Ethnic Elders and American Health Care—A Physician's Perspective

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The aging process is a fugue composed of innumerable themes; the theme of "ethnicity" is by far one of its more dominant. Due to the increasing incidence of chronic, progressive infirmity and acute, catastrophic illness, the elderly are thrust into direct contact with the health care systems of their society. The experiences of ethnic elders in American health care situations are fraught with conflict and mutual dissatisfaction with the physician-patient relationship. Both providers and consumers of health care services harbor differing culture-bound perceptions of health, illness and the healing process; these cultural beliefs define personal and professional needs and expectations and notions of how those needs are to be met by others. Both physicians and patients can enhance their communication and their compassion for one another by acknowledgment of cultural differences and by increased willingness to interpret motives and behavior within native context.

It behooves us in medicine to examine the cultural traditions underlying our own attitudes, beliefs and values about the aged in a universal sense, as well as in a culturally specific sense, that we may gain insight that will be helpful in serving elderly persons more effectively, and in solving some of the problems inherent in the aging process.

Most physicians will remember with great emotion, as I do, the day of graduation from medical training; amidst the hooding, handshaking and celebration, a solemn oath was taken,

> [to] maintain by all the means in my power, the [integrity] and the [worthy] traditions of the medical profession . . .
>
> not [to] permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient . . .
>
> [to] maintain the utmost respect for human life . . . even under threat, I will not use medical knowledge contrary to the laws of humanity . . .[1(p373)]

My graduation was a time of believing that modern medicine as taught and practiced in Western civilization transcended all other forms of healing in technical skills and scientific understanding; that physicians as guardians of this realm would bestow health upon the masses in such a way that any rejection of care by a patient could only be interpreted as ignorant or ungrateful.

A disturbing revelation occurs to neophytes soon after being on the frontlines of medical practice: considerations of religion, nationality, race, party politics, social standing, gender and age—not only of one's own but also that of patients—primarily affect the physician-patient relationship within which the processes of therapy intending to restore health may take place. At best, there is a coming to grips with the fact that both provider and consumer of health care services harbor differing culture-bound perceptions of health and illness, and of how respective needs and expectations are to be met.

Professions within a society contain not only a set of techniques for doing useful work (skills), but also a set of beliefs, values and traditions (knowledge), and so may function as cultures in their own right. Medicine is undisputably a prototype of the professions in this regard, one that is also able to perpetuate itself via an educational system designed to ensure the enculturation of successive generations. This concept has

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ABBREVIATIONS USED IN TEXT

CCU = coronary care unit
CT = computed tomography

been discussed thoroughly elsewhere and will not be pursued here, other than to lay the premise.[2-4]

The focus of this article is the experiences of ethnic elders in American health care settings, with my purpose being to examine the differing culture-bound perceptions of both providers and patients in operation; to witness the manner in which beliefs and traditions in conflict are resolved, and to infer significant impact on the quality of the therapeutic encounter.

Reports of the medical cases of four older persons from major US ethnic backgrounds will be given, each case chosen for its rich illustration of the respective cultural values in conflict with the values of modern medical culture. Name initials of these patients have been used to preserve anonymity. My perceptions derive from these relationships and many others during my medical training as an internist and as a geriatrician and from exposure to the clinical and theoretical work of gerontologic researchers. I must state from the outset my awareness of the prevailing sensitive viewpoint in the gerontologic literature that it is difficult to assess the singular force of cultural factors within the process of aging.[5-11] I concur that the factors of "ethnicity," "minority status," "gender roles" and "socioeconomic class" are separate but additive dimensions of the aging process. To the extent that it is possible to identify cultural factors per se, I have approached each case presentation with the hindsight of a quarterback determined to learn new strategies.

