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Challenges to Culturally Sensitive Care for Elderly Chinese Patients: A First-Generation Chinese-American Perspective

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ABSTRACT

Physicians and medical institutions in the United States are placing increasing emphasis on providing culturally sensitive care for patients, such as implementing a Confucian family-based model of medical decision making when caring for elderly Chinese patients. In this article, I articulate various reasons why deferring to the family is not a guarantee of culturally sensitive care, particularly when family members are first-generation Chinese-Americans. Nonetheless, I offer several suggestions to help physicians, medical institutions, and family members to provide more culturally sensitive care for elderly Chinese patients.

Within the United States, medical institutions and physicians are placing increasing emphasis on providing medical care that is sensitive to the cultural beliefs and needs of patients, with the goal of improving "access to care, quality of care, and, ultimately, health outcomes."[1] The U.S. Department of Health and Human Services Office of Minority Health, for example, published in 2001 its "National Standards for Culturally and Linguistically Appropriate Services in Health Care."[2] In this document, the DHHS recognizes the importance of providing culturally sensitive healthcare and sets national standards for healthcare organizations to encourage cultural sensitivity.

When it comes to treating Chinese patients in the U.S., and particularly elderly Chinese who have immigrated to the U.S., most institutions and physicians are prepared to implement a family-based approach to medical decision making, due to the recent attention in the literature concerning Confucian medical ethics. The assumption seems to be that by adopting a family-centered model for medical decision making for Chinese patients, not only are medical practitioners in the U.S. being culturally sensitive, but family members will be able to further guide physicians in providing culturally appropriate care for the patient. There seems to be a certain reliance on family members on the part of physicians and medical institutions in the U.S. to lead the way toward providing culturally sensitive medical care.

However, in this article I argue that deferring to the family is not a guarantee that culturally sensitive medical care, that is consistent with a patient's Chinese beliefs and values, will be delivered to the patient, particularly when family members are first-generation Chinese-Americans (or members of subsequent generations) who are not well versed in Chinese customs and traditions. Family members may be unsure of how to provide culturally sensitive care, and thereby be hesitant to take on full decision-making responsibilities. I further argue that

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despite the possible ignorance of Chinese customs, the family (even first-generation Chinese-Americans) should still be the locus of decision making for elderly Chinese patients in the U.S.[3] Nonetheless, I offer several suggestions to help physicians, medical institutions, and family members to provide more culturally sensitive care for elderly Chinese patients.

CONFUCIAN MEDICAL ETHICS—A FAMILISTIC MODEL OF MEDICAL DECISION MAKING

Medical ethics is a rather young discipline in the West, having only emerged as an area of academic focus in the 1970s. Western approaches to medical ethics tend to focus on such topics as patients' autonomy, the doctor-patient relationship, truth-telling, and so on. In the past few decades, however, an increasing amount of attention has been paid to articulating Chinese approaches to medical ethics, as found particularly in Hong Kong and China. Whereas Western medical ethics focuses on the individual patient, the Chinese approach, heavily influenced by Confucianism, employs a family-care model. For Confucians, the family is the basic unit of society; more than a mere collection of individuals who are related by blood, the family is a metaphysical reality "that reflects the deep structure of the universe and carries a profound sense of necessity and normativity for human life."[4] Thus, the Chinese patient is not seen primarily as an individual, but as a member of a family. The family unit makes decisions regarding the medical care of any particular member; the family, rather than the individual, is best able to look out for the interests of the patient as a member of the familial whole. The virtue of filial piety is of central importance; for an individual person to fully realize humaneness and to relate properly to others in society, he or she must pay proper respect to parents and familial elders. Out of proper respect and filial love, it is the duty of the family to care for other family members (and particularly the elderly), which includes making decisions about medical care.

Note how different Chinese medical ethics, with the family as the center of the decision-making process, is from medical ethics in the West. The values of autonomy and self-determination of the individual patient in the West are replaced by emphasis on the patient as a member of a family in the East. It is not for the Chinese patient to determine his or her own course of medical care independently of family, but, rather, family members participate in the decision-making process.[5] As a result, the Western value of patient confidentiality is foreign in the East, where doctors oftentimes do not hesitate to speak about a patient's medical status or diagnosis with the family before speaking to the patient. The family is of such importance in Chinese culture that, if the family deems that a patient should be protected from bad news about his or her medical condition, the physician should honor the wishes of the family. After all, it is assumed that the familial whole knows what is best for the individual family member, and that the family is best suited to look after the good of both the family as a whole and of each family member. According to this Chinese approach, physicians are allowed to lie to a patient about his or her medical condition if the family so requests:

