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Taiwanese Immigrants’ Medical Experiences: An Exploratory Study

Chien-Juh Gu
Department of Sociology, Western Michigan University, Kalamazoo, Michigan, USA

ABSTRACT
Immigrants’ medical experiences are an important and yet rarely studied topic. To fill this gap, this article provides an exploratory investigation concerning how immigrant status, gender, and race affect Taiwanese immigrants’ health care choices, their perceptions of medical professionals, and their health behavior in the United States. Data are based on 16 in-depth interviews and participant observations in a Taiwanese immigrant community in a Midwestern urban area. Findings suggest that Taiwanese immigrants rely heavily on their coethnics for gathering medical information. The subjects’ perceptions of a physician’s gender convey stereotypes and reflect sexual body boundaries. While aware of their minority status and its impact on health care, the subjects show racial prejudice toward Black physicians. They also often contrast the two medical systems in the sending and receiving societies when describing their health care experiences. Implications of this study for scholars and health care providers are discussed.

KEYWORDS
Health care experience; medical encounter; Taiwanese immigrants; doctor-patient interaction

In a doctor-patient encounter, the physical body is the object of treatment, but patients also experience subjectivity in medical settings (Turner, 1992). Patients’ bodies do not exist in a social vacuum; rather, social differences shaped by gender, race, age, disability, education, socioeconomic status, marital status, and the intersectionalities of these varied dimensions of differences are also present in the body. Individuals’ structural positions not only affect their unequal health statuses and health behaviors but also how they experience medical care and how they interact with medical professionals. Therefore, patients’ medical experiences convey important information regarding doctor-patient relationships, social differences, social inequalities, and individuals’ subjectivities. They also deliver helpful information for medical professionals and social service workers to understand immigrant patients’ perceptions and behavior in the medical encounter.

Sociological investigations of embodied social differences are particularly complex when studying immigrants. As Becker states, “New situations provoke new
behavior” (Becker, 1982, p. 520). In the host society, immigrants acquire a new social status and live in a new environment, where social differences are stratified in a new way. Their social practices, cultural beliefs, and health behavior may change as they adapt to the new social context. As McCall and Wittner (1990) point out, social contexts are important in shaping individual perceptions and meanings. How do immigrants perceive their roles as patients in a medical setting? How do they choose physicians? How do they interact with medical professionals? Do they adopt new health behavior and beliefs? How do they obtain information to help them make decisions about health care?

Immigrants’ experiences are useful for discovering social practices and cultural beliefs that are often taken for granted by natives—for instance, a native-born American usually knows how to behave at a clinic and what to expect from medical professionals. However, for an immigrant who comes from a different culture, everything is a fresh start. Many decisions that immigrants make in their daily lives involve a search between two cultural systems in order to find appropriate behavioral guidance in the new social context. Immigrants’ discoveries of “how they are supposed to behave” and “how things are done” in the host society do not occur overnight. Rather, immigrants’ acculturation involves a process of trial and error when experiencing their lives after relocation. While research on immigrant acculturation and adaptation is abundant, scholars rarely discuss immigrants’ perceptions of medical professionals, ways of acquiring medical information, and their experiences in medical settings. This gap is especially critical because health care is an arena that sometimes involves life and death. Knowledge drawn from empirical research will not only enhance scholarly understanding of immigrants’ medical experiences, it will also provide useful information for medical professionals and social workers to increase the quality and accessibility of health care for immigrant groups. In light of the scarce research on the topic, the importance of this exploratory study cannot be overstated.

**Theoretical foundation**

Sociological research is scarce concerning immigrants’ health care experiences, especially as it relates to how immigrants obtain medical information, make medical decisions, perceive medical professionals, and evaluate medical systems and cultures in the sending and receiving societies. No particular sociological theory addresses immigrants’ medical experiences. To frame this exploratory study sociologically, I follow Becker (1982) and adopt a symbolic interactionist approach to examine Taiwanese immigrants’ health care experiences.

Symbolic interactionism explores how individuals give meanings to their behaviors and interactions with others—that is, how social actors make sense of their behaviors (McCall & Becker, 1990). Symbolic interactionists argue that human conduct is socially structured. Individuals act toward things based on the meanings they have for them. Meanings arise from social interactions, through which
individuals negotiate, modify, and interpret their realities (Blumer, 1969). Symbolic interactionism is the most developed explanation of the connection between individual perception and social organization in sociology. Therefore, it is a useful theoretical framework to discover individuals’ thoughts in medical encounters.

From a symbolic interactionist perspective, people do not simply do what they do. Rather, individuals make choices based on how they understand their roles, contexts, and interactions with others. Using Mead’s (1934) term, people develop “minds” through role taking or through how they think of others’ perceptions of themselves. In other words, individuals’ choices are always linked to social structures and constraints. Following this viewpoint, immigrants’ daily decisions are conditioned by the social, economic, and cultural contexts of the host society. In the process of acculturation and adaptation, immigrants develop their minds through taking the roles of foreign-born individuals in the United States, in general, and in various social institutions, in particular (e.g., workplace and hospital). Their interactions with others in different social settings also shape their perspectives and behaviors.

Immigrants’ health care experiences provide a valuable opportunity to study human conduct from a symbolic interactionist perspective. Immigrants socialized in different cultures usually do not take things for granted in the host society and often do not simply “do what they used to do” in their new societal contexts. So, I ask, how are immigrants’ medical choices conditioned by their foreign-born status and past experiences in the sending society? How do they make health care choices based on the available information? Where does the information come from? How do immigrants make sense of medical encounters when in the patient role? This study aims to answer these questions.

