Chinese seniors’ perspectives on end-of-life decisions

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Abstract

Making end-of-life decisions is a painful and difficult process; one that can be intensified by cultural differences between physicians and their patients. The objective of this study was to examine attitudes of Chinese seniors towards end-of-life decisions. We conducted a qualitative survey in a Chinese community centre in Toronto, Canada. Face-to-face interviews, in Cantonese, were conducted with 40 Chinese seniors 65 years of age or older. Respondents based their end-of-life decision making on the following factors: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the family. Respondents rejected advance directives. Respondents’ attitudes toward end-of-life decision making can be understood through the lens of values from Confucianist, Buddhist and Taoist traditions. Health care workers can best achieve quality end-of-life care — and address the cultural differences that may arise — by focusing primarily on understanding the perspectives of patients and their families, and by continually striving for balanced and open communication at all stages of the caregiving process. © 2001 Elsevier Science Ltd. All rights reserved.

Keywords: End-of-life; Advance directives; Chinese Canadians

Introduction

Making end-of-life decisions is a painful and difficult process; one that can be intensified by cultural differences between physicians and their patients (Kleinman, Eisenberg, & Good, 1978; Kaufert & O’Neil, 1990; Dalla-Vorgia et al., 1992; Thomsen, Wulff, Martin, & Singer, 1993; Caralis, Davis, Wright, & Marcial, 1993; Asai, Fukuhara, & Lo, 1995; Blackhall, Murphy, Frank, Michel, & Azen, 1995; Carrese & Rhodes, 1995; Ip, Gilligan, Koenig, & Raffin, 1998; Hui, Ho, Tsang, Lee, & Woo, 1997; Feldman, Zhang, & Cummings, 1999; Liu et al., 1999). Attitudes about end-of-life decision making may reflect cultural values of a society. Cultures are maps of meaning through which people understand the world and interpret the things around them. When patients and health care workers have different cultural backgrounds, they frequently follow different “maps”, which can hinder effective communication.

The purpose of this study is to describe the attitudes of 40 Chinese seniors towards end-of-life decisions. We focused on the Chinese because of their demographic importance, rich philosophic traditions, and distinction from Western perspectives. We focused on end-of-life decisions because they commonly represent a source of conflict in clinical practice. Because our primary purpose was to understand Chinese perspectives, we followed an approach common in ethnographic research and did not use a Western comparison group.

Chinese culture is not a monolithic entity. Views of individuals and regions are apt to vary. This study does not attempt to generalize about Chinese culture; rather, it is meant to sample a small group of Chinese seniors.
using in-depth qualitative methods, and explore their attitudes toward end-of-life decisions. Western culture is also pluralistic, diverse and complex. We do not attempt to define it, but instead chose to consider respondents’ attitudes in relation to prevailing practices in Western health care, such as the focus on individual choice and the adherence to patient wishes through the use of advance directives.

Although there has been recent research on culture and end-of-life decisions, few of these studies have used qualitative methods. We are aware of three studies on Chinese culture and end-of-life care, and all of these used quantitative methods (Hui et al., 1997; Feldman et al., 1999; Liu et al., 1999).

This study used qualitative methods to provide a rich description of participants’ views about end-of-life decisions. More importantly, it offers direction for health care workers on addressing and overcoming cultural differences in the decision-making process. Specifically, we learn that we can best achieve quality end-of-life care — and address the cultural differences that may arise — by focusing primarily on understanding the perspectives of patients and their families, and by continually striving for balanced and open communication at all stages of the caregiving process.

Methods

Participants

We interviewed a sample of 40 healthy Chinese seniors who were living in or were members of a Chinese community centre in Toronto, Canada, which encompassed both residential, community and day programs. We included people over 65 years of age, born in either Hong Kong or the People’s Republic of China, and fluent in Cantonese. We excluded those who were cognitively impaired or for whom discussions of end-of-life decisions would likely cause emotional distress. Information was collected about participants’ age, gender, education, physical functioning, socioeconomic status, and acculturation (Hlatsky, Boireu, Higgenbotham, et al., 1989; Marin, Sabogal, & Marin, 1987).

We purposefully chose a non-assimilated group of respondents. This was ascertained by using The Marin Acculturation scale, as shown in Table 1. The mean score on the Marin scale places the group in the “low acculturation” category. All respondents had come to Canada between 1975 and 1986. Our goal was to limit the influence of acculturation, since the views of highly acculturated Chinese individuals may more closely approximate the Western health care practices.

Table 1

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<td>Marin acculturation scale</td>
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</table>

*The mean score on the Duke physical function scale places the average respondent in the category, “able to perform all activities of daily living, yet limited in activities requiring great amounts of physical exertion”.

bThe mean score on the Marin acculturation scale places the average respondent in the “low acculturation” category.

