Bioethics for clinicians: 20. Chinese bioethics

Kerry W. Bowman, Edwin C. Hui

Abstract

CHINESE CANADIANS FORM ONE OF THE LARGEST GROUPS in the Canadian cultural mosaic. Many of the assumptions implicit in a Western autonomy-based approach to bioethical deliberation may not be shared by Chinese Canadians. In traditional Chinese culture, greater social and moral meaning rests in the interdependence of family and community, which overrides self-determination. Consequently, many Chinese may vest in family members the right to receive and disclose information, to make decisions and to organize patient care. Furthermore, interactions between Chinese patients and health care workers may be affected by important differences in values and goals and in the perception of the nature and meaning of illness. Acknowledging and negotiating these differences can lead to considerable improvement in communication and in the quality of care.

Mr. Y is a 75-year-old Chinese Canadian who has been admitted to the intensive care unit because of respiratory failure. He has a long history of respiratory problems. Mechanical ventilation is started. Mr. Y is oriented to time, person and place. He spends much of his time reading and enjoys his family's visits. Attempts to wean him from the ventilator have failed; consequently, he is facing a situation of permanent dependence on the breathing machine. It is unclear as to what Mr. Y's wishes related to this would be. The physician in charge wishes to inform Mr. Y that he is unable to get him to a point where he can be taken off the ventilator and wants to introduce the option of gradually weaning him off the ventilator and keeping him comfortable so that nature may take its course and he may die in peace. The patient's eldest son is described to the health care team as "the decision-maker." He approaches the physician and asks emphatically that his father not be told that he is permanently dependent on the ventilator as it would take away his hope, terrify him and, in turn, make him sicker. The son feels that telling his father would be cruel and is therefore unjustifiable.

What is Chinese bioethics?

Bioethics as a discipline does not formally exist within traditional Chinese culture. For many Chinese Canadians who have grown up or spent much of their lives in a culture characterized by strong communal values and an emphasis on social harmony, the process of explicit bioethical deliberation will be unfamiliar. Much of conventional Western bioethical analysis is based on such dichotomies as autonomy versus paternalism and duties versus rights. "Either/or" distinctions contrast sharply with the conception of moral order in Chinese culture, which treats apparent opposites, such as the individual and the group, as complementary rather than mutually exclusive. Thus the "person," "family," "clan" and "community" exist in a dynamic state of reciprocal definition.[1]

The concept of autonomy best highlights the contrast between Western and Chinese cultures. In the West, the principle of autonomy implies that every person has the right to self-determination. In the context of health care, this means that the patient is the best person to make health care decisions. Within Chinese culture, however, the person is viewed as a "relational self" — a self for whom social relationships, rather than rationality and individualism, provide the basis for moral

Review

Synthèse

Dr. Bowman is a bioethicist with the Mount Sinai Hospital and the University of Toronto Joint Centre for Bioethics, Toronto, Ont. Dr. Hui is Professor of Biomedical Ethics, Regent College (University of British Columbia), Vancouver, BC.

This article has been peer reviewed.

CMAJ 2000;163(11):1481-5

Series editor: *Dr. Peter A. Singer, University of Toronto Joint Centre for Bioethics, 88 College St., Toronto ON M5G 1L4; fax 416 978-1911; peter.singer@utoronto.ca*

This series began in the July 15, 1996, issue and can be found on CMAJ*'s Web site (www.cma.ca/cmaj/series/bioethic.htm).*

Return to November 28, 2000 Table of Contents

judgement. From this perspective, an insistence on self-determination erodes the value placed on personal interconnectedness and the social and moral meaning of such relationships.

