospitals trying to surpass language difficulties. In Sogo hospital there are a few doctors with dictionaries in the ambulatory clinic. In Gyoda`s hospital, she was able to speak in Spanish with a medical doctor.

c. Japanese-Peruvian laborer, 38years old, 10 years living in Japan

- In a period of hard stress at work she experienced abdominal discomfort and dyspepsia. Even though she is able to talk in Japanese for daily life encounters, when she felt sick she found difficulties in expressing her symptoms. She searched in a dictionary of medical terms, and she found the word ulcer in Japanese to express her symptoms, but she wanted to say gastritis, (used as a lay term in Peru for dyspepsia). After two consultations, she found the word on the internet and she told it to the doctor. In the end, she had a gastroscopy. For that procedure, the hospital brought a medical translator, who told her that there was no problem. Because she continued with the symptoms, she came back to Peru and there, she had a new gastroscopy with a result of gastritis, the biopsy result of the gastroscopy. The symptoms finally disappeared when she changed to another job.

d. Japanese Peruvian laborer, 20 years working in Japan

- He did not have any bad experience in health care in Japan. In his opinion, more than a language problem there is an attitude problem. Certain previous experiences can badly influence the following encounters with foreigners. In his case, he had been hospitalized for the study of a diarrhea problem related with stress 2 weeks earlier. His brother died because of a work accident. A necropsy was performed on his brother, and he was told the results of the necropsy. He had the possibility to arrange the transfer of his brother`s body for religious ceremony to another prefecture. Even though his brother was not updated in the health insurance, the compensation and pension was granted to his sister-in-law. Another friend whose brother was diagnosed with gastric cancer, even though he was not updated in his health insurance he was granted the treatment.
- From the Peruvian side, the attitude problems he mentioned were, the ways of starting questions, without greeting, in a demanding attitude, just thinking about ourselves, not the other, and not what the other is thinking. "There are things that are important to Japanese people that we, as Peruvian, need to acknowledge, recognize, and respect".
- Bad previous experiences with foreigners may determine the following encounters. Once he went to request a service to his car, the mechanic thought either he did not have the money to pay for the service or that he was going to run without paying. "You know what I mean, the culture of theft, if it is there and I don`t take it, I am a fool"
- There is also the bad disposition for the difficulties in communication itself.
- There are people living in Japan, 15 or 20 years without having a dictionary of Japanese, without doing an effort of learning Japanese language. "We are in Japan not in Peru".

e. Brazilian Helper, working 20 years in Sogo Hospital. Volunteer for medical translation but not officially as one of her duties as helper in the hospital.

- She said she had no preparation as medical translator, but as Brazilian, she helped those immigrant laborers who cannot speak English in the hospital, mostly Japanese-Peruvian.
- In the past, immigrant patients in the hospital were 30 to 50 patients a day. With the moving of laborer immigrants to Saitama and Gunma, and especially after the recession, there are only 3 to 4 immigrant patients a day. She was sick and hospitalized for a long period last year and that might have also contributed to the decrease of immigrant patients to the hospital.

3. Discussion

In a globalized world, with the concomitant rapid spread of technology, cultural indigenous values and cultural diversity set the scenario in which personal and community interactions occur (Benedict XVI, 2009). "In our times, suffering, illness and affliction are abstracted from experience. They are made into lines, shapes, and graphs. They become merely technical conditions. And as this shift in cultural representation occurs, the experience of suffering alters...begins to "thin out", it loses its humanity" (Kleinman, 2006).

In this framework, interactions in medical settings are challenged by the increasing presence of migrants throughout the world. "Culture, often made a synonymous with ethnicity, nationality and language, expands to comprise multiple variables, affecting all aspects of life experience. Culture is inseparable from economic, political, religious, psychological, and biological conditions". (Kleinman, 2006)

Health care access of undocumented immigrants in the US seems to be to a lesser extent than the access of them to health care in Europe and Canada (Uiters, 2009). Because of the lower access to prevention and regular health care treatment, the use of emergency care of immigrants and US citizens without health care coverage generate greater expenses for health care to the government (Okie S. 2007). In Canada, there are no economic barriers to the access to health care to immigrants, but they do not use the services as much as expected for reasons such as the lack of satisfaction with the scarce attention they receive from doctors, and the over reliance of doctors on medication (Kirmayer, 2007).

