

# Cross-cultural Medicine

## A Decade Later

### Ethical Dilemmas in a Cross-cultural Context A Chinese Example



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Considerable attention is now being given to ethical conflicts raised by such issues as the disclosure of diagnosis and prognosis, the role of the family in making medical decisions, and the withholding or withdrawing of treatment of terminally ill patients. Already complicated, these issues take on added complexity in contexts where medical professionals and patients have differing cultural beliefs and practices. Ethical dilemmas that develop in multicultural settings have been largely unaddressed. Through the analysis of a case involving the hospital admission and death of a Chinese woman with metastatic lung cancer, we examine some of these dilemmas and their effect on the patient, family, and physicians. Many issues were raised by this case regarding the relationships among ethnic background, bioethics, and medical care.

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Unprecedented advances in medical technology and changes in the social and economic climates of medical practice over the past 20 years have produced challenging ethical and legal questions. Such issues as the disclosure of medical information to patients, the role of surrogates in medical decision making for incompetent patients, and the withdrawal or withholding of life-sustaining treatment of terminally ill patients have attracted the attention of physicians, medical ethicists, attorneys, and policymakers alike.<sup>1</sup>

Despite growing interest in these subjects, comparatively little attention has been paid to ethical dilemmas that emerge in culturally diverse contexts, where conflicts among ethical principles are rendered even more complex by ethnic and language differences.<sup>2-8\*</sup> In this article we discuss the ways in which differing cultural values, expectations, and practices shaped the interactions between a team of American physicians and a terminally ill Chinese woman and her family. Focusing on three areas—the telling of “bad news,” the withholding of treatment, and the role of the family—we examine several issues: the culture-bound perceptions of both the physicians and the patient and her family, the conflicts that emerged, the attempts made to resolve these conflicts, and the effects on the interactions.

We have not selected this case for analysis because we assume it is representative of all interactions between Chinese families and American physicians. Such a claim would be foolhardy to make in light of the substantial cultural and individual differences that exist among the Chinese who have immigrated to the United States, depending on place of origin, religious and social class affiliation, degree of accultura-

tion, and personal motivations. Rather, we discuss this case because it raises some of the important ethical issues that can emerge during cross-cultural medical encounters.

#### Case Presentation

Mrs Lee,\* a 49-year-old Cantonese-speaking woman, had come from the People's Republic of China to the United States eight years earlier. She lived with her husband and her youngest son, Arnold, age 22; her other children lived nearby. In January 1990 she was seen at an outpatient clinic because of fever, cough, and right-sided chest pain. A presumptive diagnosis of right-sided pneumonia was made, and she was admitted to the family practice inpatient service of a university hospital. Diagnostic studies (Table 1) revealed that her lung infection was due to an obstructing bronchial squamous cell carcinoma. A metastatic workup also revealed lymph node and adrenal gland metastases. She was treated with intravenous antibiotics and palliative radiation therapy.

During her two-week hospital stay, Mrs Lee's children and husband were with her constantly. Neither Mrs Lee nor her husband could speak English. Arnold Lee, perhaps because he spoke English better than his siblings, became the spokesperson for the family and assumed primary responsibility for decisions. He made it clear that he did not wish to discuss his mother's diagnosis with her and that he did not want the physicians to speak to his mother through interpreters. The house staff taking care of Mrs Lee was concerned that because of the family's protectiveness, the patient did not know her diagnosis and was unable to make her own decisions about the type and extent of treatment to receive.

On completing the course of antibiotics, Mrs Lee was

\*See also J. Klessig, “The Effect of Values and Cultures on Life-Support Decisions,” on pages 316-322 of this issue.

\*All of the names in this article are pseudonyms.