Methodologically, symbolic interactionists rely heavily on qualitative methods because the focus is on examining what meanings subjects attribute to their behaviors. Researchers strive to put themselves in the position of the studied group to develop an adequate understanding of subjects’ minds and behaviors and to develop a connection between individuals’ perceptions and social contexts (Sandstrom, Martin, & Fine, 2010). Therefore, I used in-depth interviews, supplemented by a few participant observations, to document how Taiwanese immigrants make sense of their health care experiences in the United States. Subjects’ interview narratives were the main data used to understand their perspectives.

**Research questions**

This study aims to answer the following questions:

1. **How do new immigrants gather medical information in a foreign land?**

Decision making is central to exploring individuals’ cognition in health behavior. Since not everyone who is sick seeks professional help, the cognitive process of decision making for the use of medical services becomes important in understanding people’s behavior regarding health and illness. Decisions such as whether to seek help from medical professionals and which physician or clinic to visit reveal
important information about individual health behavior. Relocating to a new society is a drastic social action that can be financially, socially, culturally, and psychologically challenging (Gu, 2012). Immigrants’ decision making concerning their health care involves many potential risks because health care decisions can involve life-or-death situations; moreover, their status as immigrants can sometimes place them in a disadvantaged position for making fully informed decisions. Therefore, how immigrants make decisions about health care is an important topic for social research.

Social networks are important sources of medical information that can influence individuals’ decision making about health care (Ritter, 1988). In the case of immigrants, Kuo and Tsai (1986) argue that immigrants’ social ties, both to the immigrant community and to the host society, help their cultural adaptation. For immigrants whose social network crosses two communities, information from their own ethnic group and from the outside community might play different roles in shaping their perceptions of medical services and their decision-making process. Thus, this study asks the following questions: Do Taiwanese immigrants gather medical information mainly from the local society (i.e., from native-born Americans or mass media), from their own immigrant/ethnic community, or from a combination of both? How do they decide which clinic or physician to visit? How do they make medical decisions in a foreign society? Do they prefer Western or Eastern medicine?

2. How do immigrants perceive physicians’ gender and race?

Demographic factors of health care, including race, gender, and socioeconomic status, have been closely examined in many studies. Scholars point out that demographic factors affect both people’s health behavior and their interactions with physicians and that physicians treat patients differently according to their age, gender, and race (Broman, Hamilton, Hoffman, & Mavaddat, 1995; Turner & Marino, 1998). Nevertheless, previous studies have focused primarily on physicians. How patients perceive physicians’ gender and race and how these perceptions affect patients’ interactions with their physicians remain understudied. Situated in the United States, Taiwanese immigrants are a visible racial group: Asian. Race for them is an embodied characteristic that they carry everywhere, both in the larger U.S. society and in medical encounters. Being characterized as such is a new experience that they did not have in Taiwan, where almost everyone is Asian. How do Taiwanese immigrants perceive themselves as Asian patients? How do they perceive medical professionals who are of different races? Do they interact with physicians differently because of their race and gender? Why?

3. How do immigrants perceive their medical experiences in the sending and the receiving societies?

Geographers often stress the importance of place in shaping individuals’ subjectivities and identities, especially for those who migrate across national borders (Conradson & McKay, 2007). Social institutions, such as the workplace, the family, and the medical system, are major places that contextualize subjective experiences. Following these arguments, I also explore the following questions: Are Taiwanese
immigrants’ medical experiences in American medical settings different from those in Taiwan? How? How do the differences influence their perceptions of themselves as patients and of health care in general?

**Research methods**

This study was conducted in a Midwestern urban region around Lansing, Michigan. Sixteen Taiwanese immigrants were interviewed. The criteria used to recruit respondents were (1) those who had lived in the United States for at least five years; (2) those who had fairly frequent medical visits in the United States (e.g., for prenatal exams or for treating chronic illness); and (3) those who had sufficient medical experiences in both Taiwan and the United States. Several strategies were used for recruiting subjects, including snowball sampling, the researcher’s social network, and referrals through Taiwanese immigrant organizations in the region. Interviews were conducted in either Mandarin Chinese or Taiwanese, and the average length of interviews was one and a half hours. All interviews except one were tape-recorded and transcribed verbatim.

The 16 subjects (10 women and six men) were all immigrants from Taiwan. Five of the six men had acquired an advanced degree in the United States, migrated through education, and worked as professionals in the areas of medicine, engineering, and academia. One migrated through business investment. Eight of the women were housewives who migrated as dependents. Although they did not speak fluent English, all had obtained at least a bachelor’s degree in Taiwan and came from middle-class backgrounds. Two women had obtained postgraduate degrees and had professional jobs in the United States. The subjects’ ages ranged from 32 to 65. The results of this study may be constrained by these characteristics of the sample and, therefore, do not represent general patterns of this immigrant group.

The interview questions were structured based on the research questions stated earlier. As Whyte argues, “The good research interview is structured in terms of the research problem” (Whyte, 1984, p. 97). Thus, the interview questions cover three themes: (1) sources of medical information, (2) perceptions of physicians’ race and gender, and (3) comparison of overall medical experiences in the United States and in Taiwan such as involving space arrangements, medical professionals’ attitudes, and judgment of medical uncertainty. Although structured, questions were asked in an open-ended format in order to solicit extensive and detailed opinions.

