THE IMPACT OF VIETNAMESE HEALTH CARE BELIEFS UPON THE ORGANIZATIONAL CULTURE OF EMS PERSONNEL IN THE GARLAND FIRE DEPARTMENT

EXECUTIVE DEVELOPMENT

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An applied research project submitted to the National Fire Academy
as part of the Executive Fire Officer Program

October, 2000

ABSTRACT

As the suburban cities all across the country have experienced increases in cultural diversity due to immigration, so Garland, Texas has been no exception. The paramedic/ firefighters of the Garland Fire Department began expressing concern several years ago about the increasing numbers of the Vietnamese community, and associated problems such as communication. The primary problem was the perception that, as western medicine providers, they could not hope to provide quality service to a people whose health beliefs were out of the realm of anything that they had been taught.

The purpose of this study was to identify health care rituals and beliefs that were indigenous to the Vietnamese, to analyze the organizational culture of the Garland Fire Department, and to determine its flexibility and willingness to incorporate new ideas in order to provide better service.

Historical research was used to gather relevant data, and descriptive research was used in the form of surveys to compare local data to the Vietnamese immigrant population as a whole. The research questions were directed at looking at Vietnamese health care practices, looking at the social profile of the paramedic fire fighters, their organizational culture, and its flexibility.

The procedures were directed at gathering historical data for local comparison, and a literature review to highlight the main points of the historical data. Surveys were used to focus on Vietnamese health care, fire department social profiles, and organizational culture.

The outcome of the surveys revealed a focused belief system for health

care in the Vietnamese community and a definite social profile for Garland paramedic fire fighters.

The recommendations proposed to involve paramedics and management in the transition process to more client specific educational programs, an expanded quality management program, and incorporation of new knowledge by ethnographic interviews and focus groups.

TABLE OF CONTENTS

ABSTRACT……2

TABLE OF CONTENTS……..4

INTRODUCTION…….5

BACKGROUND AND SIGNIFICANCE……6

LITERATURE REVIEW…….8

PROCEDURES……11

RESULTS…….14

DISCUSSION…… 20

RECOMMENDATIONS…… 24

REFERENCES…… 27

APPENDIX A (SURVEY OF SOCIAL PROFILE)……31

APPENDIX B (SURVEY OF VIETNAMESE HEALTH BELIEFS)…… 39

APPENDIX C (SURVEY OF ORGANIZATIONAL CULTURE……44

INTRODUCTION

The Garland Fire Department (GFD) personnel have been concerned for some time that the health care needs of their increasingly diverse community are not being met. Garland is a city of fifty-seven square miles densely populated with 210,000 people. Included in that dense population is a community of Vietnamese people whose numbers are approximately 20,000. Differing health care and social practices have caused GFD personnel to identify that they do not always feel comfortable that they have done everything possible for their Vietnamese clients. The problem that GFD personnel face is that their organizational culture and work environment do not seem to allow integration of alternative health care belief systems as practiced by the Vietnamese community.

The purpose of this research project was to identify factors that predominate in Vietnamese health care belief systems, to identify factors in social background that influence personal and group experiences, and to determine the impact of alternative health beliefs upon the organizational culture of GFD personnel.

Historical and descriptive research methods were used to answer the following questions:

1. What are the predominant beliefs and practices related to health and wellness in the Vietnamese community?
2. What is the collective social background of GFD personnel and what does it bring to the organizational culture of GFD?
3. Will the organizational culture of GFD allow tolerance of alternative health care systems?

BACKGROUND AND SIGNIFICANCE

Like most cities that began as small towns in suburban to rural Texas, original Garland residents wanted to be the last families to move here. As a result Garland grew to be the size that it is today with very little planning for that growth. The downtown sector is intact with a small area of businesses and one way streets that define the square. Being largely a blue-collar town, it has given rise through the years to small business and small industry. Those industries have provided opportunities for local residents to work close to home, although the wages are generally lower than those found two miles to the west in Dallas.

In 1975, as the Vietnamese influx began into the United States, Garland became a prime target for immigration because of its close proximity to Dallas and the similarity of the weather to Vietnam. The Vietnamese discovered that they could live closely in Garland, and buy and operate small businesses in the same area, thus minimizing the need for a car. Clustered in a dense area surrounding two major thoroughfares, most businesses at the intersection of Jupiter Street and Walnut Street are owned by Vietnamese. Their goods are consumed by Vietnamese and Americans, as well as other Asian communities that have gathered in Garland. The closeness of private life and work, while considered in some respects to be ideal, has made assimilation among the older immigrants difficult to impossible. Their children, many of them now American born, have become bicultural and have become sources of conflict in the family that wants to cling to the old customs (West, 1996). Gold (1992) suggests that this type of bicultural behavior from the younger generation becomes a significant stressor for the older generations as they try to keep

the customs of their native country. Remaining isolated and clustered is extremely important to the older generations (Branigan, 1998), and the younger members are often viewed as bringing dishonor to the family as they begin to develop American ways. A similar situation exists in the Vietnamese community in New Orleans, Louisiana, in that Vietnamese parents keep their children physically within their community for as long as possible (Booth, 1998), and note that, as soon as their children begin to blend with American children, their deeply rooted value system begins to erode.