Data collection

Interviews were conducted in Cantonese by a fluently bilingual (English–Cantonese) interviewer, and were held with individual participants in their residence or the community centre. The interviewer subsequently listened to the audiotapes and, in a single step, translated and transcribed the interview into English.

A semi-structured interview guide was developed based on previous participant observation, key informant interviews, focus groups, and pilot interviews. The interview guide, which was modified as the interviews progressed, focused on four domains: decisions to forgo
treatment for a capable patient, decisions to forgo treatment for an incapable patient, advance care planning, and advance directive documents. For example, with respect to decisions to forgo treatment (incapable patient), the following scenario was presented (Thomsen et al., 1993):

Imagine a person is in a coma and has no awareness. A life support machine called a ventilator is being used to keep this person alive. It is unlikely that this person will wake up and be him or herself again. Decisions must now be made about whether to continue providing the help of the machine.

Respondents were then asked:

How should these decisions be made? Who should be involved in these decisions? What should the role of the doctor be? What should the role of the family be?

The interview guides are available from the authors on request.

Data analysis

The interviews were audio-taped, transcribed and analyzed using a method called “constant comparisons”, which breaks the textual data down into units of incidents or ideas. These units are then compared with each other, both within each participant’s transcript and across the experience of different participants. The analytic method was characterized by three coding techniques: open coding, axial coding and selective coding (Glaser & Strauss, 1967; Stern & Pyles, 1985). During open coding, the transcripts were read and text segments that related to a theme or idea were identified and given a conceptual label. As concepts accumulated and their descriptions became more detailed, similar concepts were grouped into conceptual categories. During axial coding, the conceptual categories were developed further through describing the comparisons between categories and between transcripts. During selective coding, the conceptual categories were organized according to theoretical significance, and core categories emerged as central themes of the study. Data analysis began after the first interview and continued after all the interviews were completed. To enhance trustworthiness, the interpretation of concepts from Chinese philosophy was checked by a Chinese scholar (Dr. Qui Min Huang, Shanghai Second Medical University, Shanghai, People’s Republic of China). We analyzed the data for possible differences in these views related to gender, but found none.

Sample size

Sample size was determined on the basis of “saturation”: interviews and data analysis were conducted simultaneously and continued until no new concepts emerged during subsequent interviews.

Research ethics

This study was approved by the Committee of the Use of Human Subjects for the University of Toronto.

Results

Participant characteristics are shown in Table 1. Virtually, all respondents said they would not want aggressive life support treatments. Respondents expressed indifference and negativity toward advance directives. The rationale underlying respondents’ attitudes is described in terms of a set of inter-related concepts: hope, suffering and burden, the future, emotional harmony, life cycle, respect for doctors, and the family.

Hope

Respondents perceived a situation to be hopeless when a person was of advanced age, and had completed many life cycle events such as retirement, independence of adult children, and birth of grandchildren. When these factors combined with serious illness and a small chance of useful recovery — and they were accompanied by suffering and burden — the situation was deemed “hopeless.”

Why prolong a person’s life when there is no hope? When a burden has been created?!… If he has accomplished things, he is retired, children are on their own, grandchildren healthy, why should he now suffer?

If a person is so old, then he has finished his tasks…it’s hopeless, he shouldn’t suffer anymore.

It’s different if the patient is young, there is hope if his life is saved, it’s hopeful.

Suffering and burden

Suffering, which was described not only in terms of the patient but also of the family and health care workers, was seen to be a major component of a hopeless situation.
Why should the patient’s life be prolonged if he suffers so much? ... the patient suffers his family feels sad, I think his life shouldn’t be prolonged, definitely.

Not only the patient and family suffers, the different people who work in a hospital must care for these patients who are not recovering.

The nurses and doctors suffer too, they are the ones who must care for patients who are not getting better.

Closely linked to suffering, burden was described not only in relation to the family but also in relation to the health care system, the government, and society.

Faster to “go” the better, I don’t want my children to be burdened by me... the most important thing is that I don’t be burdensome...

When I went to the nursing home to visit relatives, they were like melons... I was shaken, it was so miserable, they stayed in there for so long... it wastes so many resources that could be distributed into the society to do something useful.

Human beings are very sentimental regardless of a patient’s age, even though the chances are slim you hope there will be a miracle, but because of financial reasons even though you are using the country’s resources, it will be too much, it’s worthwhile to consider this.

The future

Respondents felt that the future was pre-ordained and thus beyond human control:

It doesn’t matter whether it [advance care planning] is good or bad... both life and death have their own timing.

I can either complete the form or not complete the form it doesn’t matter. It doesn’t change anything.

Advance directives may be a good thing or may be a bad thing it doesn’t matter to me...it doesn’t affect the future.