> If a fatal diagnosis or prognosis is involved, most physicians in the East would be willing to follow the family's preferences to withhold the truth from patients, regardless of the patients' preferences. Moreover, they don't think it is immoral to lie to patients in such cases. A general difference between the Western physician and the Eastern physician regarding such cases is clear: the Western physician would need a strong argument to justify deceiving the patient, while the Eastern physician would need a strong argument to justify telling the truth to [the] patient."[6]

Scenarios in which it would be permissible—or even advantageous—for a physician to lie to the patient, however, simply do not exist (with the exception of extreme cases such as lying in order to prevent a patient from committing suicide) in the West. Ethical codes in the West forbid a physician from lying to a patient, irrespective of the family's requests.

CULTURAL BELIEFS AND ATTITUDES RELEVANT TO MEDICAL CARE

With the recent emphasis on providing culturally sensitive care to patients, more and more physicians and medical institutions are familiar with the role of the family in providing care for elderly Chinese patients in the U.S. By including the family in the decision-making process, physicians and medical professionals are not only demonstrating sensitivity to the Chinese patient's cultural values, but also hope that the family can guide the physician in how to further provide culturally sensitive medical care that is in line with the patient's cultural beliefs and attitudes. One of the reasons for this reliance on the family in providing culturally

appropriate care is that the majority of physicians and medical institutions are unfamiliar with the complexities of Chinese attitudes toward medical care, sickness, health, death, and dying. There has been no systematic study chronicling Chinese cultural beliefs and attitudes relevant to medical care in the West, so there is no concise reference guide for physicians and institutions. Although some hospitals provide guidelines for providing medical care to Chinese patients that mention some predominant cultural beliefs and attitudes concerning pain, the role of the physician, et cetera, these guidelines barely scratch the surface of the complex beliefs and attitudes that are common to the Chinese, and particularly older generations of Chinese.[7]

In this section, I attempt to summarize a few of the common Chinese beliefs/attitudes/superstitions/taboos that may be relevant to caring for elderly Chinese patients in the U.S. The point here is not to give an exhaustive account of relevant beliefs or to give the background to these beliefs in reference to Taoism, Buddhism, Confucianism, or folk religion. In fact, this section is undoubtedly an oversimplification of the complexity of traditional Chinese beliefs and attitudes. Further, my claim is not that all Chinese persons or all elderly Chinese persons endorse all of these views. Rather, my aim in this section is to give insight into the complexity of the web of Chinese cultural beliefs relevant to Western medical care. Because of the complexity that characterizes all bodies of cultural attitudes and beliefs (not just the Chinese), it would be extremely difficult—if not impossible—for Western physicians at medical care institutions to comprehensively study these cultural beliefs as a whole and to be ready to incorporate them in practice. As a result, medical institutions and medical careproviders may find it even more important to turn to family members to make culturally sensitive decisions.

Chinese culture is influenced by three main religions/philosophies: Taoism, Buddhism, and Confucianism. These three schools of thought intertwine in complicated ways to influence Chinese cultural beliefs and attitudes. Along with a firm Confucian devotion to familism, the Chinese (in particular, the older generations) share many different beliefs, attitudes, taboos, superstitions, et cetera, regarding the nature of medical care, the human body, sickness, death, and burial. For example, the traditional Chinese view of medicine is that it restores the balance of *yin* and *yang* (two opposing yet interconnected and interdependent natural forces) in the body, often through herbal remedies or acupuncture. As a result, elderly Chinese patients may prefer to turn to herbal remedies or acupuncture rather than to Western medicine, which they might perceive as too intrusive, unnatural, or ineffective to achieve balance of yin and yang. This preference for herbal remedies or acupuncture may seem, to an untrained eye, as noncompliant, particularly if a patient refuses to take prescription medication or undergo procedures recommended by a Western physician. Yet the Chinese patient's refusal here is more complicated than simple noncompliance; a patient's reasons for refusing can be traced back to cultural beliefs about sickness and healing and the balance of yin and yang.