To look next at the internal aspects of GFD, it appears on the surface that neither the social nor the organizational cultures of GFD have any actual similarities to the Vietnamese culture. Of the 250 fire fighters surveyed, only 2% responded that they were not from Texas, 4% were not from suburban or rural Texas, and 65% have not been out of Texas (Appendix A). The social profile evolving from this survey suggests a group of people who are not sophisticated, and tend to be biased against those things with which they are unfamiliar. The organizational culture of the fire department has the same type of impact. In Executive Development, Unit 7, "Organizational Culture", discusses the fact that organizational culture is largely formed by the value systems, ethics, and assumptions that the members bring with them, combined with their experiences while they are members of the organization. It stands to reason that people from like backgrounds will form the heart of the organization and will interpret their experiences the same way.

The mission of GFD is best paraphrased by recognizing that health care is a right in the community and that quality and equality of health care should prevail regardless of the type of health beliefs that they have. The employees of GFD

embrace the mission statement, which could create a dilemma and an organizational crisis when confronted by cultures that are different from their own.

The goal of this project is to study the impact of Vietnamese health care practices on the organizational culture of GFD, and to recommend solutions to mitigate that impact.

LITERATURE REVIEW

The Vietnamese people arose primarily from primitive tribes. Until 1954 the country was occupied and governed by France (Appiah & Gates, 1996). As a result of the formation of the Viet Minh political party and the leadership of a young political figure, Ho Chi Minh, the Geneva Accords in 1954 recognized the new government in Hanoi (Appiah & Gates, 1996), and divided North and South Vietnam along the 17th Parallel (LaBorde, 1996).

The war in Vietnam ended abruptly with the fall of Saigon to North Vietnam in April, 1975. United States soldiers were rapidly deployed home and the influx of Vietnamese into this country soon began. The immigrants were certainly not all civilians. North and South Vietnamese soldiers, pilots, and their families left quickly to escape the victorious North Vietnamese (Tharp, 2000). The social profile of the first wave of immigrants, therefore, was that of a young, Catholic, well educated, English speaking city dweller (LaBorde, 1996).

The second wave of Vietnamese were largely working class people who came from an agrarian economy and spoke only Vietnamese (LaBorde, 1996). More than their predecessors to this country, this group held strongly to the traditional beliefs of living and working closely together, and adhering to the customs of their

native country (Branigan, 1998). The second wave of refugees also spent time in concentration camps waiting for papers to enter the United States. Therefore, ill health prevailed, and they often entered the country with malnutrition, tuberculosis, or Hepatitis B (Laborde, 1996). This second wave group certainly shared many cultural similarities with the first group, but were probably the most culturally displaced group because of the trauma they endured in the camps (Gold, 1992). Gold suggests further that emotional and psychological trauma existed often in this group because of the inability of the male members of the family to find employment as easily as women, and the fact that the children in the family learned English quickly; Therefore becoming the most mobile and least dependent family members.

Identification with ethnic groups does not appear to be going away, however. Immigrant parents are keeping their children immersed in enclaves for as long as they can. This is of concern to researchers who have seen an erosion of immigrant numbers who, even after citizenship, do not call themselves Americans (Booth, 1998). The tenacity to cling to native culture is most predominant in the third wave of refugees, the ethnic Chinese. This is the most entrepreneurial of the three refugee groups (Gold, 1992). The ethnic divisions between this group and the ethnic Vietnamese cause ongoing conflicts that still erupt frequently, further diminishing any hope of assimilation (Specter, 1996). However, the Vietnamese refugee groups have mixed well over all. They have a strong sense of family loyalty and gender roles, as well as a tendency to to cling to traditional health care beliefs (Specter, 1996; LaBorde, 1996). Health care beliefs and rituals are based on one of two disciplines, the first being the perception that

the cause of all illness is external and comes from evil spirits (LaBorde, 1996), and the second being the Confucian view that alterations in good health are created by disharmony of heat, cold, air, and water (Specter, 1996).

The cultural diversity of any group of immigrants often is most apparent in health care. Even the most acculturated immigrants tend to revert to the roots of their cultural belief system when faced with serious illness, either in themselves or in loved ones (Mo, 1992). The western health care provider is then challenged to try to understand that fundamental differences do exist between their beliefs and standards of practice, and the beliefs of the affected group (Mo, 1992). Fundamental beliefs about death and dying, resuscitation efforts, and even screening for prevention are often extremely different from expected practices in the local area (Koenig & Gates-Williams, 1995).