Reports of Cases

CASE 1. FC, a 70-year-old Mexican-American, Spanish-speaking woman, was admitted to an acute care hospital due to coma of unknown cause. She had been found unresponsive in the vineyards, in 40°C (104°F) midday heat, where she had been picking grapes alongside family members earlier that day. The patient was reportedly in good health before this event, though there had been complaints of dizziness and "passing out" during the previous week, unwitnessed by the family. It was thought that she might have had diagnoses of "high blood pressure"' and "diabetes" in the past; however, the patient was not known to be under the care of a regular physician, and it was certain that no medications had been taken for at least a year before admission. There was no history of cardiac, pulmonary, thyroid or renal disease. FC was a nonsmoker and drank nonalcoholic beverages only. She had immigrated to the United States from Mexico as a farm laborer some 30 years earlier, and had recently come to live with her eldest daughter in a rural farming community in California. The family requested that everything possible be done to restore her health.

On admission physical examination she was deeply comatose but breathing spontaneously at a rate of 28 per minute. Blood pressure was 190/100 mm of mercury, pulse 120, rectal temperature 38.3°C (100.9°F). Pertinent findings included the following: pupils were pinpoint, unreactive to light and tonically deviating to the left on cold calorics. The neck was rigid. Cardiac rhythm was regular with a systolic murmur grade 2/6, loudest along the aortic axis, radiating to the base of her neck; carotid upstrokes were full, with normal contour. Bilateral carotid bruits were present. Neurologically, she presented with a Glascow coma score of 7—unresponsive to deep pain, with absent reflexes. A left-sided Babinski's reflex was present. Laboratory studies showed an elevated leukocyte count with left shift and an elevated glucose level without ketosis. A computed tomographic (CT) scan of the head showed mild frontal atrophy; there was no space-occupying lesion. Chest x-ray film showed a prominent left lower lobe infiltrate. Other conditions ruled out were acute myocardial infarction, myxedema coma, nonketotic hyperosmolar coma, meningitis, adrenal crisis and status epilepticus. The initial working diagnoses on admission were massive left hemispheric stroke and aspiration pneumonitis.

On the second day after admission, an endotracheal tube was inserted and the patient was placed on mechanical ventilation after sudden respiratory arrest. Because blood pressure was not adequate, central lines (venous and arterial) were placed and a dopamine hydrochloride drip was begun. Full supportive measures were given, including fluid and electrolyte replacement, antibiotics and insulin. On physical examination on day 6 she had fixed, midpositioned pupils, absent doll's eyes, complete areflexia and no spontaneous respiratory effort for 120 seconds supported by mechanical ventilation. Two electroencephalograms taken on consecutive days recorded the absence of brain wave function.

The criteria for brain death established by Harvard, the University of Minnesota and the National Institute of Neurological and Communicative Disorders and Stroke Collaborative Study were satisfied no later than day 8.[12-14] According to the California Brain Death Statute, "the patient shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function."[15] The medical team therefore announced to the family that the patient was to be pronounced dead and that all supportive measures were to be stopped.

The family, weary from an eight-day vigil at the hospital, was unprepared to receive this declaration. Chaos ensued—20 men, women and children, weeping and shouting angrily in Spanish and nonfluent English, but their message was unequivocally "Do not stop resuscitative measures." Initially, the medical house-staff team interpreted this response as "appropriate hysteria, expressing grief and denial of death." Several hours later, the family's disbelief was voiced more clearly at the bedside: "What is the meaning of 'brain death'?"

To them, the patient appeared to be asleep, her body still warm, heart still beating, lungs still breathing and a leg or arm twitching every so often; how could she possibly be dead?

The medical house staff was annoyed by the delay caused by these simplistic questions, especially because full explanations had repeatedly been given to them: (1) the patient was still warm because the blood pressure was being maintained pharmacologically with pressor agents so that perfusion of her tissues was adequate; (2) spontaneous cessation of heartbeat within a few hours or days usually occurs in patients with brain death who are receiving respiratory ventilation and supportive care of vital functions[16,17]; (3) the machine was forcibly exchanging air in the patient's lungs and was "breathing for her," and (4) her limbs still moved due to random "peripheral reflex spinal arcs" severed from upper motor neurons. So why could not these people understand that "she will never wake up"? The house staff was further outraged that here was a patient certainly not benefiting from continued care, yet allowed to divert precious medical resources by the "selfishness" and "ignorance" of the family members. Eventually, the medical house staff could not justify to the Hospital Review Committee the prolonged occupation of a bed by a dead patient. Thus on day 10, the patient was pronounced dead and the equipment was removed. The only further discourse between house staff and family was the information that the body had been transferred to the morgue where they would later be able to claim it.

