Intercultural Issues in Conducting Healthcare Qualitative Research

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Abstract

Traditionally health care research is often valued on the evidence-based basis which is dominated by statistically motivated quantitative research. However, the increasingly popular use of qualitative methods in general and health research in particular has provided a different kind of research evidence, which reflects real life issues in social contexts. Though health care qualitative research has provided health care workers, policy makers and the public valuable insights into various aspects of population health, there are issues and problems regarding conducting qualitative research in an intercultural discourse. Sociolinguistic and cultural factors are the main causes of problems facing researchers and policy makers. Concepts such as confidentiality and security are culturally constructed. This paper examines some intercultural awareness issues which need to be considered in the conduct of health care qualitative research and some potential problems in the treatment of health qualitative data. Attention will be given to the Vietnamese health discourse.

Keywords: Qualitative method, intercultural research, health issues, pragmatics, data collection, cultural interference.

Introduction

Qualitative methodology has been widely accepted in health research. The main reason is that while quantitative research has its strengths, the scope of issues in health research is

much broader than it was many decades ago when empirical research in health was exclusively dominated by postpositivism. This paper examines some intercultural awareness issues which need to be considered in the conduct of health care qualitative research and some potential problems in the treatment of health qualitative data. Attention will be given to conducting health research in an intercultural context.

Methodology in health research

Empirical methodology has always been at the heart of health research. One of the main reasons is that heath research has been firmly situated in a scientifically orientated discourse which values objectivity, generalisation, and measurable impact. This strand has become an established tradition in health research. It is not just about research inquiry but also associated with power and politics. As Foucault pointed out, 'medicine, as a general technique of health even more than as a service to the sick or an art of cures, assumes an increasingly important place in the administrative system and the machinery of power' (Foucault 1980, p. 176)

In the current context of health research, the principles governing clinically-orientated research in health have been questioned. The concept and principles inherent in evidence-based research have been received differently in qualitative research. While some qualitative researchers treat the concept 'evidence' broadly and favourably, others challenge critically the concept in asserting that the evidence-based movement in health sciences constitutes a good example of 'microfascism' at play in the contemporary scientific arena. Holmes et al (2006, p. 181) wrote:

> Rather than risk being alienated from their colleagues, many scientists find themselves interpellated by hegemonic discourses and come to disregard all others. Unfortunately, privileging a single discourse (evidence-based medicine (EBM)) situated within a single scientific paradigm (postpositivism) confines the researcher to a yoke of exactly reproducing the established order. To a large degree, the dominant discourse represents the ladder of success in academic and research milieus where it establishes itself as a weapon used against those who praise the freedom of scientific inquiry and the free debate of ideas.

It can be argued that since health research has become multidimensional and collaborative in nature, it is important to employ a variety of research methods and perspectives. The

case of cancer research is a good illustration of the multidimensional aspects of research. Cancer research these days can involve laboratory-based scientists and clinician researchers, statisticians and population health experts from different fields such as cell biology, specific human cancers, statistics, and advanced cancer imaging.

Similarly, epidemiology research examines various aspects such as the amount of people having cancer; who gets what specific type of cancer; and what factors (such as environment, job hazards, family patterns, and personal habits, such as smoking and diet) play a part in the development of cancer.

In response to the increasing growth and spread of health research across disciplines, research methodology needs to accommodate this phenomenon by expanding its traditional research methodology such as experiment, clinical observation and survey. It is more insightful to include qualitative research which reinforces clinically-based research by taking into consideration the multi-discourses of health research.

Thus empirical research is no longer confined to statistically based methodology. Discourse analysis, conversational analysis and narrative research have also been used in health research as they provide different insights into health issues which quantitative research alone cannot fully cover.

> The result is a rich body of work examining discursive constructions of health and illness, and the impact these constructions have on the conceptualisation and material regulation of health, as well the negotiation of health related behaviour, at an individual, organisational, or societal level (University of Western Sydney 2006, p. 1).