Fire Department personnel find that these health care beliefs and rituals challenge the heart of their personal and organizational cultures. The National Highway Traffic Safety Association (NHTSA) has proposed *Emergency Medical Services: Agenda for the future*. In that document, it is suggested that the future primary link to health care and the community will be Emergency Medical Services (EMS), (NHTSA, 1998). The vision of the NHTSA document extends outward and well past the long held belief that ambulances only go to hospital emergency departments, suggesting that referrals will be provided to the community to clinics and social service agencies. Medical advice, assisting with an at home treatment regimens, or referral to other public safety agencies may also become options.

Fire service organizational culture is similar to most organizations that are

consistent with a built in hierarchy, a subset of rewards and punishments, rites of passage, and rites of degradation. It encourages group thinking and group response, and subconsciously discourages independent thinking and independent activity (Hellriegel, Slocum, & Woodman, 1998). Boyett and Conn (1991), suggest that the most successful employees will be those who see every change in their organization as a new opportunity. As paramedics at GFD seek to bridge the gap between cultures to enhance service quality they should ideally embrace this effort as a unique business opportunity. Their success in doing so will depend greatly upon the support coming from Fire and City Administration.

In summary, the reviewed literature defines the process of immigration of Vietnamese into the United States and reflects upon the standards of the prevailing health care beliefs and practices within that community. The organizational culture of businesses is explored and the pertinent factors of fire service organizational culture that relate to this study are identified.

PROCEDURES

Through historical research, factors were identified that exist consistently in Vietnamese health care practices. While historical research identified those practices globally, descriptive research through surveys was used to identify those practices in the Garland Vietnamese community. Historical research provided some data related to the organizational culture of the fire service, but the specific survey of GFD employees provided the best picture of the organizational culture of GFD.

A literature review of historical data was conducted to look at the past and present health care practices of the Vietnamese people as a determinant of their potential approach to future health care approaches in this country. Descriptive research was used

by surveying fire personnel related to social profiles and organizational culture.

The purpose of the background survey (Appendix A), was to determine a point of commonality, if any, and to draw from the results some conclusions related to the organizational culture of GFD (Appendix C). The background survey was distributed to all of the 107 fire fighter paramedics in GFD. 102 responded and the results provided a clear picture of a predominantly male population that is not widely traveled, not educated past high school, raised in rural Texas, and has never left either Texas or, in most cases, his small, rural environment. Other indicators from the survey revealed that the majority judged themselves to be minimally intolerant, but only because they were unfamiliar with Vietnamese health practices. Several surveys also indicated some resistance to change, a factor which was demonstrated more clearly in the last survey (Appendix C).

The survey on organizational culture (Appendix C) was distributed to all operations personnel. 198 out of 250 responded and all are certified either as EMT or paramedic. The results provided a picture of the perception of organizational culture by station personnel. The indicators are those of a paramilitary work environment where the rules are not enforced consistently. There does exist, however, a clear idea of the mission, vision, and values of the department. Another outcome was an expressed need to have increased communication with chief officers, and a need to take change methodically, especially in EMS. Many responders admit to having concerns about change, and EMS changes are expressed as being often intimidating because of new skills, and a required, but expanded knowledge base.

The third survey (Appendix B), was distributed to the Vietnamese community in

two ways. The predominant method of distribution was one per household, distributed house by house. A local newspaper published primarily in Vietnamese, provided instructions in Vietnamese to go with the survey, but requested that responses be in English, if at all possible. The majority of the responses returned were written in Vietnamese. The return was successful, but the translation of the responses was inconsistent. This was the biggest limitation noted in using descriptive research for this particular survey group. Other survey efforts, such as attending Vietnamese craft and food fairs, yielded few results. Patrons of the fairs were approached by paramedics and asked the questions from the survey in English. Only six surveys were the result of this effort. Most of the patrons avoided the surveyors but those that were curious actually approached the surveyors and demonstrated their willingness to respond to the survey. Unit 3 of the student manual, "Research", suggests that a survey of a population size of about twenty thousand should yield at least 377 responses in order to have a 95% confidence rate. The final number of responses for this survey was 384. The survey revealed a group of people who, like other immigrants that share their culture (Specter, 1996), do not see American physicians and do not embrace western medicine. Most families have someone living within the family unit who is skilled in the utilization of the herbs of Chinese medicine, which are specific to each ailment (AAOM, 1998). The most elderly members of the family are usually the ones who are entrusted to paramedics, and they are only turned over to paramedics after all other efforts and remedies have been exhausted. Other members of the family respond to ethnic treatment modalities and typically do not need to see a western physician.

Other than translation, the other limitations included timeliness of responses by fire fighters as well as the ever-present paranoia as to how the information would be used. Anonymity, however, was assured and the results of the survey (Appendix C) did not appear to be skewed by any underlying concerns.