Discussion. This woeful breakdown in communication might possibly have been averted had someone perceived the dynamics of several major cultural issues in this situation. The Mexican-American culture has different expectations of the therapeutic relationship, based on the *curandero* model. These folk curers are expected to be warm, friendly and interested in all aspects of a patient's life. Western medical practitioners have been taught that impersonal objectivity is a vital part of a physician's role as an applied scientist. In addition, physicians tend to value efficiency of time and of energy, a survival trait reinforced by years of heavy clinical duty in postgraduate medical training programs. Thus, dispensing with social congenialities and "getting down to business" may be examples of emotional economy and time efficiency, whereas in the Mexican-American culture, efficiency of any kind is not a particularly admirable trait.[18] Rather, the impersonal objectivity and efficiency that typify the clinical manner of a Western physician can seem imperious and even rude to people who are familiar with different norms of behavior for their therapists.

Mexican-American families take a much more active role in the medical care of family members. Patients usually do not make their own medical choices without their relatives assisting in the decision-making process, whereas physicians assume that the special training they have received qualifies them to take authority and to render decisions alone; they do not expect to be challenged by patients or other health care professionals.[19]

The language barrier was definitely a factor contributing to poor communication, as was the use of technical terminology laden with medical jargon.[20] Pride and shyness may prevent Spanish-speaking patients from reiterating pertinent questions until meaningful answers are obtained.

Beyond these discussed cultural barriers to effective relating, this case highlights yet a more subtle issue of cultural content, that of defining "the seat of self." Modern medical professionals believe that the brain contains the essence of who we are—our personality, drives and consciousness itself. The brain innervates and ultimately controls all thoughts, muscles and organ function. Loss of brain function is equated with loss of purposeful life. Contrarily, the Mexican-American culture holds to a more holistic view of being and personhood in its belief that mind and body are inseparable.[21] The soul of a person dwells nevertheless in one who sleeps, or appears to be asleep.

Looking again at this case, one can see that this family carried an enormous burden to act on behalf of their elder in her comatose state. Had the family been approached by a more courteous, empathic medical team, seeking the family's counsel and cooperation during the ten-day hospital course and using bilingual interpreters to insure optimal communication, a relationship of mutual trust and goodwill might very well have been established. In the safety and strength of such a bond having been developed between care providers and family participants, the sensitive exploration of the idea that the patient would never regain former health and consciousness might have resulted in a joint decision to terminate supportive care.

CASE 2. JR, a 75-year-old Mexican-American, Spanish-speaking woman, was admitted to a coronary care unit (CCU) to rule out an acute myocardial infarction. She had had symptoms of muscle aching of the entire body, especially the chest, head, neck, back and right knee, persistent for the past three days. She noted the onset of increasing exertional dyspnea and fatigue about a year before. She specified that she had not had antecedent hemoptysis, sore throat or skin infection. Coronary risk factors included hypertension "for many years," though she had not seen a physician in the past ten years and was currently taking no medicine. She had no medical history of diabetes mellitus, cigarette smoking, family history of early cardiac events or lipidemia. In the past she had had similar bouts of total body aching, chest tightness and fever, beginning in her childhood in Mexico, at which time she had been told by the village *curandero* that she had been "bewitched."

At the time of admission, the elderly patient was obese and appeared anxious. Blood pressure was 180/90 mm of mercury, her pulse was 92 beats per minute, respirations 22 and she was afebrile. Abnormal findings were mild congestive heart failure with scant bibasilar lung rales. Cardiac rhythm and rate were regu-

lar with a prominent diastolic murmur, the typical rumbling and opening snap of mitral stenosis. Serial electrocardiograms showed nonprogressive anterior ST elevation and T-wave inversion, and serum creatine phosphokinase isoenzyme studies were negative, ruling out an acute myocardial infarction. Antistreptolysin-O titer was pending. As the patient improved clinically with diuresis, pulmonary arteriogram or lung scan to rule out acute pulmonary embolism was not done.