Further questions may arise concerning the intrusiveness of Western medicine. A common Chinese tradition is to bury each person as a whole, with all organs intact and in place, to ensure that the spirit can travel safely to the afterlife. The ramifications of this belief for topics such as kidney removal, organ donation, and autopsies are clear. With respect to life-prolonging measures, traditional Chinese beliefs about death may be relevant. The Taoist view is that death is not an end; the soul continues to exist, and hence one ought not to fear death.[8] Buddhists believe in reincarnation and hope that subsequent rebirths will bring them closer to the achievement of Nirvana and the absence of pain and suffering.[9] The Confucian view holds that the time of death is determined by fate, and what is important is that people fulfill their duties and social responsibilities during life. Given this, life-prolonging measures (particularly invasive ones) may be rejected: "Chinese people have a strong belief in fate regarding life and death issues. . . . In the present study, participants also expressed that birth and death were parts of the life course and it was predetermined by fate. . . . Since life course is predetermined, participants believed that they had to accept whatever fate brings to life."[10] Out of profound respect for the family, life-prolonging technologies may be rejected by the elderly for fear they will burden their families.

There are traditional Chinese cultural beliefs with respect to pain and pain management. In *Concepts within the Chinese Culture that Influence the Cancer Pain Experience,* Lih-Mih Chen, RN, PhD, and colleagues introduce Taoist, Buddhist, and Confucian views of pain and pain relief:

> Within the beliefs of Taoism/energy, pain occurs if Qi, or blood circulation, is blocked. To relieve pain, the blockage of Qi/blood must be removed and the person needs to maintain harmony with the universe. Within the beliefs of Buddhism, pain/suffering is a power, unwanted but existent, that comes from a barrier in the last life;

from the objective world; from a person's own sensation; or from other people, animals, and materials. Only by following the 8 right ways (i.e., right view, right intention, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration) can an individual end the path of pain/suffering. Confucianism teaches that pain is an essential element of life, a "trial" or a "sacrifice."[11]

Given these influences, elderly Chinese patients may turn to non-Western methods of pain relief, such as acupuncture. Or, given that the Confucian view is that pain ought to be endured, some Chinese may be unwilling to request pain relief directly from a medical practitioner, even when they are experiencing excruciating pain. They might be willing to speak to close family relatives about their pain to request that the relative speak to a physician on their behalf. Or they might be willing to accept pain relief if it is offered by the medical practitioner.

Cultural taboos against wearing certain colors or bringing certain types of flowers when visiting the sick also exist. For example, the colors white and blue are associated with death and mourning. Also, white chrysanthemums are symbolic of grief. Clearly, visiting an elderly relative while wearing white or blue and/or bringing white chrysanthemums would be ill advised. The elderly patient might endorse these taboos, and the Chinese-American family member, even if ignorant of these taboos, would show great disrespect if she or he were to accidentally breach these taboos.

DIFFICULTIES FOR FAMILY MEMBERS IN BRIDGING THE CULTURAL DIVIDE

With the tangled web of cultural beliefs that are relevant to the medical care of elderly Chinese patients, medical practitioners in the West must rely upon family members to make known any relevant cultural beliefs or attitudes when they attempt to provide culturally sensitive care. Family members are supposed to bridge the cultural divide. However, despite the best of intentions, family members may be unable to give medical practitioners much guidance regarding the cultural needs of elderly Chinese patients. That is, even if they embrace their duty to take care of their elderly family members and take part in the medical decision-making process, they might be at a loss because they are unfamiliar with the cultural beliefs of their family member. In particular, first-generation Chinese-Americans (and subsequent generations) who are in a position to provide care for their elderly family members who have immigrated to the U.S. may experience many barriers to fulfilling the role of cultural diplomat. Here I speak from firsthand experience as a first-generation Chinese-American who has encountered many of the barriers I describe below in trying to provide care for aging grandparents.

Although first-generation Chinese-Americans are brought up in the U.S., and, as such, undoubtedly are influenced by American values such as individualism, independence, freedom from parental authority, and so on, it is a nearly universal experience that, in the home, the Confucian virtues of filial piety and respect for one's elders are drilled into Chinese-Americans. Just as in China and Hong Kong, Chinese parents in the U.S. would do anything to help and nurture their children, and children respond with filial love and respect. Similarly, because Confucianism is deep-seated in the upbringing of first generation Chinese-Americans, they feel it is their duty to take care of elderly family members—parents, grandparents, aunts, uncles, et cetera—out of love, respect, and filial piety. This care might include taking care of the elderly in the home, rather than sending them to an institutional care facility, and coming together with other family members to make decisions about medical care, funeral preparations, burial, et cetera. Although Chinese-Americans who are raised in a Confucian household know about the general duty that they should respect their parents and elderly family members, which includes taking care of them in their old age, they may not know what Chinese customs specifically dictate in particular circumstances. The Chinese-American family member may be unfamiliar with traditional Chinese attitudes toward medicine, sickness, pain relief, or death and dying. Or, they may not know their elderly family members' wishes about end-of-life care or their attitudes toward death and dying and burial.