RESULTS

Answers to Research Questions

Research Question 1. In order to find the most accurate information related to health and wellness practices the Vietnamese community was consulted through surveys. The survey was looking for consistency of health practices in the community and at the impact of fire department personnel involvement in those practices. 98% of the participants in the study responded to health maintenance questions with nutritious food and tea. Another common response for health maintenance was fish soup. These responses are consistent with national data (Freeman, 1995), which suggests that Vietnamese cuisine and good health go hand in hand because the food is some of the most nutritious in the world. A number of respondents, thirty women of childbearing age, cited the practice of drinking urine from seven year old boys routinely to maintain youth and to help with ease of childbirth. This practice could not be substantiated in the historical data.

Apart from food products, other practices consistently mentioned were the practices of coining, or hot coins placed on the body to draw out pain and fever, application of herbal compresses, and cupping, which is described by LaBorde (1996) as a form of moxibustion, or heating the air in a cup which is then placed on the skin in order to create a bruised or ecchymotic area, which would be expected to enhance the

therapeutic value of heat in certain areas of the body. Once illness does occur, the majority of respondents in the age groups of forty or younger go directly to Chinese medicine and acupuncture, utilizing specific herbs for specific ailments (AAOM, 1998; Yarnall, 1998).

The majority of respondents in all age groups do not see American physicians and would not unless absolutely necessary. They also would not take American medications if prescribed, or over the counter (Branigan, 1998). Five of the respondents said that they would take American medications if they could afford to do so. Since the survey did not address financial issues, there were no clear indicators on the status of finances or health insurance. National data suggests that these are significant problems among immigrant groups (Fletcher, 1999).

Thirty-two respondents reported experience with paramedics in their home. None them had encountered paramedics because of their own health care needs but because one of the elderly members of the family was ill and all of their treatment modalities had failed. This group of respondents were all women and all of them reported a good comfort level with the actions of the paramedics. One of the respondents reported frustration at not being able to speak to the paramedics directly, even though she spoke English. Historical data suggests that this was due to her status in the family, and that she would have to yield to the male elder in the family, even though his English might not be as good (West, 1999). The Vietnamese community in Garland does not utilize GFD frequently and the only noted pattern is with the older members of their families. The only variances noted are such things as accidents, car crashes, or other unusual types of events. This is consistent with national data, which suggests

that there are no real trends in particular ethnic groups in their use of Emergency Medical Services (EMS) (McConnel & Wilson, 1999).

Research Question 2. The background survey (Appendix A), indicates that the majority of Garland firefighters are from Texas, still live in or near the small, rural town in which they were raised, have never lived anywhere else in Texas, and have never left Texas, even on vacation. The predominant level of education is high school, they typically speak no languages other than English, and are members of the Southern Baptist faith. The majority of the respondents report several home remedies passed from grandparents, to parents, to respondents, and on to their children and grandchildren, but those remedies are not viewed as alternative medicines or alternative therapies. The majority of the respondents know nothing about alternative health care except for the practices that they have observed in the Vietnamese community. The majority of the respondents, however, report an interest in knowing more about alternative health care practices in the Vietnamese community, but also about those remedies practiced by their peers and the families of their peers.

The survey respondents report that the Vietnamese community is very helpful in informing the paramedics of the history of the patient. In most cases, following the relating of the history, they often leave the room. If they remain it is usually to translate, and never question the activities of the paramedics as they follow their protocols and guidelines for treatment. The paramedics report that they are often puzzled about the alternative therapies because they do not understand the rationale, and are collectively puzzled by these types of therapy. All respondents agree that an expanded knowledge base related to alternative practices would be very helpful.

The survey on GFD organizational culture (Appendix C), reveals that our organizational culture is at least partially impacted by the commonality of social background of GFD personnel (Appendix A). In this survey (Appendix C), the respondents in majority describe a workplace that is a regimented, paramilitary environment with a perception of selective enforcement of the rules. Knowledge of the language and intent of the mission, vision, and values statements is in place, however. They do not worry about job security because of what they perceive to be protection by civil service laws, admitting at the same time that even civil service can not always provide absolute protection. Most respondents would like the opportunity to visit with Chief Officers to give them the line firefighters perspective The respondents do understand the chain of command, but report that it is selectively practiced. Respondents report a common background and see the one point of stability in the fire department as EMS. The respondents report that the EMS practice standards are the same throughout the department, and that they always know what is expected of them. This is in sharp contrast, they report, to the fire service where the perception is that standards of safety and efficiency vary from station to station and from shift to shift. Several respondents report concern about the future of EMS and their anticipated expanded roles, but most acknowledge a comfort level with their personal abilities in meeting forthcoming challenges.

The consistency of the background in the majority of fire department personnel gives added strength to EMS. The provider culture (Specter, 1996), has developed because of the insight related to a common culture and the willingness to understand and appreciate the health cultures of other groups.

This is a mandatory outcome if health care professionals hope to be effective in their practice (Specter, 1996).

