

# Adapting to rural communities by overseas-born health professionals

Quynh Lê<sup>1</sup>, Shandell Elmer<sup>1</sup>, Sue Kilpatrick<sup>1</sup>

<sup>1</sup>University of Tasmania

## Abstract

### Introduction

As with other multicultural nations, cultural diversity is a prominent feature of Australian society that leads to intercultural awareness and respect through citizen interactions. While this enriching multicultural interaction is clearly seen in big cities like Sydney and Melbourne, it can be very different in the Australian rural context. Living in an isolated rural area is challenging for health professionals who were brought up in urban areas, particularly those born overseas as they experience two types of cultural and social adaptation: urban into rural and native culture into new culture.

As a result of workforce shortages, many overseas trained health professionals are recruited to work in Australia, particularly in rural areas. This has given rise to various initiatives and strategies developed to support and assist these health professionals in their dual cultural and social adaptation. These include University Departments of Rural Health and Rural Clinical Schools programs as well as the Rural Workforce Agencies. However, these programs do not extend to those health professionals who were born overseas and trained in Australia as they are 'Australian graduates'. In this paper we argue that in ways similar to those born and trained overseas, overseas-born Australian-trained health professionals may require additional support during the acculturation process and making the transition to working in rural communities.

### Aim

The aim of this study is to examine some aspects of the acculturation of overseas-born Australian-trained health professionals working in rural areas. This study seeks to understand the particular issues that emerge as a result of cultural difference in order to propose strategies that may more adequately prepare these Australian graduates for their rural health experience.

### Method

Six overseas-born Australian-trained health professionals were invited to participate in this qualitative study using snowball sampling. The interviews were recorded with the approval of the participants. The interview data were transcribed as raw data and later coded for thematic analysis, which includes topics and themes arising from the raw data as well as from the interview questions with a focus on issues and strategies of acculturation into a rural health context.

### Results/conclusion

There were different factors which facilitated or hindered the acculturation of overseas-born health professionals into a rural workforce such as professional isolation, cultural shock, family pressure, and cultural identity. The acculturation process was also affected by the quality of their perceived 'social and cultural capital'. Different coping strategies were employed to deal with the changes in a new rural environment. The paper discusses some implications of this study with focus on how to improve the

living and working conditions of overseas-born Australian-trained health professionals in order to attract them to rural Australia.

## Introduction

In Australia, there are increasing numbers of people born overseas undertaking training and education to become health professionals. Statistics reveal that many non-English speaking students with a migrant background (particularly those from Asian backgrounds) successfully achieve a place at university<sup>1</sup>. For example, in 2004, domestic overseas-born students represented 30.2% of medical students, 51.6% of dentistry students and 43.1% of optometry students<sup>1</sup>. This success has been linked to the parental drive to succeed and preparedness to invest in their children's education<sup>1, 2</sup>. According to the 2006 census, 50% of generalist medical practitioners, 42% of specialists, 47% of dental practitioners and 27% of nurses were born overseas which is significant considering 22% of the total Australian population were born overseas<sup>3</sup>. The census data includes overseas-born health professionals who were trained in Australia and overseas.

In every state of Australia the demand for health care has increased but there are not enough health workers to take care of the population<sup>4, 5</sup> particularly in rural and remote areas. Recruitment to rural and remote areas is especially difficult because of factors such as unfamiliarity with rural life, lack of facilities and resources, cultural and distance isolation, family commitments, lack of spouse employment opportunities, lifestyle and fear of the unknown environments<sup>6</sup>. Various suggestions and solutions have been advanced to deal with the shortage crisis<sup>5, 7, 8</sup> including the employment of overseas-trained health professionals to work in remote and rural areas.