In traditional Chinese society, the influences of which still endure, the family is based on an extended or clan structure and plays a central role in an individual's life. The family is a semi-autonomous unit consisting of an elaborate hierarchy of kin and is held responsible for the care of its aged, sick, unemployed and disabled members. The traditional family structure is patriarchal, with communication and authority flowing downward.[2] All major decisions made by the family are thus informed by these hierarchical structures. This pattern of familial collectivity has deep roots. In the second century BC, a Confucianist social order that was focused on the quality of selflessness began to evolve. This notion emphasized allegiance — first to the family, second to the clan and finally to the community. In Chinese culture, the family functions as collective decision-maker, and also as a powerful conduit for moral, religious and social norms.[3,4] The family's role in self-determination is therefore integral to any notion of Chinese bioethics.

Why is Chinese bioethics important?

Demographics

In the last 2 decades, slightly over 1 million ethnic Chinese from the Far East have settled in Canada. In the 1980s Cantonese-speaking Chinese, primarily from Hong Kong, made up the majority of the immigrants. In the last decade Mandarin-speaking Chinese from Taiwan and Mainland China have rapidly grown in number. As people from this population enter the health care system in Canada, it is crucial that health care professionals understand their cultural perspectives. Although Chinese immigrants from these 3 geographical areas have much in common, subcultural differences between and among these groups add to the need for health care providers to recognize the diversity within Chinese culture and avoid broad-based assumptions.

Conceptions of illness

All cultures generate explanatory models that attempt, either explicitly or implicitly, to account for the phenomenon of illness and its place in human existence. Such models undertake to define what a disease is, how it occurs, why it exists, what measures can prevent or control it, and why some people and not others are affected. Identifying and reconciling differences between cultural models is crucial to the successful treatment of illness.[5] In Western medicine, the primary explanatory model of illness focuses on abnormalities in the structure and function of bodily organs and systems. Traditional Chinese medicine, on the other hand, views the body, soul and spirit as an integrated whole. Furthermore, because human beings are considered products of nature, humankind and the natural environment are seen to be inseparably and interdependently related; protecting the integrity of the human–nature dyad is thus fundamental to health.

The Chinese understanding of nature and the cosmos is expressed in 3 important philosophical concepts: *Ch'i* (material or vital force), yin and yang (complementary, interdependent opposites) and *wu-hsing* (the 5 elements).

Ch'i: Traditional Chinese medicine identifies 12 main channels in the human body through which the *ch'i* moves. Health implies that the *ch'i* is flowing normally between the organs; this is detected by the pulse. Accordingly, one of the main causes of disease is an obstruction of *ch'i* in the body. For example, the symptoms of a stroke may be attributed to the obstruction of *ch'i* at a point of vital energy flow in the body.

Yin and yang: This is a dialectical concept that attempts to explain phenomena that appear to be simultaneously dependent on and in opposition to each other. All bodily functions are the result of the harmony of yin and yang; a mild imbalance implies a diseased state, and a total disruption of the harmony leads to death. Many foods and food groups are divided into yin–yang categories. For example, if an illness is believed to be caused by too much yang, one way to compensate would be to eat foods that are considered yin.

Wu-hsing: The 5 elements are fundamental categories of matter. Because the human body is part of nature, the 5 elements are distributed to the 5 most important organs in the body, which determine the functions of all the other parts of the body, including emotions. Thus, the liver is associated with wood, the heart with fire, the spleen with earth, the lungs with metal and the kidneys with water. Through this system, traditional Chinese medicine explains not only the various interactions between the body organs, but also the influence of environmental factors (e.g., seasons and weather) on the human body and emotions.[6]

From the perspective of traditional Chinese medicine, a person enjoys perfect health when she or he has a strong and unobstructed flow of *ch'i*, is under the influence of well-balanced yin–yang forces and is in harmony with the 5 elements. The focus is thus primarily on maintaining and promoting the flow of *ch'i* (building up body resistance) and only secondarily on pathogenic factors. Thus, traditional Chinese medicine emphasizes preventive medicine and health maintenance; therapeutic intervention to dispel pathogenic factors is reserved for acute conditions. Even for acute conditions, health maintenance procedures (measures to strengthen resistance) are usually implemented simultaneously with therapeutic interventions.