JR had recently moved to California from Texas to live with a daughter and her family. The present family situation was described as "stressful" and the patient's illness was causing more disruption. She interpreted her own symptoms to mean that she was "being warned" that she was in danger while living with her daughter. While the patient was in the CCU, the family visited daily; however, they were not allowed to stay at the bedside for more than five minutes per person, once in the afternoon and once in the evening. The family brought field flowers to place on her bedstand, and these were immediately removed by the nursing staff after their departure, as flowers carrying insects and dander were not permitted. The family brought home-cooked food for her, but the medical staff would literally take it out of her mouth, as she was on a strict CCU protocol that did not allow eating in the first few days of an acute coronary event. No singing or praying aloud was permitted in this unit. Physical contact with the patient was nearly impossible as she was entangled in electrocardiographic leads, oxygen cannulas and intravenous tubing, disruption of which triggered the ascent of alarmed nurses to the bedside, blaming the bystanders for disturbing the patient's healing process. By the end of the hospital stay, JR was convinced that her family did not care about her welfare or her recovery. There also was an element of magical ideation in her perceptions that the flowers and foods had "vanished" from the bedside; though the family had made attempts to support her, their efforts were thwarted by "evil" spirits.

The house staff approached the patient with a full explanation of her probable history of rheumatic fever and the sequela of valvular heart disease—mitral stenosis—and offered her the option of mitral valve replacement. She sharply dismissed them, saying that she was returning to Texas, which would put an end to her symptoms. The medical house staff was on the verge of calling for psychiatric consultation for this elderly woman who appeared to be expressing bizarre thoughts and refusing irrationally a lifesaving procedure—to evaluate whether she was displaying a variant of "intensive care unit psychosis" and stimuli deprivation.

Discussion. In discussing the cultural issues inherent in this situation, I will describe further the folk beliefs of the Mexican-American culture mentioned in the previous case. A patient is seen as the passive recipient of disease; patients themselves are blameless, as disharmony is the work of witches or evil spirits. The power wielded by *curanderos* is not so much that of cursing or appeasing these spirits, as it is that of emphasizing the *curanderos'* connections with the sacred and using skills to interpret the significance of the imbalance between a patient and these external forces. Perhaps JR had earlier in her youth received from a *curandero* a similar interpretation of the periodic relapses of her illness: sickness was a warning of immediate danger in her environment.

Our medical culture values sterility, meticulous order and quiet in the healing environment, and intensive care units are notorious for their enforcement of regulations to insure sterility, order and quiet—in some cases, much to the detriment of patients who believe the healing process to be a time of increased family attention, rather than abnegation. Had the house staff recognized the disparity between the outer appearance of this elderly woman, whose body submitted to "protocol" without complaint, and the inner reality of cultural beliefs processing the events of the natural and supernatural world, some effort would have been made to reconcile the family and their elder parent, and to facilitate what may have been primarily an adjustment reaction to residential relocation and reintegration into the family structure.

CASE 3. HL, a 66-year-old Chinese-American man, was admitted to hospital with symptomatic hypocalcemia of undetermined cause. He had been in his usual state of good health until about 12 months before admission, when fatigue, abdominal cramps and muscle aching began. The patient treated these symptoms with acupuncture and a variety of Chinese herbal medications, and believed these to be efficacious. Two weeks before, he had a viral syndrome with loose, nonbloody stools, resolving after one week. On the morning of admission, HL awoke with frank carpopedal spasms, unrelieved by acupuncture or herbal teas. His admission serum calcium level was 6.4 mg per dl (normal, 8.5 to 10.5), with normal serum phosphorus, magnesium and albumin levels.

He had not had a neck operation, renal disease, alcohol abuse, chronic diarrhea or pancreatitis, nor had he ever taken medications associated with hypocalcemia, such as anticonvulsants. There was no family history of parathyroid, adrenal, thyroid or ovarian disease, or pernicious anemia. His diet contained a meager amount of milk or dairy products; the patient said that he had never liked these foods and so avoided them. HL had immigrated to America from Canton in his early 20s and had married a Chinese bride in this country. He had been employed as a restaurant cook for the past 25 years, supporting his wife and three sons.

