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Abstract

Despite the rapid increase in Korean immigrant women in the United States, research on healthcare utilization and health-seeking behavior among Korean immigrant women is limited. The present study was designed to understand the health-seeking behavior and healthcare utilization of premenopausal Korean immigrant women living in suburban communities in the United States. The study was designed and guided by interpretive hermeneutic phenomenology. Twenty participants were recruited from suburban communities in Western New York. Individual, semistructured interviews were conducted and analyzed using a team approach. Korean immigrants experienced difficulties using the US healthcare system and significant differences between the US and Korean healthcare systems. They actively sought health information through local ethnic networks, using the Internet, and they relied on self-management that was based on Korean traditional medicine. They also utilized Korean healthcare services whenever they visited Korea. They resided in-between spaces of two healthcare systems that included both geographic and cultural space. They carefully calculated usefulness, cost-effectiveness, convenience, familiarity, and accessibility to make choices between the two. This study emphasizes the importance of minimizing structural and cultural barriers to healthcare access for new immigrants. Ethnic networks and media could be utilized as an informational reservoir to promote various healthcare resources, disseminate information, and navigate new immigrants through a complex healthcare system.

Keywords: Asian people, Asian cultures, healthcare utilization, hermeneutics, immigrants, migrants, lived experience

Introduction

Millions of people have migrated to other countries in recent years, and the number of international migrants has increased substantially. Among popular destination countries, the United States attracted more international migrants than any other country (Connor, 2016). Upon increased immigration into the United States, multicultural population has been rapidly increasing. Asians are one of the fastest growing ethnic groups in the United States which accounted for 30% of the total US immigration in 2014 and this percentage has increased by 26-fold during the last 55 years (Zong & Batalova, 2016). Immigrants and refugees face challenges and experience distress in unfamiliar environments in their host country including social marginalization, low socioeconomic status, lack of societal resources, immigration stress, and poor access to healthcare services (Ahmed et al., 2016; Mirza et al., 2014; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015). Inadequate healthcare access can result in a serious negative impact on their health and well-being (Castañeda et al., 2015). Healthy People 2020 renewed their focus on identifying and reducing instances of

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health disparities (Office of Disease Prevention and Health Promotion, 2017). They found that compared to their male counterpart, female immigrants experience more socioeconomic barriers to obtaining health coverage related to healthcare utilization (Landsbergis, Grzywacz, & LaMontagne, 2014).

Researchers have identified several barriers to healthcare access for immigrants such as language, cost, transportation, community awareness, and cultural sensitivity (Ahmed et al., 2016; Seo et al., 2014; Mirza et al., 2014). However, understanding healthcare use by Asian Americans is plagued by frequent use of the monolithic category of Asians, wherein all Asians are considered as a single group, which ignores significant "within- and between-group" variations (Augsberger, Yeung, Dougher, & Hahm, 2015; Park, Cho, Park, Bernstein, & Shin, 2013). Therefore, considering the heterogeneity of the Asian American population, it is important to understand the experiences of each specific immigrant population from their perspective to study immigrants' health status and their use of healthcare.

Korean Americans recently numbered 1.5 million people, representing the fifth largest Asian group in the United States (US Census Bureau, 2016). In 2015, about 1.1 million of these were Korean-born, 77% were 18–54 years old, and 57.2% were women (Zong & Batalova, 2017). Over 50% of Korean immigrants resided in metropolitan areas in California, New York, and New Jersey (US Census Bureau, 2016). Due to the increase in the Korean immigrant population in the United States, a considerable number of studies have been conducted to identify cultural influences (e.g., acculturation and cultural beliefs) on health behavior, and to identify several barriers to healthcare among Korean immigrant women (KIW) (Seo et al., 2016). KIW tended to delay and/or underutilize professional healthcare services, except for childbirth (Seo et al., 2014, K. Lee, 2013). Such behavioral patterns were linked to individual characteristics such as low income, employment, lack of health insurance, limited English proficiency, and unfamiliar healthcare system (Seo et al., 2014). However, simply identifying factors that led to health disparities failed to explain their health-related decision-making and their experiences in health seeking in an unfamiliar healthcare system (Seo et al.,2016).

Due to a relatively short immigration history, KIW's pattern of underutilization of health services and health-seeking experiences are rarely studied. The majority of current studies target menopausal or postmenopausal women residing in metropolitan areas with large Korean ethnic communities (Seo et al., 2016; Lee et al., 2014). However, considering the fact that the remaining 50% of Korean immigrants live in dispersed suburban areas, studying premenopausal KIW's health-seeking experiences living in a mid-sized suburban city without major Korean communities is meaningful to provide a missing piece in the current literature. To our knowledge, this study is the first to explore the lived experiences of KIW's health seeking and healthcare utilization in the United States system. The purpose of this study was to understand the experiences of KIW's health seeking and healthcare utilization in suburban communities in the United States The specific aims of this study were (1) to describe the common meanings and shared practices of KIW's health seeking and healthcare utilization in the United States, (2) to understand these women's perspectives on health, well-being, and illness, and (3) to explore the women's common resources for health seeking and healthcare utilization, and to appreciate the value of available resources.