Another significant consideration in assessing Chinese Canadians' attitudes toward health and illness is the degree to which they have acquired Western beliefs through acculturation or the recent effort in Mainland China to combine both Chinese and Western medicine.

Specific issues

The moral perspective of traditional China is influenced primarily by Confucianism, but also by Taoism and Buddhism. Some areas that highlight the differences between Western bioethics and Chinese tradition include beginning-of-life issues, death and dying, and informed consent.

Beginning-of-life issues

The Chinese conception of the relational self has significant ethical implications for beginning-of-life issues. For example, one of the most important ways to show filial piety (a responsibility or sense of duty to one's parents) is to provide offspring, especially male offspring. This explains why births in general — and male births in particular — are welcome events in Chinese society. Hence, the Chinese attitude toward abortion is generally negative, especially for male fetuses if the sex of the fetus is known. Life is always viewed as precious, and the taking of a life is something to be done only with careful consideration and the utmost caution. This high value placed on life is complemented by the Buddhist teaching of compassion and the prohibition against killing any living thing.

Death and dying

In Confucian teaching, death is evaluated in terms of accomplishment in this world (i.e., the fulfillment of *jen*). *Jen* denotes the cultivation of positive human attributes such as humaneness, charity and beneficence. A death is a "good" one — worthy and acceptable — only when most, if not all, of one's moral duties in life have been fulfilled. Resistance to acknowledging a terminal illness or to foregoing futile medical treatments may reflect a patient's perception of unfinished business and his or her desire to extend life in order to complete unfinished tasks or fulfil moral duties.

But even when an elderly Chinese patient is resigned to a "good death," his or her children may be reluctant to grant this wish for reasons related to filial piety. Because filial piety can be expressed only when a parent is alive, to extend an ailing parent's life is to extend the opportunity to show filial piety. For this reason, children may not consent to a physician's judgement that further intervention is futile and insist that heroic measures be taken for their dying parent.

Another significant reason to resist inevitable death is the belief in religious Taoism, which teaches the postmortem survival of the whole bodily person and an afterlife of torture and suffering in endless Hell. To avoid this, Taoism focuses on maintaining youth and attaining longevity and immortality. Patients with a strong Taoist religious background may therefore consider death an obstacle to be overcome and desperately cling to any means of extending life.

Philosophical Taoism, on the other hand, has a radically different perspective, which is reflected in the phrase, "Man comes into life and goes out to death." For this reason, one should view death with equanimity. In the face of death, acceptance is the only appropriate response. Any artificial or heroic measures contradict the course of natural events and should not be undertaken.

A Buddhist follower may have a more unpredictable response to the suffering of dying and the event of death. If the person maintains his or her belief in the impermanence and cyclical nature of life, he or she may be easily resigned to death. But if the person sees the suffering of the dying event as an occasion to "work out" his or her karma (which may include suffering from one's bad deeds) in this lifetime, then the person may not welcome death quite so readily.

Informed consent

The notion of respect for an individual's right to self-determination is not prominent in traditional Chinese culture. In fact, the Confucian concept of relational personhood challenges the assumption that the patient should be given the diagnosis and prognosis and the opportunity to make his or her own medical decisions. Social and moral meaning rests in *interdependence*, which overrides self-determination. Consequently, many Chinese Canadians may give the family or community the right to receive and disclose information, to make decisions and to coordinate patient care, even when they themselves are competent. If not acknowledged, these differences in perspective can lead to a complete breakdown in communication.

The roots of both traditional and modern Chinese culture and philosophy are simultaneously diverse and tightly intertwined. This legacy has produced a people, a culture and a moral perspective that are neither homogeneous nor in any sense monolithic. Furthermore, for Chinese Canadians, the process of acculturating to Canadian life adds yet another layer of complexity. Chinese Canadians' attitudes toward bioethical questions are therefore likely to be variable, complex and difficult to predict.