Japan has one of the highest standards of health care in the world, as it can be clearly seen as having one of the longer rates of life expectancy. The fact of the increasing need of migrant workers in Japan will challenge also the adaptation of health services for immigrants. For this reason, there is also a necessity to increase awareness to cultural diversity in the medical settings.

In the US, the actual tendency in the medical patient relationship has turned to affirm the autonomy of the patient (Hartzband, 2009). Medical patient relationship in Latin-American countries, yet, tends to be guided by a paternalistic tendency in the interaction. The patients trust their medical doctors with the task of making the decisions of medical treatment, without the need of explanation or informed consent. In this vertical approach of the medical patient relationship, an overlapping of the indigenous cultural values can be seen. This factor present in the act of being healed enhances the process of healing itself. However, in this paternalistic approach in Latin-America, the patient receives many times verbal and non-verbal reassurance of the nonthreatening condition of their sickness. In Japan, Japanese-Peruvian, trust in their Japanese doctors, as they continue visiting them, even if they can not fully understand their explanations, diagnosis or treatment. Japanese verbal communication might be felt to be limited and scarce in comparison with the Western style of communication (Ochiai K. 2006). The need of reassurance in verbal and nonverbal communication, and the lack of understanding of this reassurance from the doctors, is being felt as indifference or "cold logic" medical patient relationship.

Another example of the paternalism of the medical patient relationship in Japan is the case of the hospitalization of a Peruvian tuberculosis patient. The patient was not informed previously neither of her diagnosis nor about the long term hospitalization needed. Tuberculosis inpatient treatment in Peru is reserved only to patients with intolerance to the treatment or drug resistant tuberculosis. The regular ambulatory treatment strategy of Tuberculosis (DOT) Direct Observed Treatment, allows the patient to continue with daily life such as home duties and child care. These country differences in the management of the same disease may let the patient think her state of disease is worse. Not being previously informed of the inpatient requirement of treatment, she could not prepare child care required during the mother`s hospitalization.

Even though there are some services and materials available for health care to immigrants, (Nakahagi, 2003), (Ward, 2009), (Oshima, 2006); they are not well known by the immigrants and are not used at great length. Some examples of these available materials are the outpatient forms for specialized consultation, available in Spanish and some other languages, and the medical dictionaries in English, Portuguese and Spanish.

The lack of patience of Japanese-Peruvians in getting the relief from symptoms might be related to a cultural attitude but also to the habit of self medication extended in Peru. Before going to the doctor, patients would take medication available without prescription in drugstores, following previous personal experiences, or family or friend`s experiences.

Sometimes, when patients starts their consultation with a previous diagnosis it does not have to be a medical diagnosis for sure. In Peru, patients may refer to common symptoms of dyspepsia as gastritis with the use of medical terms. It is necessary to ask again about the meaning of the words the patient use to explain the condition.

Some of the current Japanese medicines, such as powder or patches, are not commonly used in Peru. Instead, in Peru, there is a strong belief about the efficacy of parenteral medication rather than oral or rectal. Moreover, because of the lower doses of the Japanese medicines, the need of having to take 2 pills at a time instead of 1, is difficult to follow. That can explain the widespread saying amongst immigrants that Japanese medicine is weak. Even having understood the prescription, patients may decide about how many of the pills given they will take. Commonly they will take less tablets than the number they got in the prescription.

There is increasing interest among doctors for improving communication difficulties in the medical settings which can be seen in the availability of medical dictionaries in outpatient's settings in Saitama and Gunma. On the other side, there is an apparent lack of interest in some immigrants that even 15 or 20 years after they settled they continue to rely on friends and relatives for translation and they do not yet have a dictionary.