Methods

Design

The study used Heideggerian hermeneutic phenomenology to design and guide the methodology (Heidegger, 1962). Hermeneutic phenomenology, both as philosophy and research methodology, was selected since it provides better understanding of human experiences of a given phenomenon and fill gaps which are often left by traditional quantitative research approach (Plager, 1994). Hermeneutic phenomenology focuses on average everydayness of a human being's lived experience (Heidegger, 1962), which should be understood within the cultural, social, and historical period in which they live (Wojnar & Swanson, 2007). According to Heidegger (1962), human beings are situated in their relationships with other people and things in the world; therefore, meaning exists in the context of these relationships that reflects the way they are engaged and involved in the situation (Plager, 1994). Language or discourse, in particular, plays an important role in expressing one's perspective to the world, and it helps to uncover one's understanding of being-in-the-world (Heidegger, 1962).

Sample and Settings

The current study recruited KIW who had not reached menopause, and who were living in a suburban city in the United States. Recruitment strategies included a combination of purposive and snowball sampling. The study was conducted in suburban areas

of a medium-sized city located in Western New York. In the city, there was no distinct Korean ethnic town, but there were five small-scale Korean grocery markets and five Korean churches, including a Korean Catholic church, spreading throughout a wide geographical area. Inclusion criteria for the study were KIW who: (1) were born and raised in Korea until at least age 18, (2) were 35–45 years old, (3) had not reached menopause (menopause means woman has missed menses for 12 consecutive months), and (4) consented to participate in the study. The recruitment flyers were displayed in all Korean grocery markets, Korean churches, and church websites. Recruitment was continued until the researchers reached saturation when no new themes emerged.

Data Collection

Data collection (consent, interview, and surveys) including recruitment was conducted in Korean. After advertising for recruits, those women who contacted the researcher by e-mail, telephone, and referral were considered for participation. Initial screening for eligibility was conducted by phone or e-mail without asking for personal identifying information. If they agreed to participate in the study, the researcher scheduled the date, time, and location based on the participant's preference, which might have included the participant's home or a conference room in the public library. All interviews were conducted in Korean by the first author from June to August, 2013. The first author was born in Korea and immigrated to the United States She had lived in the same suburban city for 10 years. She shared the same linguistic and ethnic background, marital status, gender, and approximate age with study participants. An open-ended, semistructured interview encouraged the participants to share their lived experience of health seeking and healthcare utilization. To facilitate data collection, an interview guide (Table 1) was created based on the Heideggerian hermeneutics approach (Cohen, Kahn, & Steeves, 2000). Interviews began with a general question: "Tell me the most important thing/event that has happened to your health recently?," and then the interviewer probed until the experience was described fully. Each interview lasted 60 min and was audio-recorded. After the interview, the participant filled out a demographic questionnaire and survey about their utilization of past health services. Participants were compensated with a $25 gift card. A total of 20 interviews were collected until the researchers had achieved saturation when no new theme emerged or the data were repeated. After data analysis, the researchers contacted study participants (n = 5) by phone who agreed to future follow up interviews for member checking. Participants agreed that our findings represented their experiences; however, no further interviews were collected.

Ethical Considerations

The institutional review board at the university approved the study protocol. Prior to the interview, each participant reviewed and signed the consent form with the researcher and had their questions answered. Participants gave permission for audiotaping, dissemination of findings, and future contact for data confirmation. The researcher emphasized to the participants the voluntary and confidential nature of the study and gave them a copy of the consent for their records. Throughout all stages of data collection and analysis, participants' anonymity and confidentiality were maintained.

Table 1. *Interview Guide*

Grand tour question:
Would you please share your story related to health seeking and healthcare utilization in the United States?
Example probing questions:
Tell me the most important thing/event that has happened to your health recently.
What do you think about your health? How do you evaluate your overall health status?
What do you usually do to maintain your health and well-being in the United States?
What is your meaning of "being healthy" or "being ill"?
What has been the most difficult or the most beneficial aspect of health seeking in the United States?
What has been the most difficult aspect of utilizing healthcare services in the United States?
What has been the most beneficial aspect of utilizing healthcare services in the United States?
Have you had any changes to decide utilizing healthcare services comparing when you were in Korea?
How (what) do you do differently when you are ill/sick to seek your health compared to when you are healthy?
Where did you obtain health-related information? What source was the most helpful? What source was the least helpful?
What suggestions do you have for other KIW regarding health seeking and healthcare utilization in the United States? What do you want to tell them?
For your better healthcare utilization, what suggestions do you have for healthcare providers?

Table 2. *Modified Seven-stage Hermeneutical Process for Interpretation*

Stage	Analytic process
1*	Independent reading the narrative as a whole to gain an overall understanding and impression of the narrative, and then rereading the narrative line by line
2*	Writing interpretive summaries and identifying common themes with exemplar quotations from the narrative to support the interpretation
3*	Meeting weekly or biweekly to discuss interpretations for similarities, differences, or contradictions. If conflict occurs or if further interpretation is needed, returning to original text or consulting original interviewers for clarification
4*	Returning to the text and rereading all texts to identify hidden meaning and to link themes
5	Developing constitutive pattern to demonstrate the relationships among emergent themes across all the texts in English
6	Validating the results with research participants in Korean
7	Producing the final draft and asking research team or peers for suggestions on the final draft in English

Note. Modified from Diekelmann et al. (1989) methodology.
*This process will occur in Korean and English separately but simultaneously.