The introduction of qualitative methodology in health research has not been enthusiastically welcomed by some 'hardline researchers' whose research ideology cannot be compromised by using 'weak' or 'unreliable' data and subjective analysis. However, empirical research in health is no longer confined to quantitative research methodology in which statistical evidence is highly valued. Participant observation, narrative text, discourse analysis, interview, reflection and conversation analysis are now widely used in social research and this change has been present in health research. However, there are problems and issues which need to be addressed when conducting qualitative healthcare research in an intercultural discourse.

Ethics in intercultural health research

Ethics is one of the most important aspects in research. In Australia, ethics approval is a prerequisite for conducting a research project. Any research which involves or affects human beings must have ethics approval of the participating agencies or organisations. Researchers need to consider the potential risks which could occur during the research period and after the completion of the research. Particular attention is given to sensitive matters and vulnerable participants. There are sensitive topics and issues which may adversely impact upon the participants such as abortion, abuse, rape, terminal illness etc. Some topics and fields such as religion and race, if not handled properly, may have the potential of disrupting social harmony. However, ethics in research is perceived and treated differently by researchers in different cultures. For instance, it is acceptable for a health worker to involve children in a health clinic in a health research project without the consent of the children and their parents in some developing countries where researchers are not expected to seek consent from the participants or their guardians. Children may be interviewed about their eating habits, disease in the family, and domestic violence. Whereas, these matters are treated as extremely sensitive in Australian research, in some developing countries, it can be offensive to require the participants to sign a consent form before participating in a research project. In Vietnam, for instance, it is not unethical for researchers to offer gifts to participants and health officials who help to facilitate a study. Showing appreciation to others is common social practices in Vietnamese culture, particularly to those who have show their willingness to participate in an activity.

Ethics consideration in research is not confined to institutional control. In many cases, particularly in some developing countries where the legal system does not protect vulnerable people, research ethics in health is at the mercy of individual researchers. The limited or virtually complete lack of ethical control governing the conduct of health research may first appear as a positive factor for research development. However, such freedom demands great responsibility on the part of the health researchers. They are the ones who decide whether the research topic, methodology and impact are ethical or not. The treatment and wellbeing of participants are in the hands of the researchers. Lack of ethical control can lead to mistreatment and abuse. For instance, one can conduct a case study of a person with mental illness without seeking consent. In Vietnam, labels such as 'crazy', 'mad', 'stupid', etc are used to stigmatise people with mental illness, and are thus

perceived as mentally and socially unfit. Such negative perception leads to negative attitudes towards them. As a result, people with mental illness can easily be victims of abuse in health research when ethical issues are not properly considered. This indicates a conflict between a cultural discourse and a research discourse in intercultural healthcare research.

The question of privacy in health research

In many developed cultures, privacy is highly valued and researchers need to ensure that participants' privacy is respected. Privacy often involves personal background and information such as age, political belief, religion, finance, and family. This type of information can be sought by the use of survey questions while maintaining participants' anonymity. However, in Vietnamese culture, the boundary between private and public domains is not clearly marked. Vietnamese parents have varied degrees of control over the privacy of their children. They have the right to know their children's private world. The age of children does not matter as parents are figuratively the heads, socially and emotionally. The parents also have varied degrees of power over their children's destiny, which may include life aspects such as education, career, marriage and health. It is worth noting that this social power of the parents is still strong in families with commitment to the Confucian tradition, particularly in rural areas where family harmony and unity are social priorities.