On physical examination, he appeared to be younger than his stated age of 66 years, was well developed, slender and short statured, with no obvious skeletal abnormalities. There was a positive Chvostek's sign (tapping the facial nerve produced a contraction of the facial muscle) and a Trousseau's sign (tourniquet-induced spasm of the forearm). The initial tetany had been terminated in the emergency room by the intravenous administration of calcium gluconate. X-ray

films taken during the hospital course did not show osteoblastic disease or basal ganglia calcification. There was no clinical or laboratory evidence of rhabdomyolysis or renal failure. Determinations of serum vitamin D and parathyroid hormone levels and fecal fat values were pending. As HL did not progress to more serious complications such as convulsions, he was discharged with the recommendation to take calcium tablets, and encouraged to increase his dietary intake of milk products.

The patient returned to medical clinic in one week for follow-up examination. The serum calcium value was then 7.4 mg per dl with a normal phosphorus level. Latent carpopedal spasms were evident. He informed the clinic team that he did not take any of the calcium supplements, nor did he alter his diet to include more milk products. Several clinic visits later, the medical team members became more exasperated by the futility of their efforts to improve the patient's condition, and they began to describe this patient as "noncompliant" and "stubborn," and to hold him responsible for prolonging his illness. HL missed the next two consecutive clinic appointments. Subsequently, the results of the vitamin D and parathyroid hormone levels returned as high-borderline normal and low, respectively. The 24-hour fecal fat was quantified as greater than 5 grams, suggestive of a malabsorption syndrome.

A clinic physician called HL to ask him why he had not kept his clinic appointments and to discuss the necessity of obtaining more tests to rule out small bowel disease as the cause of intestinal malabsorption; fat malabsorption would cause a subsequent decrease in vitamin D (as well as other fat-soluble vitamins) stored in the body, thereby altering calcium balance. The patient was very reluctant to return to a health care setting to be chastised for noncompliance with a regimen that he could not accept. Furthermore, he was reluctant to undergo any invasive testing. He explained that milk and dairy products were not prominent foods in the Chinese cuisine and, to his knowledge, had never been. The patient had enjoyed relatively good health all his life, and he felt that it was "unnatural" to begin at the age of 66 to ingest each day 14 pills of assorted calcium carbonate, magnesium oxide and vitamin D_2.

Discussion. There are several cultural issues to be reckoned with in this case of seemingly polarized wills. Traditional Chinese medicine avoids intrusive techniques such as venipuncture, surgical procedures and contrast radiology; and diagnoses conditions relying exclusively on astute history taking and physical examination.[22] Western medicine attracts students who enter medical schools with the highest of social values, but who emerge into practice idealizing advanced technology. Our economic reimbursement system and the Western consumer's technophilic beliefs have certainly reinforced this shift in value system to one that deprecates interpersonal skills in favor of physical technologic skills, including greater reliance on acute and pharmacologic interventions rather than long-term, interpersonal interventions that are primarily needed to manage the chronic conditions of the aging process and population.[23] As HL was not bothered with severe symptoms of calcium deficiency, he was content "to leave well enough alone" and not to cooperate with unnecessary tests or technologic procedures. He reasoned that acupuncture was best in treating yang (intestinal) conditions, and so he would continue to apply this method of maintaining health.

Traditional Chinese medicine also views the body as a gift given by parents and forebears. Not being our personal property, the body must be cared for and well maintained. Confucian teaching states "only those shall be truly revered who at the end of their lives will return their physical bodies whole and sound."[21] Ethnographic research asserts that Chinese-American patients want very much to understand their illnesses, to know the cause of the illness and how that cause is linked to symptoms.[24] For a medical team of Western-trained nurses, physicians and dietitians to accuse this Chinese-American elder of noncompliance was more than mere insinuation that he was not taking care of himself or not interested in his health—it was a direct personal and ancestral insult. One wonders if wounded pride prevented him from trusting the physician enough to proceed with more invasive investigation in the pursuit of a definitive diagnosis.