Diseases related with stress, such as dyspepsia and the irritable bowel syndrome can also be seen in immigrant laborers. Post migratory symptoms usually start after the immigration reality does not meet the immigration expectation. The change of the life style, alimentary habits and the excess of work have been found as causes for these symptoms in immigrants in Canada (Whitley, 2006). Psychosomatic diseases and somatization can be particularly difficult to explain and understand because of its strong bonds to the precedent culture (Karasz, 2007). In the scenario of sickness, people who yet can speak Japanese enough for daily life can not manage to translate properly their symptoms and feelings to the doctors. (Muraji, 2007)

"Latinos", is a term used to call the Spanish-speaking immigrants in Japan. Unofficially, there seems to be 50,000, mostly from Peru, but also from Argentina, Bolivia, Paraguay, Colombia, Mexico, Ecuador and the Dominican Republic. The undocumented Spanish-speaking immigrants seem to be the same amount as the official number of Spanish-speaking migrants that claim to be Japanese descendants (Reyes-Ruiz, 2005). In Peru, in contrast to the "Peruvians", Japanese descendants are considered "honest, responsible and hard-working" (Takenaka, 2003). The "attitude problem", quoted by one of the interviewees, gather some particular way of Latino interaction that clashes with the Japanese respectful manners. The way of asking in a demanding attitude, the missed greeting, the lack of the other`s point of view in the communication, these differences should be also take into account by Latino patients in their approach to the Japanese health care system and society.

In the cultural approach to the health care services among Japanese-Peruvians, we found the overlapping of the cultural indigenous values into the contemporary

paternalistic medical patient relationship which is related to their kinship system. Furthermore, it is necessary to make a bigger effort to apply cultural diversity knowledge to develop mutual understanding and adequate and comfortable communication, because we are sure that some of them are really traumatized with the cultural friction with Japanese values. Such an intangible mental symptom can be hardly discovered by Japanese medical doctors. We must know their indigenous kinship system and social structure which gives us their ideal life quality and direction.

In medical anthropology much of the preceding discussion about indigenous populations and genre relationships has been related to the question of Human Rights in Ethics in medicine.

Anthropological trans-cultural research and the increasing feeling of its important role place it in a key position to talk about Global Human Rights and Ethics problems in medicine.

On this account, in considering what anthropologists have to contribute to the issue of human rights in medicare programs, we must first ask some basic questions:

1. What are human rights and medicare ethics?
2. Is there a universal set of human rights and medicare?
3. Are local cultural definitions of human rights that clash with those of other groups defendable?

No states would go on record as being opposed to human rights. Yet those from different states and from different political, cultural and religious traditions, continue to disagree on which rights have universal force and who is protected under them. Ethical relativists argued, however, that anthropologists had not discovered any universal moral values, each society's values are valid with respect to that society's circumstances and conditions. No society could claim any superior position over another regarding ethics and morality. So we should better speak of Ethical relativism.

When we think about Cross? Cultural Research on Diagnostic Categories and their Criteria as anthropologists' role, we have an opportunity to submit the new diagnostic categories and their criteria to systematic cross cultural research, both through combined clinical and ethnographic research and through collaborating in epidemiological studies.

In Mental Health and Psychiatry, anthropologists have almost entirely focused their attention on culture-bound disorders to the exclusion of studies of brief psychoses, schizophrenic disorders, manic-depressive illness, depression, and anxiety disorders.

Culture plays a profound role in the experience and expression of symptoms ? in the process of symptom-formation. Anthropologists would, therefore, expect that diagnostic criteria defined as symptoms will vary cross-culturally.

In that perspective, trans-cultural care is concerned with a comparison between cultures in terms of their caring behavior, health and illness (indigenous concept), values, their beliefs and patterns of behavior. The focus of this approach is on the care-giver who has to develop expertise in understanding the groups he/she is working with in order to effectively deliver care. Thus, the clinician is taught to recognize and understand the values, beliefs and practices of different cultures and in so doing is enabled to deliver care in a culturally sensitive and appropriate manner.

For cross? cultural caring, key issues in this approach are how well the cross? cultural bridge can be established in order to allow, for instance, a white European obstetrician to care for an Indian woman. On this concern the multicultural care system will enrich its potentiality with the professional collaboration of anthropologists. To this account we

would like to propose further joint research among medical doctor and social anthropologist.

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