This lack of familiarity is a problem specific to the U.S. and other Western countries that lack a majority Chinese population. In Hong Kong and China, social norms about how to treat the elderly and the sick, Chinese attitudes toward death and dying, and cultural expectations about burial and funerary practices are not simply passed down from one generation to the next through verbal instruction. Rather, these cultural truths are absorbed by living within a community of practitioners—one lives and breathes the culture. The communal celebration of holidays and festivals help to sustain a culture, and this is true especially of the Chinese, whose culture, as influenced by Confucianism, is

highly ritualized.[12] Ritual practices convey cultural truths. For example, by participating in ritual ceremonies, Chinese demonstrate proper respect to ancestors and elders, and the rituals cement in their minds and hearts that ancestors and elders are worthy of respect. Traditional rites and customs are practiced by the entire community, and, as such, the truths that they convey need not be formally articulated in verbal instruction to those who are living within the community.

In the pluralistic and multi-ethnic U.S., however, there may not be such community support for the communal celebration of cultural festivals and holidays or for group participation in rites and rituals that transmit cultural truths about the human condition, life, death, the role of the family and the elderly, and so forth (with the exception, perhaps, of Chinatowns around the nation). Rather, within the U.S., these rites and rituals are practiced primarily within the home (if at all), which does not give first-generation (and subsequent generations of) Chinese-Americans enough opportunity to learn about traditional Chinese culture. Even more, older generations are concerned that cultural values that are passed down to younger generations are modernized and watered-down or passed down as historical interests only, rather than as truths. Most first-generation Chinese-Americans are unsure of what traditional Chinese beliefs teach about death, dying, and funerary practices, other than the very general principle that they must pay proper respect to their elders. As a result, many Chinese-Americans may be ill equipped to specify how to offer care to their elders in a way that is aligned with traditional Chinese beliefs about healing, medicine, old age, and death. Thus, even though they feel strongly that they are called, as family members, to care for their elders, they may be at a loss as to how to adequately provide this care.

Learning about Chinese attitudes toward sickness, end-of-life care, and dying through shared participation in rituals, cultural celebrations, and activities is important, because oftentimes, the younger generations are unable to ask older generations directly about these topics for a variety of reasons. First and foremost, there may be a language barrier. In the best-case scenario, a Chinese-American is fluent in the mother tongue. In the worst-case scenario, communication is severely limited because elderly patients do not speak the same language as younger family members. Perhaps a grandparent only speaks Chinese, and the grandchild who is left to care for him or her only speaks English. Or, in the most common scenario, the first-generation Chinese-American is fluent in conversational Chinese and is able to speak on a basic level about the elderly family member's medical condition. However, most American-born Chinese lack the language skills to translate in detail the complexities of the medical condition and requisite care. This language barrier makes it difficult for family members to consult elderly patients for their opinions and preferences toward medical care as shaped by their beliefs, values, and cultural background.

Setting aside any possible language barrier, there is also a cultural barrier that may prevent Chinese-Americans from asking elderly relatives for their views on sickness and eventual death. Many Chinese people are very superstitious and believe that speaking about sickness and death will bring bad luck or cause sickness or death to become imminent. In fact, speaking about death is such a taboo that even homonyms for "death" in the Chinese language are avoided. So deep is this taboo that the number four (which, in Chinese, sounds similar to the Chinese word for "death") is often considered to be an unlucky number. Although many in the younger generations no longer adhere to these taboos against speaking about death and sickness, many of the elderly are still unwilling to broach the subject of death. Or, even if the elderly are open to speaking about death, they refuse to bring up the subject for fear of alienating their children or grandchildren, or because they fear that others hold the taboo. In turn, children and grandchildren may be unwilling to broach the subject of death with elderly family members for fear of showing disrespect or upsetting them.