How should I approach Chinese bioethics in practice?

When working with Chinese Canadians it is important to remember that Western and Chinese cultures may hold sharply divergent views about autonomy and the nature and meaning of illness. The most effective way to address such cultural differences is through open and balanced communication. When health care workers are uncertain about how a Chinese patient or family perceives a situation, it is best simply to ask. Frequently, differences are easily negotiated. Many Chinese Canadians already hold blended cultural perspectives and views of health. The mere acknowledgement of such differences will usually lead to improved communication.

Although the notion of Chinese bioethics does not exist in any traditional sense, health care workers should con-

Table 1: Essential qualities of ethical approaches to communication and caregiving involving Chinese people

Assume diverse opinions: There is no monolithic Chinese culture; when dealing with Chinese Canadian patients, a broad range of beliefs should be anticipated. Furthermore, culture is not static, particularly in the case of immigration. Many Chinese Canadians hold beliefs and attitudes that are both blended and in transition. When uncertain of beliefs and perspectives, avoid assumptions and ask the patient or family directly.	**Use interpreters:** Use an interpreter if there is any doubt about fluency in or understanding of English. It is always best to avoid using family members or close family friends as interpreters because they may not be comfortable with the direct nature of informed consent.
Acknowledge potential differences in emotional expression: Chinese Canadians may not be comfortable with frank, direct styles of communication. Emotional containment does not mean indifference. Be cautious in assessing a person's emotional reaction.	**Involve the family:** Chinese Canadians may believe that consent is a family — rather than an individual patient — decision. Making decisions based solely on a patient's wishes or perspectives on quality of life may be foreign to many Chinese Canadians. Moreover, "immediate family" may include multiple generations. Allow for large or multiple-generation family conferences. Applying the notion of autonomy cross-culturally may therefore warrant accepting each person's terms of reference for their definition of self. We respect patients' and families' autonomy by bringing their cultural values and beliefs into the decision-making process.
Anticipate different views on informed consent: Many of the values common to traditional Chinese culture differ from the concept of autonomy that underpins Western bioethics. The Chinese patient may not strongly distinguish his or her wishes from those of the family. For many Chinese Canadians, withholding a diagnosis or controlling negative information may be seen as a way of fostering and maintaining hope in a patient. Identifying and negotiating these differences is therefore crucial to effective health care.	**Anticipate differences in the understanding and meaning of illness:** Because of radically different cultural and historical roots, some Chinese Canadians may hold perspectives on the nature and meaning of illness that differ substantially from a Western biomedical view. Again, it is best to ask about and negotiate these differences when building a treatment plan.

sider the essential qualities of ethical approaches to communication and caregiving involving Chinese patients that are outlined in Table 1.

The case

In the Confucian social hierarchy, the elderly sick person can expect to be cared for by his or her family. The patient is relieved of a large share of personal responsibility, including decision-making, even though he or she may be rational and competent. Furthermore, from a Confucian point of view, which is governed by the rule of filial piety and protection, a parent should not be given the news of a terminal illness; it is considered morally inexcusable to disclose any news that may cause further harm to one's parent.[6–8]

In the face of serious illness, Mr. Y's family, much like many people of non-Western cultures,[9–19] believe that focusing on the negative may be a way of creating negative outcomes. His family has made it clear that hope was central to their concern for their father. All societies seem to recognize "the need for hope," yet each differs in understanding the conditions for hope. In contemporary North American health care, the doctor is often perceived to be someone who works in partnership with the terminally ill patient to maintain the patient's dignity, quality of life, personal choice over treatments, and hope. In Western terms, therefore, hope appears to be upheld through autonomy and active participation in treatment choices and regimens.