TABLE 1.—*The Course of the Patient's Illness*

Date	Event	Diagnostic Study	Results	Action
1/31/90	Patient admitted with presumptive pneumonia	Chest radiograph	Right middle lobe and right lower lobe collapse	IV antibiotic therapy
2/02/90	--	Bronchoscopy	Lesion obstructing right main-stem bronchus; tissue diagnosis of squamous cell carcinoma	Palliative radiation therapy for lung tumor
2/09/90	--	CT scans of chest and abdomen	Large bronchial tumor; peritracheal adenopathy; large adrenal mass	--
2/09/90	Son assumes decision-making responsibility	--	--	--
2/17/90	Patient discharged	--	--	Outpatient clinic follow-up
5/14/90	Increasing back pain	Magnetic resonance imaging	Spinal cord compression; diffuse spinal metastases	Radiation therapy to back
6/--/90	Patient and family continually refuse to discuss DNR order	--	--	--
6/27/90	Patient admitted with altered mental status	CT scan of the head	Multiple brain metastases	Radiation therapy to the head; dexamethasone therapy
6/29/90	Patient discharged	--	--	Acetaminophen with codeine for pain; home oxygen therapy
8/08/90	Family declines hospice care	--	--	--
8/12/90	Patient admitted with SOB, fever, and cough with blood-tinged sputum	Chest radiograph	Diffuse bilateral infiltrates	IV antibiotics, oxygen, diuretics
8/12/90	Physicians decide medical ICU admission not advised	--	--	--
8/13/90	Patient's condition worsens; family reluctantly agrees to DNR order	--	--	--
8/13/90	Son demands intubation	--	--	Request denied
8/14/90	Patient dies	--	--	--

CT = computed tomography, DNR = do not resuscitate, ICU = intensive care unit, IV = intravenous, SOB = shortness of breath

discharged and observed as an outpatient by her primary physician. Knowing her poor prognosis, her physician tried numerous times to discuss a "do-not-resuscitate" (DNR) order and the possibility of foregoing cardiopulmonary resuscitation or other treatment in the event of a cardiac or respiratory arrest. Arnold Lee, who always accompanied his mother to clinic visits and spoke for her, would not allow such a discussion and became agitated whenever the subject was raised. Unclear about what the patient herself wanted, the primary physician became increasingly frustrated at not being able to communicate directly with Mrs Lee and at the family's apparent denial of the implications of the diagnosis.

Over the next four months, Mrs Lee had increasing back pain and decreased strength in her legs. After a magnetic resonance image revealed evidence of diffuse spinal metastases and spinal cord compression, radiation therapy was started to Mrs Lee's back. Toward the end of June she was briefly admitted to the hospital because of altered mental status and weakness. Diagnostic studies revealed multiple brain metastases, requiring further palliative radiation therapy. After discharge Mrs Lee went home, where she used oxygen intermittently and was kept free of pain with acetaminophen with codeine. The primary physician suggested hospice care, which the family declined.

On August 12, 1990, Mrs Lee came to the emergency department with progressive shortness of breath, fever, and cough productive of blood-tinged sputum. On physical examination she appeared ill, had cushingoid habitus, and was in moderate respiratory distress. She was admitted and treated with a regimen of intravenous antibiotics, oxygen therapy, and diuretics. Over the next 48 hours, the patient's condition deteriorated until she became nonresponsive with labored

breathing. House staff repeatedly brought up with the family the question of her code status. The family adamantly refused to consider a DNR order and insisted that she receive all possible care. Convinced that the family had unrealistic expectations about the patient's prognosis, the resident and intern became increasingly upset and anxious. They were worried that the invasive interventions required if the patient had to be resuscitated not only would be medically futile but would cause the patient great suffering and indignity. The attending physician concurred with their assessment, wrote a DNR order in the patient's medical record, and informed the patient's husband of this decision. The family reluctantly agreed to the order.

As Mrs Lee's condition worsened, her family became more visibly upset and more vocal in their insistence on extensive and aggressive therapy. When Arnold Lee discovered that ventilator support was a medical intervention that prolonged life, he demanded that his mother be intubated. The resident refused, at which point Arnold insisted on seeing the attending physician. As the attending physician entered the room, Arnold sank to his knees, pleading for him to intubate Mrs Lee. When the physician denied his request, Arnold became even more distraught, accusing the team of physicians of deliberately taking inadequate care of his mother because she was Chinese. Arnold's accusations of racial bias quickly escalated to threats of litigation.

The family's anger, suspicion, and mistrust made the house staff and attending physician question their decisions. Even though they were sure that further treatment of Mrs Lee would be useless, they discussed among themselves the difficulty of determining medical futility and re-examined the diagnostic studies to convince themselves they had reached

the right diagnosis and treatment plan. The attending physician also consulted with the senior resident covering the medical intensive care unit to verify that an admission to that unit was not warranted. In addition, they openly explored the possibility of racial and cultural bias among themselves.