In addition to in-depth interviews, limited participant observations were also conducted in this study to supplement my understanding. A few informants allowed me to accompany them to their doctors’ appointments. During these visits, I observed closely how the informants interacted with physicians and nurses in medical encounters. Pseudonyms are used in this article to ensure the subjects’ confidentiality.

The research site, the larger Lansing area, includes three cities: Lansing, East Lansing, and Okemos. Lansing is the capital of Michigan, which attracts many professionals who work for the state government or various corporations. The East
Lansing–Okemos area surrounds Michigan State University, where many middle-class families, diverse racial groups, and small business owners reside. According to the 2010 census data, this region has a population of 184,245, including 12,467 Asians. In 2010, 266 Taiwanese resided in the area, approximately 2% of the total Asian population in the larger Lansing area (U.S. Census Bureau, 2010).

**Who are Taiwanese immigrants?**

Along with their counterparts from China and Hong Kong, Taiwanese immigrants are one of the three major ethnic-Chinese-American groups (Holdaway, 2007). Although sharing a Confucian tradition, these three groups have distinct historical, economic, social, and political backgrounds that characterize each group’s life experiences and worldviews and determine the relevant immigration-related issues such as migration motives, ability to migrate, policies under which they entered the United States, and resources they brought with them. It is therefore important to recognize the heterogeneity among ethnic-Chinese groups and the distinctiveness of Taiwanese immigrants in the United States.

Roughly the size of Maryland, Taiwan is an island located 96 miles east of the southern China coast. It has a population of 23 million. In 2010, there were 358,460 Taiwanese immigrants living in the United States, which is comparable to the number of Italian and Brazilian immigrants. In contrast to Chinese immigrants, who have spent over a century in the United States, Taiwanese who live in the United States are primarily post-1965 immigrants (Ng, 1998; Ward, 2006). Most Taiwanese immigrants initially came to the United States in pursuit of higher education, especially in scientific fields. Although the group’s diversity has been increasing since the 1980s, immigration through education remains the major pattern of Taiwanese immigration to the United States (Gu, 2006, 2012).

Unlike Chinese immigrants, who tend to reside in ethnic enclaves such as Chinatown, Taiwanese immigrants are scattered throughout suburban White areas (Gu, 2006, p. 118; U.S. Bureau of the Census, 2010). Both Taiwanese immigrant men and women present a high-education, high-income professional profile; their income levels are significantly higher than their Asian counterparts from India, China, Korea, and Japan (U.S. Bureau of the Census, 2010).

Two major ethnic groups, benshengren and waishengren, constitute Taiwanese immigrants; they speak different languages (Taiwanese and Mandarin Chinese, respectively) and have different cultural traditions and historical origins. Benshengren migrated from China to Taiwan prior to World War II; their migration history can be traced back to as early as the 16th century. Waishengren migrated from China to Taiwan after World War II. Although the majority of Taiwanese people are benshengren, waishengren controlled most political and social resources on the island until the end of the 1980s. The waishengren were highly educated, and most worked for the government or served in the army or police. Many benshengren migrated to the United States in the 1970s to escape the waishengren’s dominance.
and oppression. On the other hand, a great number of waishengren chose to move to the United States after living in Taiwan for a while because they did not consider Taiwan their homeland, but they also did not wish to submit themselves to communist governance in China (Ng, 1998).

No statistics are available on the numbers of benshengren and waishengren in the United States; the Taiwanese immigrant community and the differences of the two ethnic groups are rarely discussed in scholarly work. My study (Gu, 2006, 2014) of Taiwanese immigrants provides some analyses concerning the two ethnic groups’ assimilation experiences. While both groups began their immigration journeys to pursue higher education, most benshengren settled in the United States for job opportunities, while waishengren chose to stay to unite their families. This pattern led to waishengren developing greater kinship networks and support in the host society. Moreover, waishengren couples are much more egalitarian than their benshengren counterparts. These differences may also shape their perceptions of the U.S. health system.

Taiwanese immigrants’ medical experiences

In this section, I present findings of this exploratory study according to the three aspects of medical experience outlined in the following research questions: (1) How do immigrants obtain medical information in a foreign country? (2) How do immigrants perceive physicians’ gender and race? (3) How do immigrants’ medical experiences differ in the sending and receiving societies?

Medical information and decision making in a foreign country

Taiwanese immigrants exchange medical information within their ethnic community. All but one of the subjects obtained medical information from their coethnics. This phenomenon was particularly evident among homemakers. Sharing a lot of similarities (e.g., coming from the same society, being homemakers, lacking fluency in English), these wives formed a social network comprising fellow immigrant women. Their medical information thus came from other Taiwanese immigrant wives. These female subjects explained:

Most of the information I have gotten is from a Taiwanese immigrant wife. She gave birth here and is very experienced. Whenever I have questions, I always call her to ask.

We don’t have many American friends … Many Taiwanese immigrant wives were pregnant at that time, so I had a lot of information and didn’t think of asking other people.

In contrast to their female counterparts who were housewives, male subjects had many more contacts and interactions with people outside of their ethnic group. A few waishengren mentioned that their relatives provided helpful medical information because they had lived in the United States longer and were more familiar with the health care system. Compared to their benshengren counterparts, waishengren had more extended family members in the United States; therefore, they
acquired most health care information from their kinship while benshengren relied more on fellow immigrants.

All male subjects’ social networks included both Taiwanese and non-Taiwanese. Even so, these men still tended to gather medical information only from the Taiwanese immigrant community. Although some obtained medical information from the media or from clinics, few asked their U.S.-born friends about the medical system or physicians. They tended to make medical decisions according to other Taiwanese immigrants’ experiences and recommendations.