Data Analysis

The audio-recorded interviews were transcribed in Korean by a bilingual Korean (a registered nurse with a master's degree) to reflect the actual words used by Korean women. The researcher reviewed all transcripts for accuracy and de-identified personal information. Korean transcripts were then translated into English for non-Korean-speaking team members. Translation was carefully conducted by a bilingual doctoral student from the linguistic department to convey concepts that were accurate culturally. Prior to analysis, the first author reviewed all of the translated transcripts for cultural accuracy. The researcher and the analysis team analyzed the data following a modified Diekelmann, Allen, and Tanner (1989) method using the seven-stage hermeneutical process. Data analysis was conducted in Korean and English separately but simultaneously (Table 2). The interpretive process was circular, and followed a part-whole strategy until the researchers were satisfied with the depth of his/her understanding. The researchers obtained a sensible meaning of texts within the hermeneutic circle. Descriptive data analysis for the demographic information was performed in SPSS 20.

Rigor

To increase the credibility of the analysis, researchers paid careful attention to the text, using team analysis, personal journaling, and following the hermeneutic circle to obtain a sensible meaning of the text (Koch, 1996; Whitehead, 2004). Verification of findings was conducted by using verbatim quotes and member checking (Koch, 1996; Lincoln & Guba, 1985). The "thick description" technique that described detailed information of the setting and participants was used to achieve transferability (Lincoln & Guba, 1985, p. 316). To establish dependability, a decision trail was used to establish audit trail linkages (Koch, 1994). To enhance confirmability, an audit trail and a reflective journal were used.

The researchers were attentive in maintaining rigor in this cross-cultural research. To capture the accurate meaning of the experiences of KIW, the interviews were conducted in Korean. Through a team approach, interviews were analyzed in both Korean and English. An additional Korean researcher with the first author was involved in the analysis to confirm cultural meanings between Korean and English. Including a Korean researcher is invaluable in providing a framework for the non-Korean researchers regarding the sociocultural background which was embedded in the data. Korean transcripts were translated into English by an experienced Korean doctoral student from the linguistic department who emphasized the meaning-based translations rather than a word-for-word translation (Larkin, de Casterlé, & Schotsmans, 2007).

Results

Twenty KIW were included (Table 3). Participants' demographic characteristics are summarized in Table 4. The average age of the participants was 38.6 years (range of 35–45) with an average duration of time lived in the United States of 7.55 years (range: 1–15 years). All participants were married, had at least a bachelor's degree, most spoke Korean at home, and most reported that they had limited English proficiency. Participants' access to care and health service utilization are presented in Table 5. Five participants had no health insurance (25%) and

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Table 3. *Participants' Summary (n = 20)*

Participants	Age	Level of education	Marital status	Occupation	Years in the United States	Family size	Housing	English proficiency	Attending Korean church	Chronic conditions	Perception of health
P1	45	Master degree	Married	Housewife	5	4	Rent	Poor	Yes	No	Fair
P2	35	Bachelor degree	Married	Housewife	3	4	Rent	Some	Yes	No	Fair
P3	36	Bachelor degree	Married	Housewife	9	4	Rent	Some	Yes	No	Very good
P4	37	Bachelor degree	Married	Housewife	8	4	Rent	Some	Yes	No	Good
P5	39	Master degree	Married	Student	3	3	Rent	Good/excellent	Yes	No	Fair
P6	43	Master degree	Married	Accountant	14	3	Own	Good/excellent	No	Yes	Good
P7	35	Bachelor degree	Married	Student	5	4	Rent	Some	Yes	No	Good
P8	43	Bachelor degree	Married	Student	3	4	Rent	Some	Yes	No	Poor
P9	36	Master degree	Married	Housewife	10	5	Rent	Some	Yes	No	Good
P10	37	Bachelor degree	Married	Housewife	1	4	Rent	Some	Yes	No	Fair
P11	37	Master degree	Married	Housewife	10	4	Rent	Some	Yes	No	Good
P12	35	Bachelor degree	Married	Small business	7	3	Rent	Some	No	No	Good
P13	42	Bachelor degree	Married	Housewife	15	5	Own	Some	Yes	No	Fair
P14	42	Bachelor degree	Married	Housewife	13	4	Rent	Some	No	Yes	Fair
P15	38	Bachelor degree	Married	Housewife	10	5	Own	Some	Yes	No	Fair
P16	40	Bachelor degree	Married	Housewife	11	4	Own	Some	Yes	No	Good
P17	37	Master degree	Married	Student	10	4	Rent	Good/excellent	Yes	No	Fair
P18	39	Bachelor degree	Married	Housewife	3	4	Own	Some	Yes	No	Fair
P19	37	Bachelor degree	Married	Housewife	8	4	Rent	Some	Yes	No	Fair
P20	39	Master degree	Married	Housewife	3	3	Rent	Some	No	No	Good