What are the implications for conducting health research in this cultural context? As indicated, if the parents or caretakers (relatives, spouses) have responsibility/control over the lives of their children or relatives, they would expect to be informed about the wellbeing of their loved ones under their care. It is fundamentally about social coherence which underlies interpersonal roles and interpersonal relationship among members in a family. The following case illustrates a conflict in the treatment of privacy in an intercultural health context and it has implications for intercultural health research. A Vietnamese migrant in Australia was very sick and her husband took her to a hospital for treatment. She was diagnosed with terminal cancer. The doctor informed the patient of her serious condition without prior consultation with her husband. This action infuriated the patient's husband. The doctor's decision was made on the grounds that doctors are health professionals whose experience and expertise entitled them to inform their patients directly. Secondly, patients are entitled to know about their health conditions directly

from a health professional. However, from the Vietnamese husband's perspective, he was the person who understood his wife, physically, mentally and emotionally than any outsiders. Thus he should be the first person to be informed. For him privacy is not the property of an individual but is collectively based.

In conducting research in an intercultural discourse in which privacy is collectively based, researchers encounter problems normally raised in qualitative research: relationship between participants and researchers, data reliability, discourse as data, power and empowerment. In a traditional anthropological research, it is expected that there should be a distinction between the role of a researcher and that of the participants. This distinction is essential for maintaining the integrity of research. Otherwise research objectivity could be compromised. This can be illustrated by using a metaphor of a police investigator whose task is to examine and report a case without bias and prejudice. Familiarity and close interpersonal relationship between an investigator and the people involved in the legal case can lead to conflicts of interests. It has been argued that this interference should not happen in research. However, this view has been questioned by social researchers on the grounds that researchers cannot be personally detached from the research participants. According to Burns (1997, p. 292), social reality is the product of meaningful social interaction as perceived from the perspectives of those involved, and not from the perspective of the observer. The qualitative researcher is not concerned with objective truth but rather with the truth as the informant perceives it.

Researchers are social beings that conduct data collection as a social activity and it is impossible not to be socially involved in a research discourse. In stead of treating interpersonal relationship as a negative factor in research data collection, researchers are also participants in a research discourse. Malinowski, well-known for his early publication *'Argonauts of the Western Pacific'* (Malinowski 1922), argued that researchers should not be detached from the real context of research. His concept 'participant observation' marks a strong adoption of ethnography in research. According to Malinowski, researchers need to experience the everyday life of their informants along with them. Metaphorically it should not be conducted on a verandah which symbolises the detached roles between the researchers and their informants. They must have daily contact with their informants if they are to adequately record the 'imponderabilia of everyday life' that is so important to understanding a different culture. Thus instead of avoiding personal relationships with informants, researchers need to cultivate them as a

way of finding and understanding the informants in their cultural discourse. This is also an important question in Grounded Theory (GT) developed by Glaser and Strauss (1967). *Awareness of Dying* (Glaser & Strauss 2005) marked the authors' collaboration in research on dying hospital patients and a focus on how to maintain the integrity of data in relation to interpersonal relationship and interpretation. Strauss and Corbin (1998, p. 48) explained this by giving the following specific example:

> It is not the researcher's perception or perspective that matters but rather how research participants see events or happenings. For example, one of the authors might know that a certain piece of equipment in a hospital is used to take x-rays. But others may view it as an outdated machine, as a physical threat, or as meaning more work to do. It is these other interpretations that the researcher is seeking. What helps is that the researcher has a comparative base against which she can measure the range of meanings given by others and a beginning list of properties and dimensions that she can use to gain greater understanding of their explanations.

In my view, the issue is not how close the interpersonal relationships between researchers and participants are. Fundamentally, the key question is how researchers can handle the relationships in such a way that data interpretation is not intentionally or unintentionally distorted due to such relationships. In conducting research, researcher as social beings can perform different social roles such as observer, academic, stranger, visitor etc. Thus, there can be subjective judgments and socially inappropriate actions. It is important that they can develop some strategies to safeguard their interference and they should never reveal such background information in their interpretation.