**Language barriers in the medical encounter**

Language barriers are one of the major obstacles for immigrants seeking medical treatment, which requires accurate expressions of symptoms and a good understanding of medical terminology. In this study, many subjects reported that language was a major concern when selecting physicians. For those subjects who chose to see a Taiwanese or Chinese physician, their major purpose was to communicate with physicians in Mandarin Chinese. The informants explained:

> I have a language barrier, so, I hope to see a doctor who can listen to me patiently and who can understand me better [than someone who does not speak Mandarin].

> If you are fluent in English, it doesn’t matter if you see an American or [a] Chinese doctor. But if you are not, then seeing a Chinese doctor would be very convenient.

Many Taiwanese housewives spoke little English. However, their husbands’ involvement in their health care helped to address the language barrier. Accompanying one couple to the hospital during my research, I observed that the wife always asked her husband’s opinions in order to confirm her answers to the physician’s questions. In other words, the husband played an important role in their visits to the clinic because the wife greatly relied on him to communicate with the physician. Therefore, although many homemaker-participants did not speak fluent English, visiting a physician was never a problem because their husbands always accompanied them to their doctor’s appointments and helped them communicate with physicians. One woman commented:

> My husband can answer almost every question for me, so, I just sat there watching their conversation. It seemed that the one who was pregnant was him, not me.

Communication was less of a problem for those individuals who were fluent in English and who had studied in the United States, but the high demand for accurate vocabulary in medical encounters could sometimes be stressful. Many informants expressed their anxiety about interacting with medical professionals because they lacked confidence in having mastered the language. Fortunately, the physicians’ and nurses’ friendly attitudes often eased the informants’ worries. Some informants described:
Sometimes I didn’t understand what the doctor was talking about, but he was very patient. He tried to express the words in different ways to help me understand him. I think American physicians and nurses are nice. They are very patient even when they don’t understand me.

In sum, the language barrier in medical encounters was a common problem among the informants, but the severity of such a barrier varied depending on the informants’ fluency in English. Both benshengren and waishengren men accompanied their wives to their doctor visits. Husbands’ involvement and medical professionals’ friendly attitudes both helped overcome such obstacles in the doctor-patient interaction.

**Hybrid beliefs of health and medicine**

Most subjects in this study preferred Western medicine over Chinese medicine, especially waishengren. Only three informants, all benshengren, were taking Chinese medicine: two men took Jan Lu Wan (Chinese herb pills for stomach- and intestine-related symptoms), and one woman took Chinese herbal medicine for her allergies. These subjects chose Chinese medicine over Western medicine because “it worked better for their symptoms,” according to an informant. In contrast, two male waishengren respondents argued that “Chinese medicine is not scientific” and asserted their strong belief in Western medicine. None of the informants in this study practiced religious healing, which is popular in Taiwanese society.

Health care is full of uncertainty. When talking about medical uncertainty and seeking health care treatment in a foreign country, most respondents expressed their trust in the advanced medical technology and professionals in the United States.

I think these physicians here are very good, as well as the technology and examination … I think the technology is more advanced here [than in Taiwan], so I don’t think I will have any problem giving birth in the States. I don’t worry about it.

I don’t think Chinese medicine is scientific, compared with modern medicine. The technology and professional skills are very good in the United States. They have very advanced medical technology.

Even though Taiwanese immigrants expressed their trust in Western medicine and American physicians, some retained traditional Chinese culture in their medical beliefs and health behavior. This was particularly evident when female benshengren respondents spoke of their beliefs regarding postpartum care.

Chinese herbal nutrition has been known for thousands of years that it helps women to recover after giving birth. I believe that … your health will become worse if you don’t take nourishing Chinese food during postpartum period.

I obeyed everything in the Chinese tradition for the postpartum period as much as I possibly could. For example, it was said that I shouldn’t take a shower for one month after giving birth, and I endured that for two weeks.
The concepts of “cold” and “hot” nutrition are demonstrated in female subjects’ narratives when explaining what is good for their postpartum recovery. From their perspectives, what Western women do—drinking cold milk and water, going outdoors within the first month after giving birth—are “cold health practices” that are harmful for the postpartum body. The women followed traditional Chinese beliefs to practice “hot health behavior,” such as drinking hot water, consuming hot chicken soup, and staying indoors for a month after delivery to avoid cold air, even in the summer. They also avoided behavioral taboos for pregnant women. For instance, Chinese folklore believes that holding scissors can cause physical disability to the baby and moving furniture around can ruin the feng shui and the “chi” in the house. Subjects tried to follow these rules as much as possible because they did not want to risk their and their babies’ health.

Moreover, perceptions of hospital visiting hours illustrate how Taiwanese immigrants bring their own culture into the American medical setting. One subject who worked in the medical area commented:

> Usually, Americans obey the rules set up by the hospitals regarding visiting hours. However, Taiwanese don’t know about this, because we are used to taking care of relatives in hospitals … Many nurses complained to me that Taiwanese stayed in the patient’s room twenty-four hours a day, and it made their work inconvenient … It’s very strange that they don’t know the medical system, even though they’ve been here for a long time.