The organizational culture of the fire department is one of diverse cultural groups in the minority, and one common background of caucasian, protestant, high school educated men in the majority. Collective behavior within the department is largely determined by the focal points of background, the vision and values of the Chief, the strategic plan, and the needs of the firefighters in operations (Barkdoll, 1999).

Having been promoted through the ranks, the Chief Officers in this department were firefighters and paramedics in operations at one time. With the exception of one, they also share the same general background as most of the operations personnel. Therefore, the organizational structure has flattened and become more decentralized as each Chief in the current group has been promoted. This flattened, decentralized organization provides the ability for close evaluation and an appreciation of the changing approaches in EMS, thus impacting the organizational culture in a positive way (Boyett & Conn, 1991). The strongest impact on the organizational culture of GFD has been the opportunity of operations personnel to be actively involved in most of the decision making in EMS issues. The strongest negative impact has been their inability to be involved in that process on the fire service side (Packard, 1995).

Research Question 3. Looking once again at fire department decentralization, it is noted that the decentralization is such that station officers are able to run their own small fire departments where the rules of firefighting change based upon who is on shift.

While this is effective practice from the standpoint of individual innovation, it is difficult to establish a focal point of consistency in performance. In EMS, the contrary is true. Establishing a focal point of consistency in EMS is simple because the guidelines are clear, and the standards of practice are established. The rules, protocols, guidelines, and objectives are measurable and are best assured through a quality management program.

A quality management program has an impact on organizational culture, primarily because it often changes the norms for people in an organization, especially managers in a decentralized organization (Packard, 1995). Acceptance of a quality management program is made more simple when the stakeholders, in this case firefighters and paramedics, have helped to design the parameters. Given the fact that employees usually support what they helped to create (FEMA, 1998), their involvement in changing EMS at the local level to meet the needs of their Vietnamese clients,while concurrently measuring and monitoring their own progress, should be easy to accomplish. Addressing the newly imposed requirements on paramedics by the new National Standard Curriculum for Paramedics (NHTSA, 1998), will provide further measurable objectives, and addresses alternative health care as well as the affective domain in its text.

The background survey (Appendix A), indicated that, while somewhat intolerant of alternative medicine practices, paramedics wanted to know more about them in order to appreciate them more. Further, their expectation is that they could provide more effective health care to the Vietnamese community if they also would be able to incorporate at least some of the alternative practices into current protocols and guidelines. The expectation of the Vietnamese community is

the same. Although the climate is right for changes in EMS at the community level, and changes in EMS will find support within the organizational structure and culture of GFD, deeply rooted changes in the EMS health model, even locally, will involve a much closer look at the health expectations of both the paramedics and the Vietnamese community (Specter, 1996). Once the decision to make group specific changes is made, the process must address the appropriate issues, such as acupuncture, herbal therapy, and nutritional factors for health maintenance. Most important, however, is that once the commitment to the process is established by both parties, it must allow for some resistance, it must be continuous, it must allow for steady and consistent implementation (Hellriegel, Slocum & Woodman, 1998), and most important of all, it must not cease until it is completed.

DISCUSSION

The theory of the melting pot in this country is a myth (Specter, 1996), and the City of Garland is no exception. Garland has become culturally very diverse with a large Asian population and specifically a large Vietnamese population.

Like their fellow countrymen spread all over the nation, there has been little assimilation into American culture (Branigan, 1998), especially from the perspective of health care (LaBorde, 1996). The survey of the Vietnamese community, however, (Appendix B), reveals a group of people who, although they do not understand western medicine, appear to be comfortable with GFD paramedics and their approaches to health care for Vietnamese elders.

Health and wellness practices in the Vietnamese community are based on

long standing tradition, with religious influences as well as nutrition and herbs. Rituals such as coining and cupping (LaBorde, 1996), are consistent but other, more unique practices also exist, such as the ingestion of urine.

Important information that is fundamental to health care in any culture are the beliefs related to resuscitation (Koenig & Gates-Williams, 1995), maintenance of life support (Klessig, 1992), and body image, especially in females (Mo, 1992). Each religion addresses these issues, some more rigidly than others. The western health care provider who walks into situations such as these without some direction on the expectations of the family may find himself with some disgruntled family members.

Cancer screening practices and well baby maintenance are not the normal approaches for the Vietnamese community. In a study related to cancer screening and risks, it was discovered that cancer was at least known to the participants, but the population studied was unaware of the relationship of cigarette smoking and a high fat diet to an increased risk of cancer (Jenkins, McPhee, Bird & Ha Bonilla, 1990). In a study conducted by Graham, Carlson, Sodergren, Detter and Labbe (1997), Vietnamese toddlers were found to be on whole milk by bottle typically into their second year of life with resultant iron deficiency. This is a practice characteristic of Vietnamese children. Both of these items indicate clearly the dramatic need for both community and paramedic education.