Table 4. *Demographic Characteristics of the Participants (n = 20)*

Characteristics	*n* (%)	Mean (range)
Age (years)		38.6 years (35–45 years)
Marital status		
Married	20 (100%)	
Education		
Bachelor's degree	13 (65%)	
Graduate school	7 (35%)	
Employment status		
Employed	3 (15%)	
Unemployed	17 (85%)	
Time spent in the United States (years)		7.6 years (1–15 years)
Age entering the United States (years)		31.6 years (25–40 years)
Housing		
Own	5 (25%)	
Rent	15 (75%)	
English proficiency		
Good/excellent	3 (15%)	
Some	16 (80%)	
Poor	1 (5%)	
Korean language at home		
Yes	19 (95%)	
No	1 (5%)	
Attending Korean church		
Yes	16 (80%)	
No	4 (20%)	
Perception of health		
Very good/good	9 (45%)	
Fair	10 (50%)	
Poor	1 (5%)	
Chronic disease(s)		
Yes	2 (10%)	
No	18 (90%)	

three participants had Medicaid (15%). Thirteen participants had a usual source of care (65%) and nine participants had a primary doctor (45%). Thirty percent of participant reported that they have a Korean doctor (30%). Fourteen participants had experienced childbirth in the United States (70%) and had 2.9 (range 0–15) medical visits within the past 12 months. Seven participants (35%) did not make any medical visits. For preventive health services, participants reported regular physical exam (35%), regular Pap smears (50%), regular clinical breast exam (55%), and regular mammogram (15%). Through the interpretive process, three related themes and one constitutive pattern

Table 5. *Participants' Access to Care and Healthcare Utilization (n = 20)*

	n (%)	Mean (range)
Type of health insurance		
Private	12 (60%)	
Medicaid	3 (15%)	
Not insured	5 (25%)	
Access to care		
Having usual source of care	13 (65%)	
Having a primary care provider	9 (45%)	
Having an obstetrician and gynecologist	10 (50%)	
Having a Korean doctor	6 (30%)	
Having a traditional care provider	1 (5%)	
Childbirth in the United States		
Yes	14 (70%)	
No	6 (30%)	
Numbers of visits in past 12 months		2.9 times (0–15)
Never	7 (35%)	
1–2	5 (25%)	
3–5	6 (30%)	
More than 5	2 (10%)	
Type of visits in past 12 months		
Primary care provider	10 (50%)	
Emergency department	2 (10%)	
Hospitalization	3 (15%)	
Traditional care provider	1 (5%)	
Obstetrician and gynecologist	5 (25%)	
Preventive health services in past 12 months		
Regular physical exam (annual exam)	7 (35%)	
Regular Pap smear	10 (50%)	
Regular clinical breast exam	11 (55%)	
Regular mammogram	3 (15%)	

reflecting premenopausal KIW's shared experience of health seeking and healthcare utilization in the United States emerged from the interview text.

Theme 1: Experiencing Differences and Difficulties for Healthcare Access

Accessing the U.S. healthcare system is stressful leaving them feeling isolated and lost. Most participants talked about the radical differences between the United States and Korean healthcare systems, and the frustration that arose from this difference. Their common experiences with the inconvenient US healthcare system were because an appointment was needed, and there was a long waiting time, a limited selection of doctors in their insurance

network, a referral required for a specialist doctor or procedure, and a prolonged billing process. Most participants had experienced great difficulty in making a doctor's appointment by phone and in answering copious questions on paper during their first visits. Even though all participants had at least a college degree, they still experienced communication difficulties with their healthcare providers due to difficult medical terminology.

Participants often used the expression, "getting through clinic/hospital," which meant making the first visit to enter the system. They told that getting through the system was the most difficult task in utilizing the US healthcare system. Moreover, language barriers during medical visits influenced the patient–physician relationship and health outcomes, and it resulted in less interaction, ineffective patient education (nonadherence to medication regimens), less patient satisfaction, mistrust (not open to doctors), and miscommunication (failure to follow up). Most participants relied heavily on their husbands to access healthcare services by interpreting, by searching for information, and by making decisions. Their husbands were their only intimate support, but often husbands were busy at work. One woman described her distress:

> *Even just calling makes me tremble. I beg them to slow down, and before I call, I write down all the necessary sentences beforehand…I feel distressed all the time in those situations. I construct the sentence in my mind first, and then use the sentence to talk to them, anticipating their reactions, but sometimes they respond in an unexpected way. Then, oh, my Gosh! I am embarrassed (big laughter).*

Choosing to avoid the U.S. healthcare system. By experiencing repeated difficulties and frustration whenever they accessed US healthcare services, they learned that it was better not to use healthcare services unless it was an emergency. Therefore, they often delayed seeking appropriate health services by trying not to be involved in the US healthcare system. One woman said:

> *I should think one more time, whether I should go there or not...If I think about it once more, and eventually decide not to go. Money and the insurance matter, and there are irksome things on the procedure too, so I decide not to go there (sigh and bitter smile).*

Another reason they avoided using healthcare in the United States was the cost of care. Rather than buying expensive health insurance, either they paid for each visit to the healthcare facility or they utilized Korean healthcare services on their regular visits to Korea. One described "buying health insurance was like gambling" because of the uncertainty of receiving a payback in care. Without symptoms or pain, they waited until they visited Korea to receive medical treatment, especially for expensive dental treatment or diagnostic radiology services (i.e., comprehensive health screening program designed to prevent adult diseases and for early diagnosis). As one stated:

> *(With excited voice) It is cheaper to pay only when we need the healthcare service, than to pay the insurance fee monthly. The fee is too expensive. So we cancelled the insurance after I delivered my second child… Yes, almost every time we visited Korea we used health-related services there because the cost is cheaper there, even if you include the airfare. Some people visit Korea only for that purpose… It is much too expensive here in America.*