I also witnessed such a phenomenon during my participant observations. When a Taiwanese immigrant was hospitalized after a car accident, other coethnics immediately organized a care-giving schedule in order to make sure that someone was with the patient 24 hours a day. This phenomenon illustrates that ethnic-networks are not just sources of information; they also provide important social support. Meanwhile, this community response is shaped by Taiwan’s health care culture. In Taiwan, patient care is mostly the family’s responsibility. Medical professionals only check on the hospitalized patients periodically, while the patients’ families stay at the bedside and closely monitor any changes. The subjects’ behavior suggests that immigrants continue to be influenced by their culture of origin after relocating to a foreign country and that they may not be aware of social differences between the two cultures. Eventually, the patient’s friends were asked to go home, and they later learned about the visiting-hour regulation in American hospitals. In order words, immigrants’ adaptation to the new culture requires a learning process in which information attainment is crucial.

**Demographic factors in the medical encounter**

**Sexual body boundaries and gender stereotypes**

The subjects did not significantly prefer one gender over the other when they were selecting a physician. Among the 16 informants, six preferred a female physician; four preferred male doctors; and six had no preference. Although no significant
preference was found, the informants’ explanations warrant a meaningful sociological analysis. All female respondents in this study had visited physicians for their prenatal examinations. Among these women, those who preferred seeing a female physician attributed their choice to possible embarrassment during internal examinations. They explained:

When I was in Taiwan, almost all physicians were male, so, I didn’t feel that different [regarding a physician’s gender]. But this [pregnancy] is more embarrassing because I sometimes have to disrobe … when I visit the hospital for prenatal examinations, the physician has to examine my breasts and cervix. It would be embarrassing if my doctor were male.

If it had been a male physician, I would have felt very embarrassed. As for other diseases, a physician’s gender doesn’t matter so much.

Other female respondents who preferred a male physician provided the following reasons:

Male physicians’ intellectual ability and analytical logic are better than female doctors. I feel that male physicians are more attentive than female physicians … Maybe female physicians could be insensitive about women’s pain or problems. Because they are also women, they have similar experiences with us and wouldn’t regard anything as a big deal. I feel that male physicians often show their understandings and sympathy better.

Among the four informants who preferred a male physician, two were benshengren males. One of these two male subjects believed that it was very “natural” that “male physicians see male patients and female physicians see female patients.” The other male informant had a very strong reaction when asked about a physician’s gender:

I would never see a female physician! It’s shameful!! You know what? In the United States, a physician examines every part of your body. Especially for regular check-ups, they check everything! It’s very shameful if a female physician looks at my body. I don’t feel comfortable at all.

In contrast, two male waishengren informants preferred a female physician. Both of them believed that “female physicians are nicer, more considerate and friendly” than male doctors. Among the male subjects who expressed their opinions about physicians’ gender, benshengren men preferred male doctors, while waishengren men preferred female doctors.

Two major themes emerged from the informants’ narratives. First, sexual body boundaries characterize the perceptions of those subjects who prefer a physician of their own gender. The subjects consider their bodies to be a private space that only people of the same gender can examine or touch. This tendency was particularly evident among benshengren subjects. In a study of Chinese-American women, Mo (1992) observes that cultural beliefs shape Chinese-American women’s beliefs of modesty and sexuality. This cultural characteristic of modesty also leads to Chinese-American women’s reluctance to be examined by male physicians (Mo,
1992). This tendency existed not only among women but also among men in this study. Similar to their female counterparts’ modest feelings about male doctors, men felt uncomfortable being touched by female physicians. Sexual body boundaries exist in both men’s and women’s perceptions of doctor-patient relationships.

Second, gender stereotypes are illustrated in the perceptions of those subjects who prefer a physician of the opposite gender. Cultural expectations of masculinity and femininity are associated with male and female physicians in the subjects’ narratives. In the larger society, men tend to be perceived as intelligent, objective, and more analytical than women. In contrast, women are often viewed as more caring, considerate, and patient. The informants’ perceptions of their physicians’ gender reflect such general cultural beliefs of the two genders.

Does race matter?
The subjects were fairly conscious about their race because of their yellowish skin color. This visible racial characteristic often engendered feelings of alienation and discrimination in U.S. society. Several subjects contested that being an Asian immigrant had many disadvantages. For example, they felt that they were sometimes treated with prejudice at work or in their everyday lives. A few said that most Whites did not bother to get to know immigrants, and thus, they felt isolated and marginalized. In contrast, when talking about medical experiences, only one benshengren reported having been mistreated because of his race. Most subjects emphasized that American medical professionals treated them very kindly. Nevertheless, when the informants were talking about Black physicians, many expressed racial stereotypes and prejudice:

I don’t feel very comfortable with Black physicians … I feel that they are not very serious. When you visit a doctor, you would expect that the physician is very serious and professional … He [a Black physician] seems too casual and too relaxed for a physician. It makes me feel that his attitude is too casual. He is not very serious, and I feel a little uncomfortable … Blacks are not very acceptable for Asians … Maybe it is because of their skin color. They are very different.

Maybe I would pay more attention to a Black physician, to see how he performs … Maybe the Blacks in my neighborhood have given me bad impressions in the past. They often play music very loudly. So, if some people have bad impressions of them, it’s because of their behavior. Basically, I think if a Black could become a physician, his knowledge or ability is good enough for this occupation. However, if he didn’t do his job well, I would attribute this result to his race.

Other respondents who did not interpret their attitudes toward Blacks as clearly as stated in the above quotes simply said that “I would feel very strange” or “it would be weird” if they had a Black physician. In comparison, benshengren, especially females, uttered more explicit prejudice and used more blunt language in criticizing Blacks.