The family remained upset and angry. Arnold Lee called a meeting with the team of physicians during which he continued to insist on heroic measures to prolong his mother's life. After about four hours of discussion, they were interrupted by the patient's daughter, who ran in screaming that her mother in the room next door had stopped breathing. Even though Mrs Lee was dead, the intern asked if she could administer a shot of epinephrine in response to the family's pleas to do something. Attempting to meet some of the wishes of the family, the attending physician, knowing well that it was a futile gesture, agreed. Once it was certain that his mother was dead, Arnold Lee turned to the attending physician and screamed, "Are you happy? You got what you wanted. You murderer!"

### Discussion

This case illustrates three areas in which differing cultural beliefs and practices emerged: the telling of bad news, the limiting of treatment, and the role of the family in medical encounters.

#### *The Telling of Bad News*

*The physicians.* Since the time of Hippocrates, physicians have been taught to conceal bad news from patients out of fear that disclosing information of a grave diagnosis would increase anxiety or depression or cause patients to lose hope.<sup>9</sup> Until recently American physicians rarely explicitly discussed "gloomy prognostications" with their patients.<sup>10,11</sup> Increasingly over the past two decades, however, such protectiveness has been viewed as unnecessary. Attitudes about what constitutes benefit and harm have shifted as clinicians came to realize that there was little evidence supporting the view that disclosure harms patients and considerable evidence indicating that patients often benefit from knowing their diagnosis or prognosis.<sup>11</sup>

As principles of contemporary medical ethics have been introduced into medical education and practice, American medicine has come to embrace other moral norms. Medical ethics is a discipline whose origins lie in the branches of Western philosophy and law that give primacy to the individual and to rights of self-determination and privacy. As a consequence, autonomy has become the centerpiece of contemporary theories about how patients and physicians should relate to one another. This principle holds that people have the right to determine their own course of action, even if this means refusing medical treatment.<sup>1,12</sup>

In practice, the disclosure of a life-threatening diagnosis and the ensuing discussions about medical treatment can be difficult.<sup>13</sup> Nevertheless, many physicians now believe that an important part of their role is discussing the "truth" with their patients so the patients can make autonomous, informed decisions about their health care and prepare for their deaths. Direct and honest communication of the facts is considered not only good clinical practice but a "right" to which each patient is entitled. Young physicians are now taught that under most circumstances it would be unethical *not* to talk honestly with their patients about their diagnosis and the realistic consequences of their disease.<sup>14</sup>

In the case presented here, the physicians tried to act in accord with these professional values but perceived their efforts to be largely unsuccessful. Not only did family members not allow house staff to talk directly with Mrs Lee but they appeared to keep information from her and they did not seem to appreciate the gravity of the situation. Baffled and frustrated, the physicians thought that the family was denying the reality of the disease process and its ultimate outcome.

*The family.* The Lee family appeared to have a set of cultural expectations about the treatment of dying people and the role of "truth telling" in doctor-patient-family communication that differed substantially from those of the physicians. A belief held by many Chinese is that a person is entitled to be treated as a child when ill.<sup>15</sup> Sick adults, like children, deserve "protection." Because a patient is suffering already from the illness, it is unnecessary to make them suffer even more by discussing the reality of the disease. If the patient is gravely ill, the need for protection is perceived as even greater. Among many Asian groups, including the Chinese, to tell someone he or she is dying is not only rude but dangerous.<sup>2,16-19</sup> People fear that openly acknowledging an impending death is like casting a death curse upon the person; it will make the person despair and die even sooner. Thus, to engage in discussions of code status or the possibility of hospice care, interventions that can be seen as explicit preparation for death, is courting bad luck.

"Truth telling" also signifies the withdrawing of hope; it tells patients that their physicians have given up on them and they might as well give up, too. Therefore, it would only be an unthinking, callous practitioner who would even consider engaging in an activity with such dire consequences. This does not mean that the family and patient necessarily remain unaware of the implications of a grave diagnosis. They may well know and accept the reality of the situation but, at the same time, have a tacit understanding born of cultural expectations about how to behave appropriately in such circumstances—that is, not to acknowledge or discuss it openly (B. Koenig, PhD, C. Orona, PhD, A. Davis, PhD, "Cultural Pluralism and Ethical Decision-Making: A Descriptive Study of Patients Facing Life-Threatening Cancer," Division of Medical Anthropology, University of California, San Francisco, unpublished data, 1990).