Theme 2. Maintaining Health and Well-being as Immigrants

Childbirth is over and getting older. Pregnancy and childbirth (70%) provided KIW an initial and inevitable encounter with the US healthcare system. After childbirth, half of participants rarely utilized the US healthcare services due to limited resources and perceived inconvenience, such as losing health insurance benefits (Medicaid), financial difficulty, burden of childcare, and lack of social and family support. However, as they perceived getting older at the age of 40, they started paying more attention to their aging body, felt increasing healthcare needs, and began to think about the need of preventative health services. Almost all participants believed that turning 40 meant that they were getting old. Because they were beginning to experience physical changes, such as tiredness, they started taking care of their health within the context of their situations. However, since their immigration, they seldom sought regular screening or checkups to follow their conditions in spite of family histories or personal history of chronic conditions. One woman described:

> *It has been 4 years since I gave birth to my second child. I haven't been to an ob-gyn since then. (Laughter)… I haven't gotten any other checkup, either. Right after we came to America, I didn't pay much attention to my health because I was younger then. At that time my child was also little, and there were many things about him that I had to take care of. So I didn't have regular checkups. Meanwhile, I reached my forties, and I started to be concerned. I am having changes that I haven't had before. I also had pains on my teeth… (Laughter) I have had difficulties a lot.*

These women took sole responsibility for their family and children and actually did not care for themselves. They felt they could not be sick, because there was no one to care for their children, whereas in Korea, they would have had extended family to help

and access to a different type of accessible healthcare. As one woman stated:

> *I am stressed that I might get sick. (Pause) It feels bigger than in Korea if you get sick here. For example, I have a tension that I shouldn't get sick, because I am with my child all by myself, and it makes me more worried than in Korea. I would have a person who can take care of me in Korea. (Sigh and pause) On the contrary, social support is much weaker here, which I can see true among other Korean immigrants.*

Suffering from mental health issues. Many participants expressed their struggles with mental health problems including feelings of depression, anger, and anxiety due to the stress of unstable immigration policy and lack of a social support system (formal and informal). They tolerated their symptoms without seeking professional help, such as diagnosis, treatment, or counseling services. Instead, most participants relied on personal advice from family or close friends and used self-help practices, such as religion or relaxation techniques to cope with their distress. They considered their symptoms as minor/manageable or seasonal/inconsistent; therefore, they thought professional help or treatment was unnecessary, blaming symptoms on local weather (long winter season) or life challenges, such as financial difficulty or immigration issues.

> *There have been a lot of changes. I overworked when I first came here…I came to the U.S. in middle age so I had to work hard. I should have accepted it as a long term process, but I couldn't (long pause)… I guess it was because of my psychological state. I think it was a depression (moan).*

Participants had limited personal relationships and a lack of social support because they were homebound taking care of their children, and most were unemployed. The few personal relationships that these women had were with Korean mothers in their neighborhood or Korean church. However, their relationships did not last long because of the transient nature of the immigrant family due to the husband's job or school. In addition, many participants wanted to be part of parents' meetings or volunteer opportunities at their children's school, but they often felt they were isolated from mainstream American society due to the language barrier and cultural differences. A woman told of the results of her isolation:

> *I had a mental crisis. It has been harder to live here as a foreigner than I thought… In the beginning I felt a bit of freedom, but as time passed there came tough moments. I also felt lonely because I couldn't hold meaningful relationships with people around me. I felt like I was being an invisible person, too. Nobody would have cared about me, so nothing would happen even if I disappeared. Then I had a problem with my self-esteem.*

Theme 3. Making Self-diagnosis and Relying on Self-management

Health seeking from the local Korean community. Most participants felt isolated from the mainstream of society and disadvantaged in utilizing US healthcare services due to lack of information about the system and the language barrier. Therefore, they considered it essential to seek connections with the local Korean community including Korean churches to obtain health information and to survive the process of immigration. One said, "I think networking is important if you want to live in America." Information was not shared evenly throughout the community, but the sharing of information occurred within networks of individual relationships or membership in a Korean church. Participants utilized and trusted local Korean friends and doctors in the church as a reliable way to make a medical decision. They used their social network and then verified and filtered the information using the Internet to make a self-diagnosis or to make a decision. One woman related:

> *Whenever I get sick, I get help from the people around, and if I find their advice and the information from the Internet overlap, then I believe it as the answer… I listen to what the doctors [who she personally knows] around me judge, I check myself, I ask the opinions of the moms around, and if they overlap, then I make my own diagnosis and plan. (Laughter)*

Trusting Korean medicine and traditional folk remedies. Even though many participants had access to the US healthcare system, they still trusted traditional health beliefs, practiced "Hanbang" (Korean traditional medicine based on herb and food remedies), and used Korean brand medicine to maintain their health and to manage their symptoms. Interestingly, they practiced more traditional folk remedies in the United States than when they were in Korea. Therefore, to manage their symptoms, they believed that eating specific foods was the same as taking medicine. Many said, "food as medicine," and they focused on eating a balanced and healthy diet to maintain their health. Many participants used Korean brand medicine, brought from Korea, sent by their family, or shared with their neighbors or church members (e.g., antibiotics, common cold medicines, and pain-relief patches). They thought Korean medicine was much stronger and more effective for them, because they believed their body was different from Western people. They trusted their past experiences with Korean medicine:

> *I used Korean medicine a lot when the children got sick when they were little, since there are not many types of medicine*

that we can use for little children here. People around me gave me some of what they had for my children, which they brought here from Korea. (Laughing) When my children coughed hard in winter times, American medicine didn't work, and there were not much we could try particularly. So, I gave them pear extract for coughing, and also gave them boiled water with bellflower root when they had sputum.