In summary, although skin color often reminded them of their minority status in the United States, the subjects also held racial stereotypes of African Americans.
Thus, the spectrum of skin color is presented in a paradoxical form. Relative positions on this spectrum become a racial hierarchy in the subjects’ perceptions.

Other factors: Age and length of stay in the United States
Most subjects did not comment when asked whether a physician’s age played a role in making their medical decisions or shaping their medical experiences. Two subjects commented that older physicians are more experienced, while younger doctors know more about the most recent technologies. Regardless, they did not prefer one over the other. Unlike gender and race, a physician’s age did not surface as a main consideration when evaluating health care options or physician competence. Benshengren and waishengren did not show significant differences.

Largely influenced by their lengths of stay, immigrants’ acculturation affects their familiarity and understanding of social systems and cultural values within the host society. In a general sense, the longer an immigrant lives in the host society, the more he or she knows about various aspects of that society. However, the duration of time spent in the United States did not seem to significantly affect subjects’ perceptions of health care. Several recently migrated subjects showed fair knowledge of U.S. medical policies, while some older immigrants continued to rely on their relatives and coethnics to acquire medical information.

Contrasting medical experiences in different societies
Comparing their medical experiences in the United States and in Taiwan, all respondents mentioned the less crowded settings and increased privacy in U.S. hospitals as well as physicians’ godlike authority in Taiwan.

Less crowded settings and increased privacy in U.S. hospitals
From the subjects’ viewpoint, hospitals’ space arrangement marks one of the major differences between American and Taiwanese medical institutions. In the United States, hospitals are spacious and less crowded. For example, patients usually have a private room during their clinical visits. Comfortable chairs, magazines, paintings, and beverages in the waiting area also provide a homelike atmosphere. Subjects described their impressions of American hospitals, compared to those in Taiwan:

In Taiwan, a hospital always smells like a hospital because the odor of medical liquid is very strong. But I don’t smell the same odor here.

The nurses and staff do not always dress in white here [as they do in Taiwan]. Their uniforms are in red, green, or pink, which are more colorful. In Taiwan, the colors in a hospital are usually just green and white, including the clothes medical professionals wear. They look very cold and boring.
Here, you always have your own private room when visiting a physician. In Taiwan, we don’t have separate examination rooms. In the hospital where I did my prenatal exams, the beds were separated only by some curtains. I could hear other patients’ conversations with the physician when I was in there. Others could hear mine as well. We did not have privacy at all.

As revealed in the subjects’ narratives, Taiwan’s health care culture is very different from that in the United States. Even in contemporary Taiwan, it is common for more than one patient to be allowed in the same examination room. Patients’ privacy is far less of a concern for Taiwanese medical professionals. Due to their past experiences in Taiwan, the subjects greatly appreciate that they always have a private room when seeing a doctor. Both benshengren and waishengren described apparent differences in hospital settings in the two counties. What most Americans seem to take for granted becomes a highlight for immigrant patients when describing their medical experiences in the host society.

**Physicians’ godlike authority in Taiwan**

Taiwanese physicians’ godlike authority is another important issue that subjects repeatedly mentioned when comparing their medical experiences in the two societies:

In Taiwan, the physicians are always sitting there. It is the patient who has to “move” to see a doctor. It makes me feel that everyone should be in a hurry, because there are so many patients waiting. You’d feel the pressure that you must talk about your symptoms very quickly after you sit down. Even after you describe your symptoms, the physician might say nothing to you … You must be quick. Usually after two or three sentences, you’d have to go.

Taiwanese physicians are always in a hurry and very inpatient. They always want to finish examinations as soon as they can … When I was seeing a doctor in Taiwan, I always felt that I was not supposed to ask any questions, because it would undermine their authority.

In Taiwan, physicians are very authoritarian … They do not explain anything. They even wouldn’t tell us what [caused] our problems and what kind of medication they are giving us, because we wouldn’t understand those medical terms and conditions. In order to maintain their authority, the physicians usually don’t put labels on the medication, nor do they explain to patients about their conditions.

As described in the subjects’ narratives, physicians in Taiwan are very authoritarian. Patients are expected to obediently follow medical orders and not ask questions. This “norm” in the subjects’ past experience led to a cultural shock when American medical professionals treated them with respect, encouraged them to ask questions, and explained their conditions in detail. Many were surprised by the courtesy of doctors and nurses in the United States and began to reflect upon the hierarchical nature of doctor-patient interactions in Taiwan. The contrast in their medical experiences made subjects more aware of patients’ rights and what makes good patient care. A sense of empowerment also emerged from this realization. However, this sense of empowerment is socially and geographically bounded.
Regardless of the subjects’ realization, when asked how they would behave if they had to see a doctor during their visit to Taiwan, all subjects responded that they would follow the cultural norm and behave like “Taiwanese patients” (i.e., obedient, quiet, not asking questions).

Subjects of both genders and ethnicities clearly described the evident contrasts of American and Taiwanese medical practices in terms of hospital settings, patient privacy protections, and physicians’ attitudes. Their descriptions were fairly consistent, which was the only theme that marked subjects’ medical experiences across the board in this study.

**Discussion**

The findings of this study not only provide insights for studies of immigrants’ medical experiences; they also help medical professionals and social workers understand immigrant patients’ perceptions and behavior in medical encounters. As Weidman (1989) argues, social systems and cognitive structures are two major aspects of health culture, which represent microlevel health behavior and macrolevel cultural dimensions. Therefore, both social contexts and cognitive factors will be addressed when discussing the findings of this study.