Lastly, Confucian familism may itself present a barrier to communication between elderly patients and their family members: patients might assume that speaking about their preferences is unnecessary because they are assured that their family members will make all the decisions for them, in accordance with Confucian filial piety. Ho describes:

> . . . the strong Confucian concept of filial piety leads parents to believe that children will make decisions for their best interests. . . . For some elderly, such beliefs also made them perceive that their children would make decisions regarding the end of life or death and dying. Therefore, for children to bring up topics such as the future death of a parent may only arouse unpleasant feelings in the family and disturb harmonious relationships. Because children are supposed to fulfill their filial responsibilities to their parents, it does not seem necessary to have discussions or make decisions in advance.[13]

Thus, if Chinese-Americans are unable to learn about the intricacies of taking care of the elderly because they (1) are unable to ask their elderly family members directly about their attitudes toward sickness and death, and (2) cannot learn about these attitudes through shared practices and rituals within a Confucian community, how are they going to make important decisions about providing care to their family members according to their wishes, culture, and beliefs?

A RETURN TO THE FAMILISTIC MEDICAL DECISION-MAKING MODEL

Given the above considerations about the difficulties that first-generation Chinese-Americans may encounter in trying to provide appropriate and respectful care for aging family members, it seems that turning to family members in the U.S. may be an insufficient guarantee of providing culturally sensitive care to elderly Chinese patients. Even if first-generation Chinese-American family members are committed to caring for elderly family members out of a deep sense of filial piety and want to provide this care in a manner that is in line with Chinese cultural beliefs, having been raised in the U.S., they may be unable to provide care to family members in the ways that Chinese culture demands. Further, they may be unable to consult elderly patients about their beliefs and opinions about their medical care, due to language or cultural barriers.

I want to clarify, however, a possible misconception about Chinese medical ethics and the familistic model of medical decision making. It is true that filial piety and respect for one's elders, according to the Confucian way of thinking, requires that the elderly are taken care of by family members and that family members participate in making decisions about an elderly patient's medical care. Yet we should not interpret this Confucian duty as one in which the family simply carries out the wishes of the elderly patient. In the Confucian system, the family is not merely an executor who, absent explicit instructions from the elderly patient, must guess what the patient would want. If this were the case, there would be little difference between a properly Chinese medical ethic inspired by Confucianism and Western medical ethics, which is centered on patients' autonomy and self-determination. In the Western model, elderly patients express their autonomy by making known their wishes about medical care. Family members or medical proxies are supposed to follow these wishes and instructions as best they can. However, in the Confucian model, elderly patients are not autonomous agents. Nor are they subject to the decisions of the family. Rather, they participate in the decision-making process with their family, if they are able and willing to do so.[14] Families, in discussing what would be the most appropriate course of action for elderly patients' medical care, do not simply discuss what patients want or would want. Rather, families discuss what they judge to be the best for the patients. While they take into consideration the beliefs, attitudes, and desires of patients, families may not honor these wishes if they deem it to be in the best interests of the patients. As Ruiping Fan notes:

> Generally, the Chinese take it for granted that the entire family makes medical decisions for a patient whether the patient is competent or not. It is the family's responsibility to pursue happiness for their loved ones as they experience a difficult time on the final path of life. If patients have particular wishes, they speak with their families. This does not mean that the family will necessarily carry out the patient's wishes. Whether the family follows the patient's wishes depends upon what the family considers the patient's best interests. The cultural assumption is that the family should make medical decisions in the best interests of the patient. If family members hold that following the patient's wishes are not for the patient's good, they will not act on such wishes. The emphasis is not placed on the patient's self-determination; rather, it is placed on the patient's good according to Confucian understanding. Accordingly, medical decisions are frequently physician-guided, family-based decisions, rather than decisions in terms of patients' self-determination.[15]

Thus, even if family members of elderly Chinese patients in the U.S. decide to request medical care for these patients in a manner that is not consistent with traditional Chinese culture and beliefs that the patients endorse, so long as family members are acting for the sake of what they see to be the patients' best interests, they are still acting in a culturally appropriate manner.

Just as cultural unfamiliarity should not be seen as an irresolvable problem in providing culturally sensitive care, language barriers may also fall away. Even if a Chinese-American family member is unable to consult an elderly patient because of a language barrier, proper understanding of the Confucian family model indicates that this is not a significant problem for the family decision-making model. The ugly truth is that most patients, even those born

in the U.S. and who are completely fluent in English, do not understand the complexities of medicine. Physicians have specialized medical knowledge, and it is not their duty to explain everything about a patient's medical condition to the patient, but to explain enough that the patient can make sound decisions. Similarly, family members need not necessarily inform Chinese patients about all of the complexities of their medical condition and the requirements of their care, particularly since translation of medical terminology can be so difficult. Rather, family members should translate as much as they can and answer as many questions as they can, so that elderly family members can participate in discussions of their medical care, if they so desire. Thus, even if patients only know about their medical condition in very general terms, the beauty of family-centered Confucianism is that they can rest assured that their family members will be looking out for their best interests and taking good care of them.