In an effort to protect Mrs Lee from unnecessary suffering, the Lee family wanted little or no information transmitted to her. The physicians, following their professional imperative of autonomous informed decision making, wanted open and direct discussion. These differing values resulted in a breakdown in communication between the house staff and family and a growing sense of mutual distrust and frustration. When the subject of withholding medical treatment was introduced, the distrust and frustration only increased.

#### *Withholding Treatment*

*The physicians.* Although a wide array of equipment and procedures is now available to prolong the lives of critically ill patients, the use of such interventions is not always indicated. There is widespread agreement among physicians that the possibility of benefits offered by a medical intervention must outweigh its burdens for it to be justified.<sup>20-24</sup> Physicians are not legally or morally obligated to provide therapy that offers no hope of medical benefit and, in the best estimation of the health care professionals, is futile.

In situations where a patient's death is imminent or further treatment is considered futile, it is now common practice to forego life-sustaining treatment. One mechanism for this is the DNR order that, when written in the patient's medical record by the attending physician, bypasses the mandatory use of life-sustaining equipment.<sup>12,25-28</sup> Guidelines for DNR orders stipulate that physicians discuss them with mentally competent patients. With incompetent patients, physicians typically either consult with or obtain permission from the family or guardian. Even when hospitals do not require family consent, physicians are generally expected to make vigorous efforts to achieve consensus. This is especially so in cases where there are conflicting notions of appropriate care or where they feel a DNR order is appropriate for a patient whose family has requested that "everything be done."<sup>29,30</sup>

In keeping with current views, Mrs Lee's physicians made two decisions that would limit the type and extent of treatment they would offer. First, they determined that resuscitation was not appropriate because the chances of her surviving a cardiopulmonary arrest were minimal. On the basis of this assessment, they made repeated and unsuccessful attempts to get agreement from the family about a DNR order. The attending physician, convinced of the futility of possible resuscitation, then wrote a DNR order without the family's agreement. Second, the physicians decided that there was no demonstrable medical benefit to admitting Mrs Lee to the medical intensive care unit and providing ventilator support. They concluded that the burden in pain and suffering far outweighed any benefit a few more hours or days of life might bring.

*The family.* In contrast to the physicians, the Lee family defined burdens and benefits in terms of the burden of disclosure and the benefit of continued treatment. Throughout the course of the patient's illness, her family was adamantly opposed to any attempt to limit or withhold treatment. When the physicians finally concluded there was nothing more they could do, Arnold Lee asked around to find out which medical interventions could prolong life and demanded that these interventions be used.

The intensity of this response was unusual for Chinese families. Heroic interventions aimed at extending the life of a substantially compromised patient are typically regarded with ambivalence and, especially if the patient is old, are often not appreciated or requested.<sup>16</sup> To understand the reaction of the Lee family, it is important to look at the patient's age and at the role Arnold Lee assumed in the family. A "good death" in Chinese society takes place when a person dies peacefully in old age.<sup>18</sup> Mrs Lee, however, was only 49. Hers was an untimely, "bad" death, making it much harder for her family to accept it. Therefore, when certain interventions that theoretically could sustain life were deliberately withheld, it appeared to Arnold Lee as "murder." As will be described, it then became his duty as family member and son to protect his mother.

#### *The Role of the Family*

*The physicians.* Among Western-trained physicians, family involvement in the health care of a patient is often perceived as directly related to the decision-making capacity of the patient. When patients are unable to make decisions for themselves, physicians turn to relatives, with the assumption that family members will make decisions according to what the patient would have wished or that they will seek to protect

the patient's "best interests."<sup>12,30,31</sup> If patients are mentally competent, physicians expect to communicate directly with them. Family members are viewed as intermediaries whose primary role is more to encourage "open" family discussion than to make decisions for patients who are capable of making their own decisions. When families take over the decision-making process, it is considered an infringement of individual rights.<sup>32</sup>

*The family.* The role of the family in health care is perceived differently in Chinese culture, where primary importance is placed on familial relationships.<sup>19,33</sup> The family is considered an entity that existed before one was born and will exist after one is dead. The accomplishments of individuals are not theirs alone but belong to the family; similarly, shame and misfortune fall on individual members and on their families together. Membership in a family also places on persons certain privileges and obligations. For example, as parents age they expect to receive care from their children. Traditionally, male children learn early, through ideology and strong sanctions, the cultural norm that parents expect to have a son who will be obedient, respectful, and capable of supporting them in their old age.<sup>34</sup>