Constitutive Pattern: Making Choices Between Two Systems

Since their initial encounters with the US healthcare system, KIW have consistently experienced differences and difficulties between the United States and Korean healthcare systems. Despite limited resources, they maintained their health by seeking health information through local ethnic networks and the Internet and by relying on self-management based on Korean traditional medicine. Compared to when they lived in Korea, they felt the need to take care of their health actively without relying on healthcare professionals or accessing healthcare services in the United States. However, even though they resided in the United States, they still maintained access to the Korean healthcare system and utilized Korean healthcare services to satisfy their health needs. They selectively compared two healthcare systems based on the urgency of their symptoms and past experiences, made choices between two healthcare systems by calculating usefulness, cost-effectiveness, convenience, familiarity, and accessibility. One woman summarized her experience and future choices:

If it would have been urgent, I might have used the system here, if it would have been an emergency. However, I will visit Korea anyway. Otherwise, I would have taken it here. I just put my heart in that way, and am waiting… It is really uncomfortable here. It is inconvenient timewise, too…They say I should accompany a guardian. However, in Korea, you don't need to bring any guardian, if it is just a simple endoscopy. This is also the hardest thing…You can't help if you get sick. (Laughter) You have no choice but to go there (US healthcare services). I know I have to start using places because I live in America… I have to take care of myself using my own solutions, so I should try really hard, and if it does not work, only then I might go to the emergency room.

Discussion

Listening to premenopausal KIW's story about their health seeking and healthcare utilization in the United States provides a missing piece in the current literature. Exploring their lived experience through phenomenological approach helped to understand KIW's healthcare practice and healthcare utilization since their childbirth experience. KIW reported that they rarely access to the US healthcare system for themselves even though they suffered from health issues after childbirth (Seo et al., 2014). The current study started from the point after their initial encounter to the US healthcare system through their childbirth and provided a broader picture to understand premenopausal KIW's health seeking and healthcare utilization in their immigration life.

KIW's health seeking and healthcare utilization experiences are highly influenced by their expectations toward a healthcare system that provides universal access and benefits to all citizens with their own choices. Their expectations were shaped by experiences in the Korean healthcare system prior to immigration, which resulted in unsatisfactory experiences of feeling lost and isolated when they used healthcare services in the United States. The Korean healthcare system is quite different from the US healthcare system. In South Korea, the national insurance system, a single insurer, is supported by the government and it provides universal coverage for all citizens (Jeon & Kwon, 2013). Patients can freely choose any doctor or any medical institution, including hospitals, without designating a primary care physician or getting preapproval from a managed care office (Lee et al., 2010). The Korean system has no role or function for family medicine or primary care (Lee et al., 2007). Patients who want rapid, good quality care tend to see specialists; large-scale hospitals, which are privately owned, provide comprehensive 1-day checkups (head to toe) for a faster general health screening (Chun, Kim, Lee, & Lee, 2009; Oh, Jun, Zhou, & Kreps, 2014). Contrary to their expectations, exposure to unfamiliar and different health care system made them feel lost and disappointed.

Donnelly (2006) brought a new concept, called "in-between space," to explain the experience of Vietnamese–Canadian immigrant women's healthcare practice, which neither belongs to Eastern nor to Western culture. In the current study, KIW also possessed similar in-between space to seek good health and to access healthcare services in the United States. This in-between space played an important role for KIW as a safety zone in which they feel secure. However, KIW showed a slightly different pattern, in which they actively utilized Korean healthcare services for screening purposes in Korea, even though they were residing in the United States. One of the most interesting findings in this study was that the KIW's in-between space included both cultural and geographic space. Quality and availability of healthcare were key considerations in their decision to return to Korea for

medical care, in addition to economic and cultural factors (Connell, 2013; Kim, Kreps, & Shin, 2015; Oh et al., 2014). A similar pattern of healthcare utilization, medical tourism was reported in New Zealand and the United States among older Korean immigrants, where they often utilized homeland medical services to seek both effective and comfortable medical care (Oh et al., 2014; Lee et al., 2010). By contrast, British KIW had transitioned to healthy citizenship in the British healthcare system successfully though their childbirth experiences because of their continued utilization of the British healthcare services after the birth of their children (Lee, 2010). In the current study, access to both healthcare systems provided them a better opportunity for urgent healthcare services, but it also made them delay regular screening to detect preventable health issues because KIW wait for this type of screening until they visit families in Korea. Possibly, they may lose opportunity for follow-up care in case of abnormal findings (Oh et al., 2014).