Although family disgrace doesn't relate directly to health care, the results often do. There is not much literature to support the definition of family disgrace by the Vietnamese (LaBorde, 1996). Local custom, however, cites the penalty as

chopping off the little finger. Local members of the Vietnamese community cite reasons for disgrace as being anything from public drunkenness to adultery. Family disgrace is often perceived by male members of the family as a result of forced role reversal. This often occurs upon arrival to this country, when the children become more mobile and more independent than the men (Gold, 1992).

The social profile of the Garland fire fighter is one of a young to middle aged male who was raised in rural Texas. He is conservative, Southern Baptist, family oriented, and tends to vote Republican. One-third of his life is spent with his fire department family, working 24 hours on shift and being off duty for 48 hours. This type of work environment, plus the team approach to fire fighting and EMS, promotes a strong organizational culture in which the social profile of the employees is one of the most critical factors.

The fire service environment is by nature geographically dispersed (Beauvais, O'Neill & Scholl, 1997), which creates individual organizations and cultures within a large one. The strength in that arrangement in Garland comes from the collective social profile that is continuous throughout the department, with very few exceptions.

GFD has a decentralized organization (Boyett & Conn, 1991), and while that lends itself to some fragmentation in fire fighting, EMS and approaches to various types of patients are not impacted in that way. Part of the rationale for being steadfast in the practice of paramedicine is for safety and saving lives, and to remain current with state and national standards, a practice which enhances patient care,and reduces the potential for liability. The new National Standard Curriculum is the most current offspring of that effort (NHTSA, 1998).

The organizational culture of GFD is one that is generally open to change and is conscious of client needs in the community. That effort is supported, both nationally and locally, because of the strength of a good quality management program (Packard, 1995), and the empowerment of personnel to participate in problem solving (Federal Benchmarking Consortium, 1997).

Managing any kind of organizational change requires that several steps be followed, not the least of which is to have a sound reason to make changes (Boyett & Boyett, 1998). Certainly several steps must be followed including not moving too fast or too slow, and having strong guiding principles. The organizational culture of the fire service is shifting nationally toward quality service and increased communication with the people they serve (Broward, 1999). The Garland Fire Department is no exception. This study saw a strength not really observed before now. That strength was the nature of the heart of GFD, which is EMS. The evolution of information from the Vietnamese culture, the organizational culture of GFD, and the commitment of the operations personnel to quality service is intense and worthy of merit. Cultures that should be diametrically opposed were not, and there exists a willingness on both sides to learn more about each other as GFD transitions into an expanded community base.

Concern has been verbalized about language barriers, about legal rights of clients related to consent, and informed decision making when language is a barrier (Perkins, Simon, Cheng, Olson & Vera, 1998; Graham, 1995). Interest was often noted related to alternative health practices. This ultimately gave rise to the thought that here stands a fire and EMS service in North Texas in what is classified

as a suburban city, both interested and willing to pioneer quality service among their culturally diverse clients. As a group, they have indicated that they anticipate minimal resistance to change.

The organizational impacts of the result of this study are as follows:

1. Dedication of more continuing education time to alternative health care.

2. The shift of emphasis in training from fire to EMS. This is already in transition, but will accelerate slightly.

3. Higher visibility of GFD in the community, which is a definite benefit.

4. The potential for budget increases, which should be minimal, but need evaluation.

5. The dedication of one managers time to fully implement the process, which could result in a compromise of other duties.

The improvement in quality service and the heightened awareness of one cultural group will be a benefit and will lead to the same process in other cultural groups in Garland.

RECOMMENDATIONS

The paramedics and fire fighters from the ambulance district where the Vietnamese community is clustered originated the concept for this study because of their concern for that community. Meeting the primary need, teaching paramedics about alternative health care, is the first step toward better service. This will require some guest instructors, and may require additional research.

The first step is to set up ethnographic interviews (Kwan-Gett, 1997). Although they often involve interpreters, they should be performed by the caregivers

themselves, at a pace and tone determined by the caregivers and informants alike. Classes, Vietnamese community meetings, and fire department networking activities should be conducted in the Vietnamese community, if possible (U.S. Dept of Health and Human Services, 1992).

The entire process should be monitored frequently. Collected data should be re-evaluated periodically (Shoup & Teutsch, 1998), in order to monitor a shift in the organizational culture, or a shift in the impacted community. This will involve transition in the quality management program to a more external focus.

An organizational shift to empower the Chief officers to let go of old ideas, and become willing to test the limits of their vision, is critical to the department's acceptance of diversity. This would best be accomplished by giving audience to the caregivers, allowing them to make presentations, develop goals, and participate in new program development. Focus groups are often a successful activity (Kwan-Gett, 1997), and have frequently been successful in Garland.

The benefits for GFD will be the increased visibility in the community which we constantly seek, and better patient care to the people that we serve. Implementation steps might best be initiated by a focus group from the district with a consulting manager, and at least one member of the Vietnamese community. Education should follow, and introduction of the process into the community is the next logical step.