We can here create a distinction between medical decisions that are *materially* sensitive to an elderly Chinese patient's culture and those that are *formally* sensitive. Decisions that are *materially* sensitive are decisions made in accord with the patient's cultural beliefs *in regard to the content of the decision.* For example, a decision to forego prescription drugs in favor of herbal remedies, made out of respect for the patient's cultural beliefs, is a decision that is materially sensitive to culture. The decision aligns with the patient's cultural attitudes and beliefs. A *formally* sensitive decision, on the other hand, is the result of a decision-making process that is sensitive to cultural demands. A decision made by the familial whole regarding the proper course of action for the patient is a decision that is formally sensitive to the Chinese patient's culture.

What seems to be most the important to elderly Chinese patients is not that decisions about their medical care are materially culturally sensitive, but rather that they are formally culturally sensitive. Cultural and generational gaps are not common only in the U.S., but rather are universal. The elderly in Hong Kong and China are aware that the younger generations (although perhaps they are more literate in Chinese culture than their American counterparts) may not share the same beliefs and commitments, and will make decisions accordingly. Yet the elderly accept this tendency as a fact of life, knowing that their children and grandchildren will look out for their best interests. In *Perspectives on End-of-Life Decision-Making among Older Chinese,* Sio-Wa Ho concludes, from interviews conducted with a small sample of Chinese elderly in Macau, that what matters most to the elderly is that their family members will make the decision that they deem to be the best:

> Family members, therefore, will make decisions for the older parents who are sick and these decisions are believed to be of the best interest to the patients after careful considerations on the overall well-being of the patient. Sometimes, the family will disregard the patient's expressed wishes if those wishes are in conflict with the family's considerations. . . . For the participants in the present study, personal preferences were not as important as maintaining good family relationships, therefore, imposing personal preferences on the family seemed to be unacceptable. . . . Therefore, even though their wishes might not be fulfilled or respected, the participants still believed that the family had tried to do the best for the parents. As a result, they would still defer their decision-making to the family."[16]

Of course, since the study was based on interviews with 18 participants, it would be hasty to make a generalization about the willingness of Chinese elderly to subordinate their own beliefs and wishes to that of their family. Yet, Ho's findings accord with numerous other articulations of the family model of medical decision making.

Xiaoyang Chen and Ruiping Fan explain that this willingness to accept whatever the family decides is thoroughly Confucian. They write that not only is the Confucian model of medical decision making characterized by a family-centered approach, but is also characterized by the notion of harmony. They identify three analogies to describe how harmony is to be reached regarding a patient's medical care. The first analogy compares a decision to a musical performance. For harmony to be possible in a musical performance, there must be different sounds and tones. In a similar way, for harmony to be possible in decision making, there must be a variety of different viewpoints, all of which must be taken into consideration: "Similarly, in the process of decision making, the way of accomplishing a harmonious decision is not by excluding a relevant person who may hold a different view from others. Rather, all relevant persons must be involved and their diverse views respected and considered before a harmonious agreement can be made."[17]

Chen and Fan then explain how different views may be harmonized through the analogy of making a delicious soup, by bringing all the different ingre-

dients into balance. The soup-making analogy indicates that, in a decision-making process that involves, at the very least, the views of the patient, the family, and the physician (all of which may be different), each side must be willing to compromise to reach a harmonious decision about what is best for the patient. Chen and Fan explain: "The point is that in order to make a harmonious decision, relevant individuals need necessarily to adjust or compromise their original opinions so as to integrate different views and achieve a proper decision."[18] No one opinion is privileged *a priori* over others. All of the parties must be ready to consult the opinions of the other relevant parties in the decision-making process, and be willing to revise their view in light of the opinions of others.

In being ready to compromise in order to work for what is best for the patient, the parties to the discussion demonstrate their commitment to Confucian virtue, which brings us to the third analogy identified by Chen and Fan. The third analogy compares a decision-making process to the pursuit of good health, which is a combination of bodily harmony, mental harmony, and life-process harmony. These three harmonies can be achieved only when one acts according to virtue—doing the right thing at the right time and in the right way. Chen and Fan summarize:

> Although the point of the soup-cooking analogy is that different opinions must be coordinated, integrated, adjusted, and compromised in order to achieve a harmonious decision, the point of this health-pursuing analogy is that such coordination, integration, adjustment, and compromise should not be done arbitrarily or as a result of social or political coercion. Rather, decisions should be made under the guidance of virtue, in just the same way in medical decision making (the patient, family members, and physician) attempts to solve their disagreements.[19]

In other words, for all the different opinions to be harmonized, all of the different parties must seek resolution in accordance with virtue.