Lactose intolerance due to lactase deficiency has an incidence in American blacks, Bantus and Asians as high as 80% to 90%.[25] This phenomenon of nature may in part be responsible for a culturally conditioned aversion to milk products in these racial groups.[26,27]

Successful resolution of this conflict pivoted on the acknowledgment to the patient that his condition was a momentary imbalance of the *yin* and *yang* forces* and that the taking of these nutrients could not only restore balance, but also prevent disease. It was suggested that he crush the calcium, magnesium and vitamin D tablets to a powder form (fortuitously it resembled ginseng powder) and drink it as a slurry. This method proved to be highly acceptable to him, possibly because other popular Chinese remedies include ingestion of pulverized sea horses for the treatment of gout and ground deer antlers for the treatment of impotence.[21]

HL was grateful to hear that it was not necessary to change his dietary habits so long as he maintained the preventive practice of drinking the calcium slurry that he prepared fresh daily. Both physician and patient were elated by the gradual rise of the serum calcium level into the low range of normal and the disappearance of fatigue and muscle aching. I suspect that spiritual well-being as well as physical (chemical) balance had been achieved, as the patient later consented to undergo a small bowel series.

CASE 4. NT, a 78-year-old Pilipino† man with

*In Chinese cosmology, *yin* is the passive principle exhibited in darkness, cold and wetness; *yang* is the active principle exhibited in light, heat or dryness; the two forces combined produce all that is.

†The spelling "Pilipino" to designate a person of Philippine ancestry corresponds to the usage adopted by the national language of the Philippines.

known prostate cancer, metastasis to the ureters and chronic renal failure due to obstructive uropathy, was admitted to hospital for the evaluation of abdominal pain for several weeks. This midepigastric pain was described as dull, unrelenting in every position, sometimes eased by milk. He had no history of peptic ulcer disease, alcohol abuse, chronic pancreatitis or gallbladder disease.

The patient had immigrated to the United States from the Philippine Islands in the 1930s, finding steady employment as an agricultural laborer in the fields and canneries of the Pacific West Coast. At the age of 50, he married a Pilipino woman 20 years his junior and fathered two daughters and one son. His wife had died swiftly of ovarian cancer within the past year, after heavy reliance on the home help of the daughters who were both married and had families of their own. The son, the youngest child, was in military service and was unable in recent years to participate in family dynamics.

On physical examination, NT was cachectic, frail and appeared to be quietly enduring severe pain. His abdomen showed a right lower quadrant pulsatile mass and a palpable mass in the epigastrium, also pulsatile with a bruit. Laboratory studies at the time of admission showed the following values: blood urea nitrogen 98 mg per dl, serum creatinine 5.3 mg per dl, potassium 5.1 mEq per liter, hemoglobin 12 grams per dl and hematocrit 37%. Results of an upper gastrointestinal series to rule out peptic ulcer disease were entirely within normal limits. Abdominal ultrasound studies ruled out abdominal aneurysms; the radiologist noted a tortuous distal aorta proximal to the bifurcation. A solid homogeneous mass 4 cm by 5 cm was located in the region of the pancreas. A CT scan of the abdomen showed a pancreatic tumor in the head and body of the pancreas. Surgeons felt that the patient was a poor operative risk for pancreatic biopsy under direct visualization. His prognosis was grim and his total care needs in his time remaining were immense. The daughters were well acquainted with the burden of total care-giving to a dying patient, having recently cared for their mother at home before her death. In fact, they were still utterly exhausted and their families that included small children were still recovering from the ordeal. The prospect of now having to bear full responsibility again, this time for their father's terminal care, was nearly unthinkable.

The ward social worker was adamant that the daughters "be honest" with their father and tell him that they were unable to take him home, but that he would be placed in the nearest and best nursing home that Medicare can buy. The daughters smiled politely and said they would inform him. Much to the social worker's surprise, the patient knew nothing about nursing home placement when she approached him three days later with the details of awaiting facility. The following day, the social worker met the daughters, again confirming the situation that home care would be impossible for them and that nursing home placement was the only viable alternative. She asked why they had not all had an "open" family discussion about the matter so that the social worker could finish making the arrangements.