Compared with the considerable body of research on the experiences of overseas-trained health professionals<sup>4, 7, 9</sup> especially doctors, very little is known about those who were born overseas into a non-Western culture but have subsequently lived and trained in Australia. This category of migrant health professionals tends to be bi-cultural in the sense that they are familiar with two cultures and as such, they may not encounter all of the issues faced by overseas-trained health professionals. However, most migrants tend to settle in metropolitan areas<sup>10</sup> and therefore newly graduated overseas-born Australian-trained (OBAT) health professionals may find working in a rural or remote place in Australia challenging culturally and professionally. Thus, health workers, policy makers and universities need to understand the many issues about their acculturation into rural health. This study seeks to explore the experiences of Vietnamese OBAT health professionals living and working in rural Australia. There is the potential for any health professional with little or no familiarity with rural Australia, whether they were born and trained overseas or in Australia, to encounter problems of acculturation into a rural context. However it is likely that cultural background, apart from other socio-cultural aspects, will play an important role in their encounter with new life in rural Australia.

## Research methodology

Following ethics approval, participants were recruited using a snowball sampling technique. Six OBAT health professionals participated in this qualitative study which used a combination of narrative research and case study. Narrative research is a form of inquiry in which the researcher studies the lives of individuals and asks them to provide stories about their lives<sup>11</sup>. These qualities of narrative research are reflected in this comment from a research participant:

While I was talking about my personal experiences with you, I reflected on the experiences that had taken place in my life here. But somehow through our conversation or interview, I also discovered things that I had not been aware of before. It was like looking at myself in a mirror, trying to make sense of what had happened personally. It was a fascinating self-discovering process for me too.

This paper explores particularly the acculturation of the participants into a rural working environment in small communities with very few migrants. The Vietnamese-born participants included 3 medical doctors (2 females), 1 male dentist, 1 female physiotherapist, and 1 female nurse. As this study focused on participants from the same cultural background, the participants had a shared cultural experience, values, beliefs and history. The findings presented relate to the processes of adaptation by the participants as a result of contact with a new culture. This depends on various factors such as family influence, age of arrival in Australia, place of settlement personality, Vietnamese networking, and peer influence. These findings take account of the situational and personal factors as well as the specific cultural ethnicity of the participants which may impact the process of acculturation.

The findings of this study should not be used as a source for stereotyping and generalising migrant health professionals. Nor should this study be viewed as a reification of culture as other social structures need to be taken into account when considering the experiences of health professionals particularly gender and social location. The case study approach taken in this research has facilitated the gathering of in-depth data for the purpose of learning more about an unknown or poorly understood situation<sup>11</sup>. Thus, the significance of this case study is not the quantity of data but the insights gained from the lived experience of individuals living and working in rural Australia.

## Rural acculturation

In intercultural interactions, acculturation is a significant phenomenon that occurs when people from different cultures come into contact, affecting the culture of either or both groups, usually one more than the other<sup>12</sup>. Studies of acculturation focus on how individuals who have grown up in one cultural context manage to adapt to new contexts and how this occurs at a group and individual (psychological) level<sup>13</sup>. The acculturation process can be minimal if the two cultures are very similar, for example, when New Zealanders move to Australia. Cultural shock or acculturative stress can occur when the two cultures are vastly different<sup>13</sup>. Key moderating factors prior to an individual's acculturation are demographic (age, sex), cultural (language, religion, distance), economic, personal (health), migration motivation (push vs. pull) and expectations (eg excessive vs realistic)<sup>14</sup>. There are also factors within the host culture which can facilitate or hinder the acculturation process of an individual such as policies, social support, and community attitudes towards new comers<sup>14</sup>. As a result of these various situational and personal factors that influence acculturation, there are wide variations in how this occurs for individuals and groups.