In sum, family members in the U.S. may not be able to make medical decisions for their elderly family members that are in line with traditional Chinese culture in terms of content. Still, by being involved in the decision-making process, these family members are making decisions that are in line with the form of traditional Chinese culture. The Chinese elderly are prepared to make their own wishes regarding medical care subordinate to the wishes of their family members.

FURTHER SUGGESTIONS

Even if medical practitioners and institutions can rely upon the family medical decision-making model as the primary vehicle to provide culturally sensitive care to elderly Chinese patients since materially sensitive decisions are less important than formally sensitive decisions, we should still strive for better cultural literacy. As Chen and Fan explain, true harmony in medical decision making demands that the views of all parties be taken into consideration, including the cultural views of elderly Chinese patients. If patients are unable or unwilling to voice their views and beliefs, then their family members might wish to learn more about Chinese cultural attitudes toward, or taboos regarding, sickness, death, and dying for the sake of a harmonious decision. The question then becomes how to meet demands for cultural literacy.

The easiest solution, of course, would be to discuss these issues directly with elderly relatives, preferably well before hospitalization or serious illness. A family discussion with all relevant parties, to gauge the elderly patients' preferences and beliefs concerning medical care and advanced planning will make things easier for the family when sickness actually strikes. Further, such discussions will allow families to have a "game plan" in the eventual case of sickness, hospitalization, or death. Younger relatives should carefully approach elderly patients to test whether they would be open to having such discussions. Such an approach has the advantage of determining how closely elderly relatives share traditional Chinese views. It may be that patients believe all of the traditional Chinese views and superstitions concerning sickness, medical care, death, and burial. But they might adhere to some and not others. Or, on closer examination, they may not believe any at all. If elderly relatives are amenable, it would be wise for family members to request that they make clear their wishes in the form of some sort of advanced directive, so that their views may be discussed and harmonized with the views of the rest of the family.

But what about when elderly relatives refuse to do any sort of advanced planning, because of strict adherence to the taboo against speaking about death or sickness? Or when an elderly relative is incapacitated and unable to state his or her views concerning the matter, yet family members assume that their relative adheres to traditional Chinese views regarding sickness and death, views with which the family is unfamiliar? One possible solution is that, just as hospitals and communities have translators to

help with any language barriers that the elderly may confront when seeking medical care, perhaps communities should seek Chinese cultural diplomats who would be willing to offer general advice and explanations about traditional Chinese beliefs about sickness, death, old age, and other such relevant topics. Perhaps there might be a member of a local senior citizens' center, or Chinese cultural organization, who is willing to talk about these topics and would be open to volunteering time to speak to concerned family members, or to serve as a liaison between elderly patients and their family. Of course, such an approach is more feasible in communities with a large Chinese population, such as San Francisco, Vancouver, or Los Angeles. Despite the limitations in scope, however, this endeavor would be worthy of pursuit.

Perhaps, simultaneous with some sort of "cultural diplomat" program to serve as a reference for younger Chinese-Americans who want to become familiar with Chinese attitudes and customs, community-wide programs could be created to shift existing taboos against talking about death. Carol K.L. Chan and Matthew K. Lau describe one such effort that has met with some success in Hong Kong:

> In Hong Kong, a predominantly Chinese community, taboos associated with death have been successfully challenged with the establishment of a societal-wide campaign, the ENABLE project. The ENABLE project conducts experimental workshops and training programs at different levels to educate the general public and professionals in the healthcare, hospice, social work, and family services sectors on making effective death preparation. . . . The project is spearheaded by academics from healthcare and social work, and is funded by a local charitable trust. The goal of the project is to aid individuals in adjusting to bereavement and loss in end-of-life by means of encouraging the elderly and their family to talk about death, as well as prepare for it.[20]

While cultural diplomats could help younger generations to understand the mindset of the older generations regarding sickness and death, programs geared toward encouraging the elderly to engage in advanced healthcare planning would help them to adjust their attitudes and come to a compromise, thereby bringing about harmony between the generations.