Although the daughters appeared to agree, this round of events was to repeat itself twice more in three days, at which point the social worker notified the medical ward team that the arrangements were made for NT to be transferred to the nursing home, but that he refused placement, saying "I am going home; my daughters will take care of me." In a state of thorough frustration, the social worker resigned from the case.

The patient's physician met with the daughters and extended family and reaffirmed his previous understanding that the family desired around-the-clock, hospice-type institutional care for their father. The daughters appeared embarrassed by this initial public discussion and asked to speak with the physician in private. When the three were alone, the elder daughter asked the physician if he would tell their father that "the hospital wants him to go to the nursing home." The physician was dumbfounded by this request and, in turn, refused "to arm-twist the patient into accepting placement," when the elder believed that arrangements at home were already made for him.

The physician and social worker were unaware of the powerful cultural issues at stake in the Pilipino family. Elders of Asian families expect to be taken care of by their young; in fact, filial duty is considered a religious mandate as well as a social obligation. To be unable to care for one's own elders would be a "loss of face" for the children, who would be admitting publicly to moral and material inadequacy, bringing shame upon themselves and their parents. Abandoning elderly persons to the care of institutions is universally deplored, and criticism of the "dumping" family may be related to (1) negative views of institutions, which conjure earlier images of asylums and poorhouses, and resulting from modern-day scandals of neglect and profiteering in nursing homes; (2) fear of escalating costs for long-term care, believing home and family care to be the cheaper alternative, and (3) guilt of intensifying the many social and psychological losses already incurred by the aged in the aging process.[28]

Direct confrontation appears not be a sanctioned style of interaction in the Pilipino community, whereas it may be a highly valued one in the American culture in general, and in its medical subculture. The use of go-betweens, in this case the physician and hospital, would lift the onus of decision-making off the shoulders and conscience of the family. The wrath and indignation of the father could then be unleashed on the medical establishment whose reputation had already been damaged publicly and, in this way, nursing home placement would come to be accepted with minimal loss of personal and family pride.

Ultimately, the house-staff physician, functioning as a scapegoat, complied with the family's request, unwittingly colluding with the family to achieve their

purposeful ends, with the result that he felt he had somehow been violated or duped.

Discussion. The physician was actually faced with having to choose between two ethical principles: the first, to keep intact the patient's social support structure that might have ruptured had NT been confronted with the fact that his family desired him to go to the institution; the elder's humiliation, anger and withdrawal might have completely prevented the family from supporting him in other genuine ways, such as meeting his emotional and psychological needs. The second ethical principle was for the physician to be true to his own cultural values of honesty and disclosure to patients. Had he understood the implications of his or the family's actions in maintaining the Pilipino cultural norms, he might have been able to participate not with a sense of duplicity, but with one of compromise for the benefit of the patient and his family's relationship with him.

The uneasy "all's well that ends well" outcome of this case, of crossed purposes somehow achieving congruent ends without the persons involved actually making connection with one another, is, as most would agree, antithetical to a therapeutic relationship. It is difficult to say to what degree both physician and family could have acknowledged their vast cultural differences and negotiated mutually comfortable terms of resolution.

Summary

The aging process is composed of innumerable themes that may by turns be the predominant dynamic in a given situation. Due to acute catastrophic illness or to chronic progressive infirmity, the elderly are thrust into contact with health care systems of their society; this event seems to exempt no one, regardless of culture.[29]

As in all healthy relationships, a shared responsibility is essential to achieving mutual satisfaction. Both physicians and patients in the therapeutic encounter can enhance their communication and their compassion for one another by acknowledging cultural differences and by an increased willingness to interpret motives and behavior within a native context.[30] To proceed otherwise risks perpetuating the present hostilities of cultural conflicts escalated by arrogance and mistrust.