**Immigrants’ social networks and medical information**

A society’s medical system and policies often involve its historical, social, and cultural traditions. As a result, acquiring information from the host society can be of great help for immigrants to thoroughly understand the medical procedures, systems, and ways of interacting with medical professionals in the host society, which could be very different from those in the sending society. In this study, however, Taiwanese immigrants relied heavily on the social networks within their ethnic community when gathering medical information. Although their middle-class status situates them in a structural position highly accessible to mainstream resources (e.g., insurance, medical benefits, health care options), most subjects did not acquire medical information outside of their ethnic or family networks. Further, when evaluating health care options, they did not seem to take full advantage of the social, economic, and cultural capital that accompanies their middle-class position. This phenomenon may partially contribute to their deficient understanding of the American medical system and policies. Therefore, how to effectively distribute medical information to immigrant communities may be crucial for enhancing immigrants’ knowledge of U.S. medical system and relevant policies.

Moreover, family environment has an important influence on individuals’ health behaviors (Sallis & Hader, 1988). Several scholars have pointed out the importance of family in ethnic-Chinese communities (Kok & Liow, 1992; Lin, Tardiff, Donetz, & Goresky, 1978; Muller & Desmond, 1992). In this study, family support, especially the husband’s high involvement in the wife’s health care, plays an important role in shaping the subjects’ medical experiences. Most Taiwanese
immigrant husbands, both benshengren and waishengren, always accompany their wives and children to their medical visits, which is a unique phenomenon among immigrant communities.

In an earlier study, Lin and his colleagues (1978) reported that Chinese patients often are kept for prolonged periods of time by their families. In contrast, many participants in this study complained that they often could not visit a physician sooner than they expected. They criticized American physicians as always wanting them to wait and see at home. In particular, several mothers complained that when their children were sick, they were very worried and wanted to take them to see a doctor immediately. Nevertheless, the doctors and nurses always told them to wait, to take primary care of their children, and to observe their children for a while. This situation upset many mothers who hoped to have their children receive medical attention sooner. Some subjects also complained about the emergency room in the United States where they often had to wait for a couple of hours for treatment. The subjects’ expectations were certainly influenced by the health care culture in Taiwan, where patients usually receive immediate and convenient access to health care.

**Institutional factors and health behavior**

As Greenley (1980) argues, health behavior is influenced by both individual and organizational characteristics. In the literature regarding immigrants’ health behavior, however, little has been discussed regarding the differences between medical systems in immigrants’ home countries and the United States and how this organizational dimension affects immigrants’ use of medical services and their health behavior in the United States.

Before the implementation of national health insurance in 1994, Taiwan adopted a fee-for-service system. The access to and use of medical services was fairly convenient, as people could go to any clinic or hospital they wished if they could afford the fees. Therefore, it was fairly common for patients to seek treatment in a large hospital for minor conditions because they wanted to be treated by famous physicians. After the implementation of national health insurance in 1994, doctor visits cost much less than before because medical services and medications are now covered under a single, affordable rate. As a result, “physician shopping” has become more prevalent. Moreover, physicians’ high social status and professional authority create asymmetrical relationships with their patients. Unlike their American counterparts, who tend to perceive themselves as “consumers” who utilize or consume medical “services,” Taiwanese patients see physicians as “life-saving gods,” as a subject commented, whose professional knowledge is unquestionable. In Taiwan’s medical encounters, therefore, patients seldom ask questions about the causes of disease, treatments, or medications.

The medical delivery and payment systems in the United States are very different from those in Taiwan. Health maintenance organizations (HMOs), managed
care, insurance payment, and referral systems in the United States represent the complexity of medical delivery compared with the medical system in Taiwan. To prevent lawsuits, and regulated by their professional association, American physicians usually follow required rules in their medical practice. Moreover, American patients show the orientation of consumerist behavior in the health care delivery system, which reflects the characteristics of American values and social structure (Wolinsky, 1988).

For immigrants who come from a different society and health care system, it takes time and experience to learn about a new medical culture and relevant policies. Compared to numerous uninsured immigrants and nonimmigrants in the United States, all subjects in this study had health insurance and adequate medical benefits because of their middle-class status. However, only one benshengren informant spent much time exploring health care options for himself and his family. Most subjects were aware of the complexity of the U.S. health system and, thus, chose what was easy and convenient—following fellow immigrants’ advice. This tendency suggests that middle-class immigrants may not necessarily make informed decisions concerning their health care. Rather, they rely heavily on their ethnic community and family networks when making health care decisions.

Furthermore, immigrants may show some old behavior socialized in their sending society or encounter unexpected experiences. For example, every Taiwanese immigrant in my study was surprised and amazed by American physicians’ patience of explaining disease-related knowledge, causes, and prevention. For American physicians, this may only be a required procedure of medical practice; however, for Taiwanese immigrants who were socialized into a submissive patient role, they react with wonder and delight to such medical experiences. Cultural expectations of patients and physicians are brought into medical encounters, which shape both parties’ perceptions, behaviors, and interactions.

**Minority status and health care**

Language difficulties have been used to explain immigrants’ underutilization of health care services in the United States. (Chin, 1992; Yamashiro & Matsuoka, 1997). Since precise diagnosis is critical in health care, and sometimes involves life and death, communication difficulties in the medical encounter could cause serious consequences. In this study, some subjects prefer Chinese-speaking physicians because they feel they can communicate better in Chinese than English. Others, who have the language barrier but prefer American physicians, are drawn toward American medical professionals’ patience and detailed explanations. For housewives who do not speak fluent English, their husbands’ high involvement in their health care reduced anxiety about the language barrier.