However, Mr. Y's family believes that hope is best maintained through the family's absorption of the impact of the illness and diagnosis, and through the family's control of medical information transmitted to Mr. Y. Their wishes reflect a belief in the shared responsibility of the illness with other family members, and an awareness of the potential physical or emotional harm that truth-telling might bring.

The negotiated approach results in asking Mr. Y if he would like to receive medical information and be involved in his treatment planning or, as his son has requested, use the son as decision-maker. Mr. Y indicates the latter preference. A consultation between the physician and the family takes place. The negotiated treatment plan consists of 2 further days of ventilation and then a gradual withdrawal of ventilation, with supportive care and comfort measures given the highest priority.

Competing interests: None declared.

Contributors: Dr. Bowman was the principal author. Dr. Hui contributed a great deal to all aspects of the paper particularly in relation to Chinese philosophy and world view.

References

1. Fox S, Swazey JP. Medical morality is not bioethics — medical ethics. In: *China and the United States*. Chicago (IL): University of Chicago; 1984.
2. Unschuld PU. *Medicine in China*. Berkeley (CA): University of California Press; 1985.
3. Kleinman A, Eisenberg L, Good B. Clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978;88:251-8.
4. Siven N. Traditional medicine. In: *Contemporary China*. Ann Arbor (MI): Center for Chinese Studies, University of Michigan; 1987. p. 94-112.
5. Kleinman A. *Patient and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley (CA): University of California Press; 1980. p. 35-49.
6. Veith I. *The Yellow Emperor's classic of internal medicine*. Berkeley (CA): University of California Press; 1967. p. 23-37.
7. Pang Mei-che S. Protective truthfulness: the Chinese way of safeguarding patients in informed treatment decisions. *J Med Ethics* 1999;25:247-53.
8. Feldman MD, Zhang J, Cummings SR. Chinese and US internists adhere to different ethical standards. *J Gen Intern Med* 1999;14:469-73.
9. Murphy ST, Palmer JM, Azen S, Frank G, Michel V, Blackhall LJ. Ethnicity and advance directives. *J Law Med Ethics* 1996;24:108-17.
10. Yeo G. Ethical considerations in Asian and Pacific Island elders. *Clin Geriatr Med* 1995;11:139-52.
11. Orona CJ, Koenig BA, Davis AJ. Cultural aspects of nondisclosure. *Camb Q Healthc Ethics* 1994;3:338-46.
12. Kaufert JM, O'Neil JD. Biomedical rituals and informed consent: native Canadians and the negotiation of clinical trust. In: Weisz G, editor. *Social science perspectives on medical ethics*. Philadelphia (PA): University of Pennsylvania Press; 1990. p. 41-63.

13. Dalla-Vorgia P, Katsouyanni K, Garanis TN, Touloumi G, Drogari P, Koutselinis A. Attitudes of a Mediterranean population to the truth-telling issue. *J Med Ethics* 1992;18:67-74.
14. Thomsen OØ, Wulff HR, Martin A, Singer PA. What do gastroenterologists in Europe tell cancer patients? *Lancet* 1993;341:473-6.
15. Caralis PV, Davis B, Wright K, Marcial E. The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *J Clin Ethics* 1993;4:155-65.
16. Asai A, Fukuhara S, Lo B. Attitudes of Japanese and Japanese-American physicians towards life-sustaining treatment. *Lancet* 1995;346:356-9.
17. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation: Benefit or harm? *JAMA* 1995;274:826-9.
18. Ip M, Gilligan T, Koenig B, Raffin TA. Ethical decision-making in critical care in Hong Kong. *Crit Care Med* 1998;26:447-51.
19. Feldman MD, Zhang J, Cummings SR. Chinese and U.S. internists adhere to different ethical standards. *J Gen Intern Med* 1999;14:469-73.

Reprint requests to: *Dr. Kerry W. Bowman, University of Toronto Joint Centre for Bioethics, 88 College St., Toronto ON M5G 1L4; kerry.bowman@utoronto.ca*