KIW experienced communication difficulties with their healthcare providers while utilizing the US healthcare system due to language barrier including both lack of English proficiency and limited health literacy (Seo et al., 2014). Language barriers negatively influenced building a trusting relationship with their healthcare providers. They also experienced perceived ineffectiveness of their treatment when comparing to their past experiences in Korea. In addition, their medical visits in the United States were not consistent and they were mostly sporadic symptom-based visits. Many were not aware of the need of regular health screening because they did not have a primary doctor to comprehensively manage their overall health status and to provide health recommendation. There is a widely held misconception called "model minority," meaning that Asian Americans experience fewer physical and mental health problems due to their higher income and educational levels compared to other ethnic minorities (Chou & Feagin, 2015). However, this observation of "better health" may be due to fewer diagnoses as a result of less frequent visits to healthcare facilities. In our study, KIW commonly relied on self-management and information received from the local Korean community to maintain their health or to treat their symptoms. Self-management was based mainly on Korean traditional medicine, which included folk remedies and which was delivered by their parents or friends. Consistent with a previous study in the United Kingdom (Lee, 2010), KIW in the United States also showed pluralistic health-seeking behaviors and healthcare utilization. Interestingly, KIW in the study seldom used "Hanyak" (herbal medicine prescribed by Korean traditional providers) due to the unavailability of local Korean providers of traditional herbs. Instead, they focused more on herb or food remedies that they could easily obtain in their current environment. In addition, KIW commonly shared their medications (e.g., antibiotics) with their neighbors. Without education or guidance from healthcare providers, their self-management and self-diagnosis raised safety concerns because of the possible delay in obtaining access to appropriate healthcare.

Limitations

As with any other research methodology, interpretive phenomenology is subjected to limitations. This study only represents KIW who live in a suburban area of a mid-sized city with a small Korean community. The participants were selected purposively from members of five Korean churches and visitors at five Korean markets. All participants were married and had at least a bachelor's degree. Therefore, findings from this study cannot be generalized to all KIW in the United States, although it provides insight into the issues faced by these women.

Implications

Understanding individual healthcare utilization is complex. Moreover, in the case of a vulnerable population, such as minorities and immigrants, to understand how people make decisions about their healthcare, it is important to fully consider cross-cultural differences in beliefs and behaviors and to capture adequately the influence of psychosocial factors (e.g., social network and social interaction) associated with race/ethnicity. Therefore, understanding KIW's unique experiences related to health seeking and utilization of health services is important to guide planning, development, and delivery of culturally sensitive care for this population. Immigrants, especially KIW, have special physical, mental, and cultural health needs that arise from the influence of a stressful immigration experiences in different environments and circumstances. The current study also evoked the need to develop culturally sensitive health education regarding regular health screening to promote good health during the midlife of KIW.

A language barrier was the major obstacle for KIW when they accessed healthcare, communicated with healthcare providers, and used decision-making skills regardless of their educational level. Even though federal law (Civil Rights Act) has mandated medical translation services be provided to people with limited English proficiency, problems still remain in the current healthcare market, particularly in suburban/rural areas.

Currently, technology is leading the way to improved access to translation services. To reduce health disparity in ethnic minority in suburban/rural areas, policy needs to assure federal support to develop technology-supported translation services. In addition, Korean immigrants are one of the most disadvantaged ethnic groups in terms of health insurance coverage. The Affordable Care Act encouraged them to have mandatory health insurance; therefore, providing improved access to the US healthcare services. However, it is uncertain if the Affordable Care Act will be continued and remain effective among recent immigrants or undocumented immigrants who are not mandated to hold health insurance. Recently, postelection uncertainty and anxiety exists toward possible change on health insurance policy due to lack of information. Federal or state government agencies can utilize ethnic networks, ethnic media, or ethnic churches as an effective informational reservoir for immigrants to introduce various healthcare resources, disseminate information, or advertise policy–related changes.

Conclusions

KIW encountered differences and difficulties confronting the realities and barriers of the US healthcare system. With limited resources during this transition, they actively assessed their needs and relied on self-management, using local social networks and the Internet to maintain their health and well-being. They resided in an in-between space of two healthcare systems. They compared the two healthcare systems, selecting choices by calculating usefulness, cost-effectiveness, convenience, familiarity, and accessibility between the two systems. The current phenomenological study provides useful information for healthcare providers who want to gain insight into KIW's health needs and challenges in utilizing healthcare services in the United States. The present study also evoked the need to develop culturally sensitive health education regarding regular health screening to promote good health during the midlife of KIW.

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References

Ahmed, S., Shommu, N. S., Rumana, N., Barron, G. R., Wicklum, S., & Turin, T. C. (2016). Barriers to access of primary healthcare by immigrant populations in Canada: A literature review. *Journal of Immigrant and Minority Health, 18*(6), 1522–1540.

Augsberger, A., Yeung, A., Dougher, M., & Hahm, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC Health Services Research, 15*(1), 542.

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health, 36*, 375–392.

Seo, J. Y., Kim, W., & Dickerson, S. S. (2014). Korean immigrant women's lived experience of childbirth in the United States. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 43*(3), 305–317.

Seo, J. Y., Bae, S.-H., & Dickerson, S. S. (2016). Korean immigrant women's health care utilization in the United States: A systematic review of literature. *Asia Pacific Journal of Public Health, 28*(2), 107–133.

Chou, R. S., & Feagin, J. R. (2015). *Myth of the Model Minority: Asian Americans Facing Racism,* (2nd ed.) : New York, NY: Routledge.

Chun, C. B., Kim, S. Y., Lee, J. Y., & Lee, S. Y. (2009). Republic of Korea: Health system review. *Health Systems in Transition, 11*(7), 1–184.

Cohen, M., Kahn, D., & Steeves, R. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Thousand Oaks, CA: Sage.