Another aspect regarding the relationship between researchers and participants is trust. According to Misztal (1998), there are three basic things that trust does in the lives of people: It makes social life predictable, it creates a sense of community, and it is easier for people to work together. When researchers conduct interviews with participants to obtain data for research, they expect that trust creates some mutual respect and a sense of responsibility in the information exchange. Thus it is expected that the information given by the participants in an interview is authentic and genuine. The information given to the investigators should truly reflect the experiences, views and attitudes of the participants. It is impossible to obtain reliable information if there is no trust between researchers and participants. Trust is difficult to build when the cultural gap between researchers and

participants is wide. One could not expect a group of Australian researchers to gain the trust of Vietnamese participants in just a short period of acquaintance, particularly when they cannot communicate in a common language.

Interviews are widely used in qualitative research. They are one of the main methods of gathering data for analysis. While the use of questionnaires restricts the response and behaviour of the respondents and imposes the topics and issues on them, interview, particularly the open-ended type, gives respondents opportunities to share their thoughts and feelings on many aspects which affect their world. However, the dilemma is that interviews as a method of data collection may not go far enough to include exchange of views between interviewers and interviewees as the word 'interview' actually designates: sharing views between people. The reason is that interviewers are reluctant to influence their interviewees in their efforts to achieve data authenticity. In a collective community, people do not want to express openly their thoughts and feelings to those who do not want to share theirs. It is a collaborative communicative process. If an interview is aimed at seeking someone's views without sharing their own views, the insights gained from an interview may be inadequate or superficial for data analysis. Particularly in the framework of *Grounded Theory*, such limited data could not be powerful enough for theorising, which is the essence of *Grounded Theory*. As Strauss and Corbin (1998, p. 25) explain:

> Theorising is the act of constructing from data an explanatory scheme that systematically integrates various concepts through statements of relationship. A theory does more than provide understanding or paint a vivid picture. It enables users to explain and predict events, thereby providing guides to action.

The traditional concept of communal identity is still very strong in Vietnamese society. It affects how individuals behave and value their lives in relation to the significant others in a family or a community. Individuals are strongly influenced or controlled by communal values and expectations. Qualitative health research should take into consideration the collective structure of the discourse to which its participants belong. For instance, in a family discourse, social features such as gender, role and position in the family, as well as family aspiration are important factors determining the wellbeing of individual family members. Certain health concepts and healthcare practices, such as those involving abortion, palliative care, childbirth, death, and funeral, are deeply rooted in the communal identity. Instead of focusing on individuals as single research participants, qualitative

researchers need to involve other family members in data collection and examine the intricacies of their collective views on those issues.

Linguistic and pragmatic barriers in data collection and interpretation

The fundamental difference between quantitative data and qualitative data is that the former is numeric and the latter generally involves text, discourse and meaning. This distinction explains why statistical methods are important in quantitative data analysis. Descriptive statistics enables researchers to summarise large quantities of data using graphical and numerical techniques and inferential statistics provides procedure for making generalisations about the characteristics of a population based on information obtained from a sample take from that population (Burns 1997, p. 42). While quantitative data is mainly numeric in nature, qualitative data is extremely varied in nature. It includes virtually any information that can be captured that is not numerical.

As stated, qualitative data includes various forms of text, discourse and meaning, language is not only a tool for obtaining and interpreting such data but also the data itself. While numerical items are linguistically universal in the sense that virtually all cultures have a common numerical framework (like different currencies which have the same exchange basis), qualitative research depends heavily on linguistic and pragmatic aspects of communication in data collection and data analysis. As culture is realised through language, a big hindrance to researchers in general and health researchers in particular is the lack of linguistic ability and pragmatic competence to carry out intercultural research. There is no strict correspondence between words and expressions among languages and this make translation very difficult and potentially culturally inappropriate. For example, in English we have a range of lexical items denoting 'giving' such as 'donate', 'grant', 'offer', 'provide' etc and there are subtle differences in meaning among them. These subtle differences may not occur in other languages. Similarly in Vietnamese, there are words which do not exist in English and they can be translated into English by using words and expressions which may be subject to misinterpretation and distortion. In other words, culture is so deeply embedded in language that only through language can researchers deeply unearth meaning underlying communication and behaviour.