Many respondents said that advance care planning was unrealistic, and that one should delay any consideration of possible future decisions until a life threatening illness actually occurs.

You have to look at the real situation. I will manage things at the time when they are real... when I am ill...

I will use an advance directive when I know what my illness is.

You can’t say it’s good or bad... you have to see the whole situation, the real situation.

It was felt that projecting one’s wishes and feelings into a future and hypothetical situation was unrealistic:

To Chinese people the directives are not necessarily true. It’s like doing a will [estate]. No matter how many wills you do, only the last will is real.

You will know how you feel at the time, a healthy person is not capable of knowing how he will feel if he is sick in the future.

You have to look at the real situation, I will manage things at the time when they are real... people have different faces at different times.

Emotional harmony

The maintenance of emotional harmony was a central theme throughout the interviews:

[A person] shouldn’t think of this thing [advance care planning]. As people often say, you should avoid any unpleasant thoughts... you should not talk about any bad things that haven’t happened yet.

I don’t think Chinese people will like to do this [advance directives]. People will avoid topics that make them feel negative.

Older Chinese people are very cautious... they avoid talking about topics which make them feel negative.

A theme related to the need to avoid emotional disharmony was that negative outcomes can result from negative thoughts:

No one does this, it’s not good because when a person is healthy he won’t do this thing... it’s not very lucky, it’s not a good sign.

It is ironic that although this group [Chinese seniors] is near the end of the road, they are more resistant to face this, they may think they will really “go” and wonder what the circumstances will be.

I wouldn’t [discuss advance directives]. ... the discussion would influence my own psychological state, because... even though I am old, I hope I can live longer, I have to be strong and have the will power to live.
Life cycle

The majority of respondents linked age with the completion of life events when considering forgoing treatment:

If a young person is so ill... the many events in life are still waiting for him... older people have completed all this...the treatments are not necessary.

I have finished my responsibilities, even though I don’t want to leave the world, you can’t escape death. I always hold one wish even though it may not come true, this is determined by the “Sky” [the cosmos, or God]. Although I am not afraid of death it is important to “Go” as quickly as possible.

If the patient is old then everyone must realize that they take the same route — birth, aging, sickness and death.

Respondents saw advance directives as having no effect on the inevitable cycle of life:

To raise all my children alone was a major responsibility. Now my children have their families and jobs. I am the only daughter. When my parents died I was responsible to take care of their funeral. I have fulfilled my responsibilities. Why bother to think of so many things? I have passed the most difficult time in my life. I don’t want to set up these responsibilities in my final days. I won’t appoint proxies. I will let my children do as they want...most important to me is that I don’t have Christian funeral arrangements. I want Buddhist.

When I was younger I always said I would be satisfied if I could reach fifty, my youngest daughter would be twenty when I would be fifty. I can’t believe I am in my eighties now. I have completed all my responsibilities, what is most important is I must die, I wish I could “Go” as fast as possible, without pain.

We must all follow the same course — birth, ageing, illness and death.

Respect for doctors

Respondents felt that the doctor, in consultation with families, should decide whether or not to forgo treatment. Doctors were considered to possess special knowledge and expertise, and they were deemed highly capable, principled, and bound to patients through a moral duty.

It’s good for doctors to discuss with family but they are the ones who must decide ... doctors have knowledge and experience ... they can make decisions for society.

It’s not a good way to let them (children) make decisions, you have to rely on doctors, children are not doctors...it’s better if the children and the doctors can discuss together.

I believe doctors are moralistic, they have good education and many experiences.

Many respondents viewed medical decision making as having a right or wrong answer that was independent of the value a patient might place on the potential outcome of a treatment. Many respondents also perceived doctors’ opinions as absolute. For example,

His wishes [patient with an advance directive] should not be carried out if they are wrong...in this case the doctor should decide.

Even though you give the patient a scenario, the patient doesn’t understand [medically] what if the patient’s opinions are different from the doctor’s? This will be a great impediment.

The patient may not be clear on his own medical condition, moreover he is the patient not the doctor.

The family

Some respondents expressed concern that children may feel they have to advocate for aggressive treatment out of a sense of duty:

The children don’t dare to decide not to save their parent’s life, they will feel uneasy.

Younger people are under so much pressure, so much pressure, they don’t want the older people to die but it’s hopeless.

Children want their parents to live one more day if possible...but it’s an irrational sentiment, rationally I think it’s not right, the longer you look at a hopeless situation the more painful it will be to you, there is a lot of emotional ambivalence in these situations you have to be rational when you make decisions.

Respondents expressed faith in their children’s ability to make decisions on their behalf if they themselves were incapable.

Why do I have to get into trouble with this? Children will look after me even though I don’t have an
advocate directive...that’s what I have to say. You ask me and I say I won’t use it.

But I believe my children will know what to do if I am sick, it doesn’t matter whether I have an advance directive or not. They know my personality for many years.