This study focuses on the process of acculturation of OBAT health professionals that result from living and working in a rural community. Some of these experiences may be shared by Australian-born health professionals who move to a rural community making the transition from an urban to a rural culture. However, we argue that the cultural differences for OBAT health professionals are amplified because of their migrant background. Five main features of the psychological acculturation process have been identified in the literature and these include:

- life events that bring about intercultural contact,
- individual's appraisal of the meaning of these experiences (behavioural shifts: culture shedding, culture learning, culture conflict),

- coping strategies (integration, separation, marginalisation, assimilation),
- physiological and emotional reactions (positive or negative),
- long-term adaptation (psychological and socio-cultural)<sup>13</sup>.

How did the participants in this study experience acculturation particularly in terms of these processes? In the discussion of this question as follows, the above processes are regrouped into three broad categories: (a) acculturation events and meanings, (b) coping and responding to acculturation, and (c) long-term adaptation.

## Acculturation events and meanings

All participants in the study moved to a rural area for the specific purpose of working as a health professional, thus the nature of their cultural contact was voluntary and goal-oriented<sup>14</sup> which often aids the acculturation process. The participants generally viewed the move as a foundation for enhancing their life opportunities. However, other life events such as aging parents and children's schooling impacted on the ability of the rural setting to fulfil health professionals' expectations. For example, one participant moved to a rural town with her family, including her parents. Her husband is a law graduate, however, there were no suitable jobs for him in the town. Overtime, her parents became lonely as their English is very limited. The children wanted to learn martial arts, musical instruments, and participate in a number of sporting activities which were not available in the town. Her youngest daughter with hearing impairment required special needs which the local school did not provide. While a similar problem could arise for an Australian from a family that has been in the country for many generations, this health professional's experience was coloured by her cultural background. Her family experienced social isolation compounded by an acute sense of feeling and being perceived as 'different'.

Participants reflected on the cultural differences between their 'normal' ways of living and the new ones. Conflicts were caused by various factors such as different lifestyles and expectations which sometimes resulted in acculturative stress ('culture shock'). For some of these OBAT health professionals their previous experience living in a crowded Asian city and then a large Australian city then a small rural town created significant acculturative stress:

For me, the obvious cultural shock that I experienced in the first few weeks in this rural town was what to do in the evening and particularly on the weekend. In the city, I used to hang out with friends, spend a lot of time shopping, visit friends, and our house was always filled with visitors during the weekend. We cooked Asian foods together and chatted about things. In a small rural town, there was not much for me to do after work. I felt rather lonely. Thus I spent a lot of time talking to my friends on the phone. (Participant)

Another significant cultural difference is the lack of interaction between town people on the basis of gender and age, for example, teenagers and older people often did not share social activities.

One thing I feel very strongly is the social separation between the young and old generations. I seldom see old and young people together. For example, I once saw a bus with only old people going to a picnic or something like that. It was rather strange. (Participant)

## Coping and responding to acculturation

As part of intercultural relations, individuals and groups need to determine how to acculturate, usually based on the desire for cultural maintenance and contact-participation<sup>14</sup>. Participants in the study did this in various ways. However, because of the voluntary and goal-oriented nature of their acculturation, most made conscious efforts to seek contact-participation in order to achieve integration.

It was so hard in the first few weeks as I felt so lonely and out of place there. However, I wouldn't give up easily. I felt that I should make an effort. I started to spend more time with people and got used to life there instead of locking myself in the house after work. It was good. I made friends with the local very easily. I like their openness and friendliness. (Participant)

The participants displayed integration strategies whereby they maintained their independence as well as their cultural identity while also engaging with the community. In this way, integration strategies include mutual engagement, being flexible in personality and participation in two cultural communities.<sup>14</sup>

When I started working there, I was invited by many local people to participate in various social activities in town. It was good that I was received warmly by the local community. I also made sure that I wasn't overly committed as I needed my own space. I declined several invitations to local events. It had to be done suitably. (Participant)

A key moderating factor in the acculturation process is the attitudes of the society of settlement, for example, prejudice and discrimination have a negative impact<sup>13</sup>. These OBAT health professionals generally found that they were warmly and enthusiastically welcomed predominantly because of the workforce shortages. In addition, while the participants were new to the rural setting, unlike their overseas trained counterparts, they are not new to Australia, however they may still be treated as a 'foreigner' by the community because of their appearance and accent.