When health researchers from an English speaking country conduct interviews in Vietnam or in Australia with Vietnamese migrants, one of the weaknesses is to translate the questions already constructed in English into Vietnamese, or similarly to translate the answers in Vietnamese into English. The meaning in the English translation is not necessarily the intended meaning in Vietnamese. It is not just a matter of degree in semantic equivalence. The translation can change the meaning from one language into another. The medium itself is the message. The following example illustrates the problem of translation used in interview for data collection:

- *Quân giặc Mỹ xâm chiếm Iraq*. (Vietnamese).

- The US army is occupying Iraq. (English translation).

The Vietnamese expressions 'quân giặc' and 'xâm chiếm' are derogatory. In Vietnamese, they usually co-occur with words denoting aggression, enemy, destruction etc.

- *Dạ thưa bác sĩ, xin ngài cứu nhân độ thế cứu cho con tui khỏi bịnh.* (Vietnamese).

- Please Doctor, please cure my child. (English translation).

The English translation does not capture the subtle cultural meaning underlying the Vietnamese sentence. The word 'ngài' shows profound respect for the doctor. It is also used to address God, Buddha or a saint. '*Cứu nhân độ thế*' reflects the Buddhist belief about '*nhân quả*' (sowing a good seed by saving people and harvesting the good result for life).

The examples illustrate the implication for conducting qualitative health research in an intercultural discourse. In order to fully obtain the meaning from the interview data, the best way is through the use of the language of the respondents, not through translation. The language issue is not just confined to different languages but also applies to linguistic variation within the same language. Awareness of linguistic variation is needed in health research as shown in the following quotation of Pope, Ziebland & Mays (2000, p. 114):

> Initially the data are read and reread to identify and index themes and categories: these may centre on particular phrases, incidents, or types of behaviour. Sometimes interesting or unfamiliar terms used by the group studied can form the basis of analytical categories. Becker and Geer's classic study of medical training

uncovered the specialist use of the term 'crock' to denote patients who were seen as less worthwhile to treat by medical staff and students.

Pragmatics has contributed to the broadening of the field of human communication with its emphasis on language in use. From the perspective of pragmatics, people use language because they expect what language can do for them. Speech acts such as greeting, promising, thanking, complementing, apologising, commanding, etc are used in daily interaction. Speech acts strongly reflect cultural norms and values in human interaction. When researchers conduct their research in a different country, pragmatic interference occurs when their cultural speech acts are used in replacement of those normally used in a new cultural context. Qualitative data obtained from interviews in an intercultural context can be defective or misleading due to lack of pragmatic awareness. The speech act of joking between a researcher and a participant, for example, can be treated as an insult even though it is not intended by the speaker. The greeting expression "*I will see you later*" can be misinterpreted as an act of self-imposed invitation. The apology expression '*I'm sorry, I can't be of any help*' may imply a polite excuse for not continuing with a particular task.

Campbell (1997) reminds us of the complexity and significance of cultural diversity in research. She argues that research needs to accept the paradigmatic shift in order to accommodate the changes in our global village.

> The research paradigm shift is only part of a larger paradigmatic shift which is taking place in the Western World in the late twentieth century. The move from modernity to post-modernity, from nationalism to globalisation, from cultural supremacy of one group over others to the concept of multi-culturalism and the acknowledgment of cultural diversity, from an understanding of one faith and its dominance in society to acceptance of multi-faiths, are some of the major changes taking place in the world in which we live and which we have to accommodate. (p. 4)

Conclusion

The adoption of qualitative methodology in health research has strengthened rather than weakened the empirical research tradition in health. Researchers now have at their disposal a number of research tools for data collection and data analysis. It is important to

note that not one tool is better than the other. What it matters most is how the tools are used appropriately for the functions for which they are designed. However, research tools should not be used without serious consideration of the cultural context in which a research is conducted, particularly in intercultural research. This paper has examined some problems facing researchers, particularly in health care research, in using research methods in an intercultural discourse in which data is strongly embedded in culture.

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