Initiating this process in another department should probably follow some basic steps: The first task is to develop a profile of your firefighters and paramedics, along with an evaluation of your own cultural values and biases. Second,

develop a profile of the community that you want to impact. Third, do an analysis of your organizational culture. Evaluate its strengths, weaknesses, and most important, analyze carefully the impact of potential change, especially if the focus of that change, and the resultant commitment, will shift out of the fire service and into the community.

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APPENDIX A

SURVEY OF SOCIAL PROFILE

June 1, 2000

Dear Paramedic:

As we watch the City of Garland grow and become more diverse we watch health care and alternatives do the same. I am currently writing a paper to address health care in the Vietnamese community and I would appreciate your input in the attached survey. As we are looking at the Vietnamese culture, I think that it is important to look at our own as well. All responses will be kept confidential.

Thank you in advance for your participation.

Sincerely,

Karen Pickard
EMS Programs Director
Garland Fire Department

BACKGROUND SURVEY

1. Are you from Texas___Other___?
2. Are you from an area that is:

   urban___

   suburban___

   rural___

   frontier___

   combination (rural area within 10 miles of urban___

3. If you are from Texas, the area in which you were raised had a population then of approximately?

   0-49,999___

   50,000-149,999___

   150,000-499,999___

   500,000-1 million___

   Higher___

4. What population does it have now?

   0-49,999___

   50,000-149,999___

   150,000-499,999___

   500,000-1 million___

   Higher___

5. Do you still live there? Yes___No___.
6. Have you ever lived somewhere besides Texas? Yes___No___.

7. If so, where and how long? (Check any that apply).

other states___

Europe___

Asia___

Canada___

Mexico___

South America___

Other___

8. If not applicable because you have never lived anywhere else, have you ever left Texas? Yes___No___.

9. If so, for: vacations___

business___

visit family or friends___

other___ (Check all that apply)

10. Do you speak another language besides English? Yes___No___.

if so, what?

Spanish___

French___

Italian___

Other___ (Please name). _____

11. What is your religious orientation?

Protestant (specific)___

Catholic___

Jewish___

Other___

None___

12. What is your level of education?

High School___

GED___

Some college___

Associate___

Bachelors___

Masters___

PhD___

13, Did your parents or grandparents have any folk remedies or home remedies that they used on you when you were growing up? Yes___No___.

14, If so, what were they? _____

---

15. Do you use them and have you passed them on to your children?Yes___ No___. N/A___.

16. Would you consider those remedies to be alternative medicine? Yes___ No___.

17. In your work as a paramedic how much exposure have you had to members of large communities that use alternative medicine for healing and/or prevention? Vast___

Some___

None.

18. If applicable, have you had the opportunity to learn the purpose of the alternative practice being used? Yes___No___.

19. If not, would you like to know more? Yes___No___N/A___.

20. Do alternative medical practices interfere with your ability to provide effective care? Yes___No___Somewhat___.

21. If you answered yes or somewhat, please be more specific_____

_____

_____

22. Do you find medical practices that deviate from western medicine:

Intolerable___

Somewhat intolerable___

Fine for them___

Doesn't matter___

Fascinated by them___

Other___

23. Male___Female___

24. Comments:_____

_____

_____

TABULATION OF SURVEY

102 RESPONSES

1. 100 from Texas.
2. 93 rural, 9 suburban
3. 0-49,999 – 102
4. 0-49,999 – 86; 50,000-149,999 – 16
5. 93 yes; 9 no.
6. 5 yes; 97 no.
7. 4 other states.
8. 34 yes; 68 no.
9. 34 vacations
10. 4 yes; 98 no.
11. 10 Catholic, 12 Church of Christ, 1 Atheist and 79 Southern Baptist.
12. 89 High School, 9 Associates, 2 Bachelors, 1 Masters.
13. 87 yes, 15 no.
14. Common examples: Castor oil, eat Vicks salve for throat, tobacco poltice for bee stings, kerosene for open wounds.
15. 60 yes, 41 no, 1 n/a.
16. 20 yes, 82 no.
17. 10 Vast, 51 some, 42 none.
18. 102 no.
19. 102 yes.
20. 10 yes, 35 no, 57 somewhat.

21. Primary response: Do not know if what they do will be a detriment to the patient when combined with current practices.

22. Intolerable – 1, 53 – Somewhat Intolerable, 16 – Fine for them, 20 – Doesn't matter, 2, Fascinated by them – 10.

23. Male – 102

24. No comments.

APPENDIX B

SURVEY OF VIETNAMESE HEALTH BELIEFS

Karen Pickard RN
Garland Fire Department

June 1, 2000

Dear Garland Resident:

The City of Garland is extremely interested in making sure that its citizens have access to the health care that they need and that health care belief rituals be maintained in this very diverse city. The Garland Fire Department is conducting a study related to specific health practices and we are very interested in some of your beliefs. Our objective in this study is to provide our paramedic/fire fighters with as much information as we can about your beliefs in order for them to provide service to you effectively and safely.