Further, the elderly may be amenable to speaking about death and dying with a disinterested third party who is not a family member. By doing so, they may not need to fear that speaking about death will bring bad luck to the family. Ho writes:

> Since talking about death with family may not be appreciated in the family because of the cultural beliefs, talking to unrelated people therefore becomes a way for older people to express their concerns about the approaching death. Though it is said that death should be accepted as it is predetermined, concerning about it as it is part of life is not an abnormal behavior. Hence, discussing about their attitudes toward death and dying with the researcher, as an unrelated person to them, is considered not to be a taboo.[21]

These community programs could provide the elderly with non-family members to whom they could express their beliefs and wishes concerning medical care and end-of-life planning.

So far, my suggestions have been aimed at helping elderly patients in the U.S. and their family members make culturally sensitive decisions about medical care. After all, the burden of making medical care culturally sensitive seems to lie with patients and their family members, rather than with physicians and hospitals, given the complexity of culture and that each individual embraces cultural beliefs and values to different degrees. Yet, as the DHHS Office of Minority Health and institutions of medicine make increased requirements for cultural sensitivity, we must give greater thought to how to provide culturally appropriate medical care. We can start with increased sociological research on the beliefs and attitudes of the elderly Chinese immigrant population in Western countries, and also with philosophical study tracing how Confucianism, Taoism, and Buddhism influence the attitudes and beliefs of the elderly Chinese population with regard to issues relevant to medical and end-of-life care. To date, systematic studies of these topics has been scarce, as Ho points out:

> Few studies have been conducted in Chinese societies on older people . . . and little is known about these older people's perspectives on their end-of-life decisions. . . . Conducting research in the Chinese cultural context can give in-depth insight into how older Chinese people make decisions on end-of-life issues. Understanding older people's care and treatment preferences at their end-of-life may help family or professionals to fulfill final wishes of the dying persons, to reduce the stress and burden put upon family members when they have to face difficult end-of-life situations for their loved ones, to promote well-being of patients and family and

to implement better services and interventions to meet their needs."[22]

Studies on the elderly Chinese immigrants in the U.S. are even more scarce, and such studies would greatly help to meet the demands for cultural sensitivity in medicine.

NOTES

1. U.S. Department of Health and Human Services Office of Minority Health, "National Standards for Culturally and Linguistically Appropriate Services in Health Care," March 2001, *http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15,* accessed 1 November 2013.

2. Ibid.

3. In this article, I focus on the issue of providing culturally sensitive medical care to elderly Chinese patients who have immigrated to the U.S. The reason for this narrow focus is that traditional Chinese beliefs (particularly those that I describe in the section "Cultural Beliefs and Attitudes Relevant to Medical Care" in this article, among others) are most likely to be strong within this very small subset of the Chinese population in the U.S. Younger generations, in Hong Kong, China and the U.S., for example, are less likely to strongly hold traditional Chinese beliefs concerning life and death, sickness, and healing care, which leads to the cultural divide that I later describe.

4. X. Chen and R. Fan, "The Family and Harmonious Medical Decision Making: Cherishing an Appropriate Confucian Moral Balance," *Journal of Medicine & Philosophy* 35, no. 5 (October 2010): 576-86, 576.

5. R. Fan, "Informed Consent and Truth Telling," *HEC Forum* 12, no. 1 (March 2000): 87-95.

6. Ibid., 92.

7. The University of Washington Medical Center, for example, has published "Communicating with Your Chinese Patient," *http://depts.washington.edu/pfes/PDFs/ChineseCultureClue.pdf,* accessed 23 April 2013.

8. S.-W. Ho, "Perspectives on End-of-Life Decision-Making among Older Chinese" (PhD dissertation, North Dakota State University of Agriculture and Applied Science, 2008), 47.

9. Ibid., 48.

10. Ibid., 57.

11. L.-M. Chen et al., "Concepts Within the Chinese Culture that Influence the Cancer Pain Experience," *Cancer Nursing* 31, no. 2 (March-April 2008): 103.

12. Chen and Fan, see note 4 above.

13. Ho, see note 8 above, p. 58.

14. Fan, see note 5 above, p. 90.

15. Ibid.

16. Ho, see note 8 above., pp. 31-2.

17. Chen and Fan, see note 4 above, pp. 580-1.

18. Ibid., 581-2.

19. Ibid., 583.

20. ENABLE is an acronym for the Empowerment Network for Adjustment to Bereavement and Loss in End-of-life. C.K. Chan and M.K. Yau, "Death Preparation Among the Ethnic Chinese Well-Elderly in Singapore: An Exploratory Study," *OMEGA* 60, no. 3 (2009-2010): 228.

21. Ho, see note 8 above, p. 62.

22. Ibid., p. 17.