The experiences of ethnic elders reflect their desire to participate in a foreboding, culturally dissimilar health care system; it is their evident spirit of cooperation that compels me to personally and professionally deepen the meaning of the final spoken vow: "The health of my patient will be my first consideration."[1]

REFERENCES

1. Declaration of Geneva, adopted by the General Assembly of the World Medical Association at Geneva, September 1948, *In* Taber's Cyclopedic Medical Dictionary. Philadelphia, FA Davis, 1981 (slightly modified by author's graduating class)

2. Becker HS, Greer B: Medical education, *In* Freeman EF, Levine S, Reeder LG (Eds): Handbook of Medical Sociology. Englewood Cliffs, NJ, Prentice Hall, 1963

3. Hughes E: The making of a physician—General statement of ideas and problems, *In* Scott WR, Volkart EH (Eds): Medical Care: Readings in the Sociology of Medical Institutions. New York, John Wiley & Sons, 1966

4. Becker H, Geer B, Hughes EC, et al: Boys in White: Student Culture in Medical School. Chicago, University of Chicago Press, 1961

5. Kalish RA: A gerontological look at ethnicity, human capacities, and individual adjustment. Gerontologist 1971 Spring; 11(Suppl):78-87

6. Clark M: The anthropology of aging—A new area for studies of culture and personality. Gerontologist 1967; 7:55-64

7. Moore JW: Situational factors affecting minority aging. Gerontologist 1971 Spring; 11(Suppl):88-93

8. Kent DP: The elderly in minority groups: Variant patterns of aging. Gerontologist 1971 Spring; 11(Suppl):26-29

9. Holzberg CS: Ethnicity and aging: Anthropological perspectives on more than just the minority elderly. Gerontologist 1982; 22:249-257

10. Markides K: Ethnicity and aging: A comment. Gerontologist 1982; 22:467-470

11. Kiefer CW: Notes on anthropology and the minority elderly. Gerontologist 1971 Spring; 11(Suppl):94-98

12. Beecher HK: A definition of irreversible coma—Report of the Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death. JAMA 1968; 205:337-340

13. Mohandas A, Chou SN: Brain death: A clinical and pathological study. J Neurosurgery 1971; 35:211-218

14. Walker AW: An appraisal of the criteria of cerebral death: A summary statement. JAMA 1977; 237:982-986

15. California Brain Death Statute, Section 7180, chapter 3.5, Uniform Anatomical Gift Act, 1974

16. Drory Y, Ouaknine G, Kosary IZ, et al: Electrocardiographic findings in brain death—Description and presumed mechanism. Chest 1975; 67:425-432

17. Black PM: Brain death. N Engl J Med 1978; 299:338-344

18. Weaver J: National Health Policy and the Underserved: Ethnic Minorities, Women, and the Elderly. St Louis, CV Mosby, 1976

19. Clark M: Health in the Mexican-American Culture. Berkeley and Los Angeles, University of California Press, 1959

20. Korsch BM, Negrete VF: Doctor-patient communication. Sci Am, 1972 Aug; pp 66-74

21. Spector R: Cultural Diversity in Health and Illness. New York, Appleton-Century-Crofts, 1979

22. Bullough B, Vern L: Health Care for the Other Americans. New York, Appleton-Century-Crofts, 1982

23. Eisdorfer C: Care of the aged: The barriers of traditions. Ann Intern Med 1981; 94:256-260

24. Harwood A (Ed): Ethnicity and Medical Care. Cambridge, Mass, Harvard University Press, 1981

25. Bayless TM, Rothfeld B, Massa C, et al: Lactose and milk intolerance: Clinical implications. N Engl J Med 1975 May 29; 292: 1156-1159

26. Chung M: Lactase deficiency in Orientals. Gastroenterology 1968 Feb; 54:225-231

27. Nandi M: Milk drinking by the lactose intolerant. J Am Diet Assoc 1972 Sep; 61:258-261

28. Brody E: The aging of the family. Ann AAPSS 1978 Jul; 438:13-26

29. Katz SH: Anthropological perspectives on aging. Ann AAPSS 1978 Jul; 438:1-12

30. Clark M, Anderson B: Culture and Aging—An Anthropological Study of Older Americans. New York, Arno Press, 1980