To me, I didn't consider myself a foreigner as I was brought up in Australia and I know more about this country than my original country. I could understand their jokes here and the Australian ways of expressions. (Participant)

However, accents did cause some communication difficulties as it is not always easy to understand rural people who speak with a very broad Australian accent (and use Australian slang) and the participants' accents vary from region to region such as Vietnamese English, Indian English and Chinese English. The participants used a number of communication strategies such as speaking slowly, repeating important sentences, writing a note if needed, asking the patients to repeat what they have heard, etc.

In the university environment, we used academic English and most people we interacted with used standard Australian English. When I moved to the rural area, it was a different linguistic environment. Sometimes I did not fully understand what some people said as their accent was so broad. Thus I had to spend more time to talk to people so that I could get used to their broad accent. (Participant)

There were also issues in relation to cultural stereotyping, particularly for the female participants in the study. For example, the towns have had several Asian women migrated there after marrying their Australian husbands and they are seen as fragile, domestic-orientated and 'passive'. These cultural stereotypes create difficulties for the female OBAT health professionals to assume an authoritative position within the community.

## Long-term adaptation

Overtime, the acculturation process may result in adaptation, or changes that are made by the acculturating individual or group to achieve a better 'fit' with the new context<sup>14</sup>. The adaptation process is considered to be multifaceted, occurring on a psychological, socio-cultural and economic level<sup>15</sup>. Within this study the psychological (self-esteem, identity consolidation, well-being and satisfaction) and socio-cultural (cultural knowledge and skills and interpersonal relations) aspects were evident. The fear of the unknown gradually disappeared and the new rural environment became 'homely':

One day when I went to a big city, I suddenly realised that I could not cope with the traffic; the behaviour of some aggressive drivers irritated me. The street noise was terrible. I just wanted to get back to the town and escape all these. Yes, I feel at home in a small town now. (Participant)

Other determining factors of the nature of adaptation are the cultural group's mobility (Indigenous peoples, immigrants), voluntariness (immigrants, refugees) and permanence (settlers, sojourners)<sup>14</sup>. In this instance, the participants voluntarily moved to the rural area. However, they could also be considered sojourners as many eventually want to return to an urban environment.

I think the experience there was great. I learned many things. Somehow at the back of my mind, I always want to live in Sydney or Melbourne. I think my life was greatly enriched by living and working in a rural place. (Participant)

## Acculturation and social and cultural capital

Intercultural studies indicate that of the four acculturation strategies (integration, assimilation, separation and marginalisation), those individuals and groups that pursue and accomplish integration appear to be better adapted<sup>16</sup>. Integrated individuals want to maintain their identity with their home culture, but also want to take on some of the characteristics of their new culture. This is possible in settlement societies where there is overt pluralist and civic ideologies<sup>17</sup>. This was evident in the stories of the study on how the participants regard their different views and experience of health care in different settings. For instance a participant spoke about the different attitudes of her parents in relation to health seeking behaviour:

My mother refused to go for regular health check-up. For her, you go to the hospital, only if you're very sick. What's the point of seeing a doctor when you're OK? She thought that doctors were busy and serious people. We shouldn't bother them unless we had real problems such as a heart attack or injury. (Participant)

Within this study, participants were asked about their views on complementary and alternative medicine (CAM) as this is an important aspect of health concepts in many Asian countries, reflecting health as a combination of three aspects: physical, mental and spiritual.

The OBAT health professionals in the study did not use CAM in their treatment of patients; however, this does not mean that they rejected the value of CAM in health. They recognised the difference in the cultural and social acceptance of CAM in different settings.