Moreover, although almost none of these respondents reported being treated unfairly in medical encounters because of their race, some showed
racial stereotypes and prejudice toward Black physicians. The finding suggests that immigrants of color may not always be victims of racism in the host country. Racial minorities’ stereotypes and prejudice toward other racial groups can be formed prior to immigration and, possibly, largely influenced by mass media. Medical professionals’ scientific knowledge and status do not exempt them from patients’ racial stereotypes. However, very few studies have discussed social attitudes and relations among racial minorities, particularly in medical contexts. In the United States medical systems in which many nurses and certified nursing assistants are non-Whites, discussing strategies or policies to reduce racial prejudice toward medical professionals would certainly lead to more-effective communication and practice in medical settings.

**Cultural dimensions of health beliefs and behavior**

Many studies of cross-culture medicine highlight the importance of cultural variations of medical practice among and within different racial and ethnical groups (Barker, 1992; Clark, 1983; Haffner, 1992). As Haffner (1992) states, many ethnic groups’ medical experiences are not only bilingual but also bicultural. In this study, Taiwanese immigrants show hybrid health beliefs and behavior influenced by both Taiwanese and American cultures. Although most subjects show strong confidence and trust in Western medical techniques, many, especially benshengren, hold traditional Chinese health beliefs and take Chinese herbal medicine.

Herbal medicine is popular in many immigrant or refugee societies (Chin, 1992; Chung & Lin, 1994). In my study, many benshengren Taiwanese immigrants took traditional Chinese herbal medicine when available. Although some Chinese herbs are available in many U.S. grocery stores, subjects usually acquired Chinese herbs and medicine directly from Taiwan or from Chinese-owned stores in the Chicago metropolitan area to ensure their authenticity.

Chinese traditional health beliefs are particularly evident in the subjects’ perceptions and practice regarding women’s postpartum recovery. According to Chinese cultural beliefs, touching water during the first postnatal month would bring on headaches for the rest of one’s life. Therefore, it is widely believed in ethnic Chinese societies that women should not shower or bathe during the first month after giving birth. In the meantime, women are told to have sesame oil chicken every day during this period in order to obtain adequate nutrition. The first month after giving birth is critical for women’s health, and sometimes a new mother totally abstains from housework to rest.

Pillsbury (1987) describes this Chinese tradition of postpartum recovery as a health practice of “doing the month.” She explains that Chinese women follow a “hot diet” to remedy imbalance between “cold” and “hot” in their postchildbirth bodies. According to classical Chinese medical theory, women are confined to the home for one month after giving birth to a child. They should follow certain rules and restrictions during this month to prevent an invasion of polluting powers.
from the external environment. Examples of these restrictions include do not touch cold water, do not cry or read, do not burn incense, do not be blown by the wind, and do not move around. Neglect of these taboos are believed to be harmful to the mother’s health (Pillsbury, 1987). Although living in a Western society, all women in this study tried their best to follow these traditional rules during their postpartum recovery.

**Conclusion**

Immigrants’ medical experiences provide rich information for exploring how societal and institutional contexts affect individuals’ cultural beliefs and behavior. When individuals’ bodies are being treated in the medical setting, their social differences (i.e., immigrant status, gender, race, age, etc.) greatly affect how they experience health care and how they interact with medical professionals. This exploratory study illustrates some of the effects by examining Taiwanese immigrants’ sources of medical information, perceptions of physicians’ race and gender, and contrasting medical experiences in the sending and host societies.

My findings suggest that, overall, Taiwanese immigrants obtain medical information from their ethnic networks. Benshengren ask their fellow immigrants for advice, while waishengren receive medical information from their relatives. In general, a physician’s gender is not a significant factor when choosing a doctor, although benshengren men differed slightly from their waishengren counterparts. The former tend to prefer male doctors, while the latter prefer female doctors. Subjects’ explanations for their choices of male or female physicians demonstrate two themes: sexual body boundaries and gender stereotypes. Those who prefer same-sex physicians draw a body boundary between the two sexes. In contrast, those who favor opposite-sex doctors often convey gender stereotypes—male doctors are knowledgeable and capable and female doctors are patient and caring.

Most subjects have not experienced racial prejudice in their own medical encounters, but some (especially benshengren) show racial prejudice and stereotypes toward Black physicians. All subjects are aware of the contrasts between Taiwanese and American medical encounters in terms of hospital setting, physicians’ attitudes, and patients’ privacy protection. Subjects defer to cultural practices more often in their health behaviors (e.g., postpartum recovery, use of Chinese medicine) and assumptions of doctors’ roles than in their medical decisions (e.g., which doctors to choose or which clinics to visit).

The findings of this study provide useful information that can help medical professionals and social service workers understand immigrants’ perceptions and behaviors, thereby, developing policies and strategies that can help immigrants effectively use health care services in the host society. For instance, hospital policies and materials of public health education should be translated into different languages to better inform foreign-born patients. They should also be distributed to local ethnic organizations to proactively deliver health-related information to
immigrant populations. Hospitals could also hold workshops for their staff to raise awareness of diversity issues. Further, medical professionals’ greater cultural sensitivity would help prevent misunderstanding and assumptions when treating minority patients. Finally, more social research is needed to explore embodied experiences in different social institutions and contexts for diverse social groups.

**Note**

1. One subject asked me not to record the interview because he “did not like to be recorded.” He did not provide further explanation.

**References**