Within this strong family-centered system, health care decisions are family decisions. In Taiwan and parts of mainland China, for example, decisions about which practitioner to see, when to go, and whether to comply or to change practitioners are typically made within the context of the family or social network.<sup>19</sup> When a person's illness is life-threatening, it is assumed that the practitioner will talk to family members rather than the patient. The family, not the practitioner or the patient, is seen as most responsible for the sick person and decisions about treatment.

Arnold Lee's behavior reflected these traditional familial obligations even though he was acculturated in his language and his knowledge about Western medical interventions. He appeared to see it as his filial duty to do everything possible to protect his mother. By excluding her from discussions with the physicians, he attempted to protect her from emotional stress or loss of hope. By insisting that she receive heroic interventions to prolong her life, he attempted to protect her not only from death but also from a health care system he feared was giving her inadequate care because she was Chinese. Although the motivations for his behavior were unknown, it is possible that to shirk these responsibilities represented "loss of face" for him, a public acknowledgement that he was an inadequate son.

The disparate expectations of the Lee family and the physicians about the nature of obligations assumed by family members led to several ethical dilemmas. For the physicians, it was immoral not to deal directly with the patient when she was still able to make decisions for herself. For the Lees, it was immoral not to deal with the family. Later, when Mrs Lee became incapacitated, the physicians found themselves caught between the wishes of the family that "everything be done" and their own judgment about what would be best for the patient. After painfully reassessing the treatment decisions they had made, they concluded that the interests of the family conflicted with the best interests of the patient. The consequence of these diametrically opposed views was that even after Mrs Lee died, the feelings of hostility and suspicion did not dissipate, leaving family and physicians alike frustrated, confused, and upset.

## Conclusions

It is difficult to generalize about cultural representativeness from one Chinese family. In many ways—the family's demand for heroic interventions, the excessive protectiveness of the son, the furious family response—this case is unusual. Nevertheless, it dramatically illustrates some of the issues physicians face in working with Chinese patients and families, such as the extensive family involvement in health care decisions and the importance placed on the nondisclosure of a terminal diagnosis.

The case also raises a few general points about bioethics, ethnicity, and medical care. Current literature on medical ethics focuses on Western biomedicine. It has been dominated by a concern for the ethical implications of developments in medical technology and ethical issues involving physicians and other biomedical professionals. This focus has not been accompanied by a concomitant interest in the ethical implications of cultural pluralism and cultural contact.<sup>6</sup> It is erroneous to assume that the precepts of Western bioethics, such as autonomy, are universally accepted. Serious ethical issues can arise from fundamental contradictions between biomedical perspectives and the norms and values of other cultural groups.

This discussion points to several ways in which physicians working in multicultural communities can attempt to bridge cultural gaps. An important first step is to be sensitive to patients' cultural beliefs and practices. This may require calling for help in interpreting behavior, either from a provider who is from the same ethnic group as the patient or from an expert familiar with the group's language, life-style, and value preferences.<sup>8</sup> Alternatively, co-management with a colleague of the same ethnic group as the patient may reduce cultural misunderstandings. Beyond that, not to fall prey to cultural stereotyping, it is critical that physicians recognize individual differences. Because persons of the same ethnicity can have very different beliefs and practices, it is important to understand the particular circumstances of the patient or family by obtaining information on place of origin, social and economic background, degree of acculturation, and personal expectations concerning health and medical care. Finally, a reflective approach is useful. Physicians should examine their own biases and expectations to understand how these influence their interactions and decision making.

Situations such as the one described are inevitably difficult to handle. When there are strong but different moral imperatives operating, decisions have to be made by balancing often competing values. In this case, increased sensitivity and understanding might not have alleviated the frustration of the health care professionals, but it might have made things more understandable to them and defused the emotional intensity of the situation. For physicians who are struggling with the intricacies of bioethical dilemmas, being sensitive to the cultural beliefs and practices of their patients and yet maintaining their own moral integrity ultimately require a juggling act that is difficult for even the most thoughtful and compassionate professionals to manage.

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