In Vietnam, traditional health practice is still strong in the community. It's important for health professionals to be sensitive in dealing with patients. My biggest concern is that some Vietnamese patients may use a combination of Western and traditional herbs which may not go well together. (Participant)

Another participant believed that Vietnamese traditional scratching massage (known as **cạo gió**) is helpful for adults suffering a bad cold. However, **cạo gió** should be used on Vietnamese adults who have been used to it.

Actually any form of mild traditional massage is very helpful, physically and psychologically. Older people often ask their family members to massage their body when their backs or legs ache. Psychologically, it's a way of communicating care and love among family members. Emotional factors play an important part in health in Vietnam. (Participant)

Other research findings relating to the success of integration strategies suggest the need to work towards successful workforce integration in rural and remote communities<sup>18</sup>. Integration is a two-way process that requires newcomers to commit to adapt to a new life in rural Australia as well as the adaptation of rural Australians to new people and cultures, that is, integration requires mutual accommodation<sup>19</sup>. This requires close attention to the generation of social and cultural capitals as these play important roles in supporting health professionals in their transition from an urban to a rural context. Bourdieu<sup>20</sup> refers to social capital as 'the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalised relationships of mutual acquaintance or recognition'. Social capital emphasises the role and place of an individual or group in a structure of relationships which provides a source of support and enhancement. Supportive relationships within the new comer's own culture and society of settlement have been shown to positively influence adaptation by enhancing integration<sup>13</sup>.

Within this study, the OBAT health professionals referred to the importance of their immediate and extended family in providing psychological, emotional and physical support and generating both social and cultural capital. For example, a participant stated she was very lucky to have her parents living with her in the rural town as they helped with cooking, cleaning, gardening and caring for their grandchildren.

There were many opportunities for the participants to become involved and develop networks within the local rural communities. Important sources of support in a rural town included the neighbourhood, social clubs, and the closely combined network of colleagues and friends.

I'm not sure if neighbourhood truly exists in a big city. There, everyone lives their own life. Most people do not know who their neighbours are, except saying hello and goodbye. It's wonderful in a town as most of our neighbours were our friends. We saw them when we looked through the windows, we met them at the local stores, and then at the sport oval. (Participant)

A number of my colleagues met socially almost every day. When mum cooked a special Asian dish, we just called them to come over. You didn't have to send an invitation in advance. Our children played with other kids on a quiet street nearby. I'm not worried at all as I knew that they were safe. By the way we sometimes forgot to lock the doors and nothing happened. (Participant)

The participants emphasised the role of colleagues in providing support at levels that may not be achieved in other work environments. In this way, the concept 'collegiate' in a rural context has a profound meaning, professionally and emotionally. The participants described the close collaborative relationships they enjoyed and the strong bonds between staff, patients and the community. These interpersonal relationships were built on trust, support, respect and care.

## Conclusion

The shortage of health professionals in rural and remote areas creates an imperative for investment in the human, social and cultural capitals and workforce diversity that result from the employment of overseas-born health professionals in these areas. This study provides some insights into the life of OBAT health professionals in a rural context. A larger study is required to inform recruitment practices of rural health providers and assist universities in preparing students for rural practice.

Studies such as this highlight the two-way nature of acculturation and the subsequent development of an intercultural space where members of both groups develop their cultural boundaries and social relationships<sup>19</sup>. While this study has focused on the experience of the OBAT health professionals, more research is also required with regards to the experiences of the society of settlement, that is, the rural towns that receive these health workers. Comprehensive understandings of the experience of both groups would assist in the development of strategies and policies to aid integration by fostering mutual accommodation. Much could be learned from the government agencies that currently support overseas-trained health professionals in this way.

This study has emphasised the role of social support in enhancing integration strategies, which can also arguably assist in the maintenance of cultural capital. Social support can result from social capital found in networks and connections characterised by trust, respect, reciprocity and shared norms and values. Previous research suggests that socio-cultural adaptation is characterised by interpersonal and intergroup relations, family and community relations as well as cultural knowledge and skills<sup>14</sup>. Further study will illuminate the ways that both the new comers and the rural communities can be better prepared to engage in social support activities in order to achieve long-term adaptation. Integration policies that reflect pluralist and civic ideologies need to be pursued to produce positive and harmonious relationships.