All answers to these questions will be kept within the fire service and will not be used to harm you or your family in any way.

We look forward to working with you more closely.

Please return the surveys to the Garland Fire Department in the stamped envelope provided with the survey.

Thank you so much for your participation.

Sincerely,

Karen Pickard RN
Garland Fire Department

HEALTH CARE SURVEY

1. What do you do to maintain good health overall? _____

_____

_____

2. Are there certain foods that you eat to help you maintain good health? _____

_____

3. Do you have remedies that you have always used for various health problems? Yes___No___.

If so, could you list some of the more common ones? _____

_____

4. Do you see a Doctor in the United States? Yes___No___.

5. If so, and the Doctor prescribes western medicines, do you take them? Yes__ No___.

6. If you do not see a Doctor here, do you have a healer? Yes___No___.

7. Do you act as healer for your family? Yes___No___.

8. While living in Garland, have you had the fire department paramedics respond to your house? Yes___No___.

9. Do you feel comfortable calling them? Yes___No___.

10. When they are at your house do they want to practice medical procedures that make you uncomfortable? Yes___No___.

11. Our run reports indicate that we rarely come into your neighborhood for anyone that is young. Usually, our patients are older and really sick. Do you know why this is true? _____

_____

12. Are you male___female___?

13. What is your age group?

10-19___

20-39___

40-59___

60-79___

80 or higher___

Thank you very much for your participation.

TABULATION OF SURVEY

384 RESPONSES

RESULTS ARE SUMMARIZED

1. Nutritious food, vegetables, rice, tea and fish soup.
2. Repeat of number one.
3. Yes!
4. 43 yes, 341 no.
5. 43 yes.
6. 185 yes, 4 no, many left unanswered.
7. 41 yes – for whole community, 4 – no, many left unanswered.
8. 32 yes, 352 no.
9. 32 yes, 285 said yes, even though they have not called.
10. 32 no.
11. Young people are not sick, because of herbs.
12. 234 Female, 150 male.
13. 10-19 – 4, 20-39 – 101, 40-59 – 262, 60-79 – 27.

APPENDIX C

SURVEY OF ORGANIZATIONAL CULTURE

1 June, 2000

Dear Paramedic:

The attached survey relates you to your work environment and attempts to define the culture of this organization.

I appreciate your participation. All information will be kept confidential within the confines of the fire service.

Sincerely,

Karen Pickard RN
EMS Programs Director

ORGANIZATIONAL CULTURE

1. Do you feel that you work in a regimented environment? Yes___No___.
2. When you first came to work here, did someone take you aside and tell you the unwritten rules? Yes___No___.
3. Do you know what the mission of the department is? Yes___No___.
4. If so, do you understand your role in the achievement of the mission? Yes___No___.
5. If not, do you know someone who could tell you? Yes___No___.
6. Do you feel that you have job security? Yes___No___.
7. Are the people you work with similar to you in background? Yes___No___.
8. Do you work with some people that you:

   (Check all that apply)

   Fear___

   Don't trust___

   Don't like___

   Look up to___

   Consider to be friends__

   Grew up with, friends before employment___

   Are above still friends now___
9. Do you ever talk to the Chief or his Assistants? Yes___No___.
10. If no, would you like to? Yes___No___.
11. Do you understand the chain of command? Yes___No___.
12. Is there one or more divisions in the fire department where work is

performed consistently and does not vary from station to station or shift to shift? If yes, which ones are they? _____ No___.

13. We anticipate sweeping changes in the focus of EMS in the next five years, with a focus away from the hospital and to the home environment. Are you concerned about making changes that you may not fully understand? yet? Yes___No___.

14. Would you like to be briefed on those changes as each one comes along? Yes___No___, or would you rather hear about everything at once? Yes___No___.

15. How long have you been employed here?

0-4 years___

5-9 years___

10-14 years___

15-20 years___

21-42 years___

16. Comments:_____

Thank you very much for your participation.

TABULATION OF SURVEY

198 RESPONSES

1. Yes
2. Yes – 92, 106 – No.
3. 191 – Yes, 7 – No.
4. 186 – Yes, 12 – No.
5. 8 – Yes, 4 – No.
6. 198 – Yes.
7. 185 – Yes, 13 – No.
8. Fear – 10, Don't trust – 9, Don't like – 4, Look up to- 24, Consider to be friends – 126, Grew up with, friends before employment – 34, Are above still friends now – 34 – Yes.
9. 84 – Yes, 114 – No.
10. 104 – Yes, 10 – No.
11. 198 – Yes.
12. EMS and Fire Marshals Office; 4 responded No.
13. 82 – yes, 116 – No.
14. 192 – Yes, 6 – No.

    198 – No.
15. 0-4 – 48, 5-9 – 31, 10-14 – 61, 15-20 - 32, 21-42 – 26.
16. No comments.