Connell, J. (2013). Medical tourism in the Caribbean islands: A cure for economies in crisis? *Island Studies Journal, 8*(1), 115–130.

Connor, P. (2016) *International migration: Key findings from the U.S., Europe and the world*. Retrieved

October 13, 2017, from https://www.pewresearch.org/fact-tank/2016/12/15/international-migration-key-findings-from-the-u-s-europe-and-the-world/

Diekelmann, N., Allen, D., & Tanner, C. (1989). *The NLN criteria for appraisal of baccalaureate programs: A critical hermeneutic analysis*. New York: National League for Nursing Press.

Donnelly, T. T. (2006). Living 'In-between'—Vietnamese Canadian women's experiences: Implications for healthcare practice. *Healthcare for Women International*, *27*(8), 695–708. https://doi.org/10.1891/2156-5287.3.1.39

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). New York, NY: Harper and Row (Original work published 1927).

Jeon, B., & Kwon, S. (2013). Effect of private health insurance on health care utilization in a universal public insurance system: A case of South Korea. *Health Policy, 113*(1–2), 69–76. https://doi.org/10.1016/j.healthpol.2013.05.007

Kim, W., Kreps, G. L., & Shin, C. N. (2015). The role of social support and social networks in health information-seeking behavior among Korean Americans: A qualitative study. *International Journal for Equity in Health, 14*, 40.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing, 19*(5), 976–986. https://doi.org/10.1111/j.1365-2648.1994.tb01177.x

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing, 24*(1), 174–184. https://doi.org/10.1046/j.1365-2648.1996.17224.x

Landsbergis, P. A., Grzywacz, J. G., & LaMontagne, A. D. (2014). Work organization, job insecurity, and occupational health disparities. *American Journal of Industrial Medicine, 57*(5), 495–515. https://doi.org/10.1002/ajim.22126

Larkin, P. J., de Casterlé, B. D., & Schotsmans, P. (2007). Multilingual translation issues in qualitative research reflections on a metaphorical process. *Qualitative Health Research, 17*(4), 468–476.

Lee, E., Menon, U., Nandy, K., Szalacha, L., Kviz, F., Cho, Y., . . . Park, H. (2014). The effect of couples intervention to increase breast cancer screening among Korean Americans. *Oncology Nursing Forum, 41*, E185–E193.

Lee, J. H., Choi, Y. J., Volk, R. J., Kim, S. Y., Kim, Y. S., Park, H. K., . . . Spann, S. J. (2007). Defining the concept of primary care in South Korea using a Delphi method. *Family Medicine, 39*(6), 425–431.

Lee, J. Y. (2010). *'My body is Korean, but not my child's ...': A Foucauldian approach to Korean migrant women's health-seeking behaviours in the UK* (Unpublished doctoral dissertation). Retrieved from http://www.etheses.nottingham.ac.uk/1744/1/Lee-PhD.pdf

Lee, J. Y., Kearns, R. A., & Friesen, W. (2010). Seeking affective healthcare: Korean immigrants' use of homeland medical services. *Health & Place, 16*(1), 108–115.

Lee, K.-E. (2013). The lived childbirth experience of Korean first-time mothers in the U.S. *International Journal of Childbirth, 3*(1), 39–51. https://doi.org/10.1891/2156-5287.3.1.39

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Mirza, M., Luna, R., Mathews, B., Hasnain, R., Hebert, E., Niebauer, A., & Mishra, U. D. (2014). Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. *Journal of Immigrant and Minority Health, 16*(4), 733–742.

Office of Disease Prevention and Health Promotion. (2017) *Access to Health Services, Healthy People 2020*. Retrived from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/

Oh, K. M., Jun, J., Zhou, Q., & Kreps, G. (2014). Korean American women's perceptions about physical examinations and cancer screening services offered in Korea: The influences of medical tourism on Korean Americans. *Journal of Community Health*, *39*(2), 221–229. https://doi.org/10.1007/s10900-013-9800-z

Park, S. Y., Cho, S., Park, Y., Bernstein, K. S., & Shin, J. K. (2013). Factors associated with mental health service utilization among Korean American immigrants. *Community Mental Health Journal, 49*(6), 765–773.

Plager, K. A. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In P. Benner (ed.), *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness* (pp. 65–83). Thousand Oaks: Sage Publications Inc.

US Census Bureau. (2016). *2015 American Community Survey 1-Year Estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Vermette, D., Shetgiri, R., Al Zuheiri, H., & Flores, G. (2015). Healthcare access for Iraqi refugee children in Texas: Persistent barriers, potential solutions, and policy implications. *Journal of Immi-*

grant and Minority Health, 17(5), 1526–1536. https://doi.org/10.1007/s10903-014-0110-z

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology. *Journal of Holistic Nursing, 25*(3), 172–180. https://doi.org/10.1177/0898010106295172

Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing, 45*(5), 512–518. https://doi.org/10.1046/j.1365-2648.2003.02934.x

Zong, J., & Batalova, J. (2016). *Asian immigrants in the United States*. Migration Policy Institute. Retrieved from http://www.migrationpolicy.org/article/asian-immigrants-united-states

Zong, J., & Batalova, J. (2017). *Korean Immigrants in the United States*. Migration Policy Institute. Retrieved from http://www.migrationpolicy.org/article/korean-immigrants-united-states