## Acknowledgment

Our gratitude goes to Cecilia Chiu for her kind proofreading.

## References

1. Dobson I, Birrell B. Are Asians Over-represented in training in the health professions? . *People and Place* 2005;13(4):60-5.
2. Dobson I, Birrell B, Rapson V. The participation of non-English-speaking-background persons in higher education. *People and Place* 1996;4(1):46-54.
3. Australian Bureau of Statistics. ABS 2006 Census of Population and Housing. Canberra: Australian Bureau of Statistics; 2006.
4. Hawthorne L, Barrell B. Doctor shortages and their impact on the quality of medical care in Australia. *People and Place* 2002;10(3):61-3.
5. Kilpatrick S, Johns S, Millar P, Le Q, Routley G. Skill shortages in health: innovative solutions using vocational education and training. *Rural and Remote Health* (online) 2007;7(1).
6. Durey A. Settling in: Overseas trained GPs and their spouses in rural Western Australia. *Rural Society* 2005;15(1):38-54.
7. McGrath BP. Integration of Overseas-Trained Doctors into the Aus-tralian Medical workforce. *Medical Journal of Australia* 2004;181(11-12):640-2.
8. Productivity Commission. *Australia's Health Workforce*. Canberra; 2005.
9. Fiscella K, Frankel R. Overcoming cultural barriers: International medical graduates in the United States. *JAMA* 2000;283:1751.
10. Birrell B, Rapson V. Two Australias: Migrant settlement at the end of the 21st century. *People and Place* 2003;10(1):10-28.

11. Creswell J. Research Design. London: Sage Publications; 2003.
12. Hruschka DJ, Hadley C. A glossary of culture in epidemiology. *J Epidemiol Community Health* 2008;62:947-51.
13. Berry JW. Immigration, Acculturation, and Adaptation. *Applied Psychology* 1997;46(1):5-34.
14. Berry JW, Sam DL. Acculturative and adaptation. In: Berry JW, Segall MH, kagitcibasi C, editors. *Handbook of cross-cultural psychology*. 2nd ed. Boston: Allyn and Bacon; 1997. vol 3 p. 291-319.
15. Berry JW, Charles S. Acculturation. In: *Encyclopedia of Applied Psychology*. New York: Elsevier; 2004. p. 27-34.
16. Berry JW. Intercultural relations in rural practice. *Canadian Psychology* 1998;40:12-21.
17. Bourhis RY, Moise LC, Perreault S, Senecal S. Towards an Interactive Acculturation Model: A Social Psychological Approach *International Journal of Psychology* 1997 32 (6):369–86
18. von Zweck C, Burnett P. The acculturation of internationally educated health professionals in Canada. *Occupational Therapy Now* 2006;8(3):22-5.
19. Berry JW. A psychology of immigration. *Journal of Social Issues* 2001;57(3):615-31.
20. Bourdieu P. Forms of Capital. In: Richards JC, editor. *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood Press; 1983.

## Presenter

**Shandell Elmer** is a Lecturer at the University Department of Rural Health, University of Tasmania. While working in various areas of the health system as a registered nurse, Shandell obtained a Bachelor of Arts degree majoring in sociology and management. Her undergraduate degree sparked an interest in health sociology, which has become the focus of her research efforts. Her interest in this area is sustained through involvement in the teaching of health sociology in the School of Sociology, Social Work and Tourism where Shandell completed her honours degree. Her honours thesis focused on the participation experiences of a small community group involved in health services in rural Tasmania. Shandell is currently undertaking a PhD that aims to explore the relationship between social capital within health service organisations and their attempts at community engagement.