From their hearts the children will do whatever they think best when the situation really occurs, I don’t mind.

Although virtually all respondents expressed the feeling that family was central to decision making, the majority felt that the identification of a formal proxy was not especially useful because a proxy lacked medical knowledge, and family conflict could follow an attempt on the part of a proxy either to limit or disregard the opinions of other family members. Respondents saw consensus amongst children as an important condition for decision making.

Other people will follow the decisions of the proxy, they won’t say anything because they know their opinions will be useless, this is a disadvantage.

If the daughter is your proxy, the son may refuse to give any opinions even if she asks him.

I have several children, other children may feel they are not as important if I just indicate one of them to be my proxy, it’s quite difficult...

Children have to ask doctors...why would I need doctors if children could save my life?

She may fear whether her older brother or younger brother agree with her or not. They must discuss together.

Discussion

Respondents’ attitudes towards end-of-life decisions emerged from a cluster of inter-related concepts: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the family. In this section, we show how these attitudes can be understood through the lens of values from Confucianist Taoist, Buddhist and traditions, and trace the implications for practice. We do not claim that these cultural values caused the attitudes we observed. Rather, we aim to demonstrate that the observed attitudes are understandable through the lens of these cultural values.

Understanding end-of-life views rooted in Chinese culture

Hope

In Chinese culture, the maintenance of hope is considered very important in the care of the dying, as hope creates a positive attitude and prevents suffering by avoiding despair. However, when old age and serious, irreversible illness intersect, respondents perceived the situation as hopeless. At this point, alleviating suffering — rather than prolonging life — becomes the primary concern.

Suffering and burden

According to Buddhist thought, whenever one person causes suffering in another, the principle of compassion is violated (Holck, 1974). This violation begets a cycle of negativity and suffering in a future incarnation of the person who caused the original harm (Gunaratne, 1966). The emphasis that respondents placed on burden may derive from the Buddhist value of justice, which would require that, in end-of-life decision making, a family’s or a community’s resources be taken into account (Hannayama, 1969; Rahaula, 1974). A person who decides to forego life-sustaining treatment because of the emotional or financial burdens that his illness incurs would be performing a compassionate act.

The future

While planning for the future in some respects is valued in Chinese culture, many major life events are considered unpredictable and uncontrollable (Qui, 1987). Although Chinese cosmology allows that an individual is not helpless, and is expected to try to ‘improve the odds’ as much as possible, the final outcome of a situation is still considered to be shaped by destiny (Ikels, 1980). In Chinese culture, moral reasoning is based on context (Pu, 1991), and moral perspective comes from examining the nature of a situation in relation to who the people are in the situation, and what kind of relationship is appropriate. Buddhist thought places emphasis on the transitive and impermanent aspects of life (Conze, 1959). Present perspectives and feelings are in a continuous state of transition, and not likely to hold their significance in any future situation (Tung, 1990).

Emotional harmony

Many respondents felt that advance care planning disturbs emotional balance by focusing on negative, rather than positive, thoughts. Both Confucian and Taoist philosophy emphasise the importance of maintaining physical, emotional, and social harmony by way of protecting health, community, and social relationships (Unschuld, 1978). A central focus of Buddhist teaching is the attainment and maintenance of a clear, calm, state of mind, a state in which one is undisturbed
by worldly events (Wang & Wu, 1973). Direct references to death are considered to be a bad omen (Hall, 1976).

**Life cycle**

The concept of life cycle is based on the Buddhist belief that once a person has entered the cycle of life, aging, illness, and death are inevitable (Hanayama, 1969); the Taoist belief in passivity, and acceptance of a natural order that allows things ‘to be’ (Fingarette, 1972); and the Confucian belief in the endless cycle of life and death in which the living are always connected to their deceased ancestors (Louie, 1985). One aspect of a “good death” in Chinese culture is when a person has completed his contribution to society through obligations such as work and family, and children are married and self-sufficient (Lee, 1991).

**Respect for doctors**

Chinese tradition values a benevolent form of medical paternalism (Tung, 1990). According to Confucian perspectives, the core of the fiduciary relationship between physicians and patients is the trustworthiness of the physician (Qui, 1991). For example, one medieval Chinese physician describes his relationship with his patients in the following way: “Medicine is applied humanness. To see other people suffer rouses compassion and pity within myself. When the ailing themselves cannot make any decisions, I will make them in their place (Takenaka, 1988).”

**The family**

The role of the family in Chinese culture emphasizes interdependence (Lee, 1991), obligations and responsibilities to others, and the common good (Fu-Chang, 1999; Berger, 1998). Respondents expressed concern that their children might decide for aggressive treatment out of a sense of respect and duty, engendered by filial piety. Confucianism regards hsiao (filial piety) as one of the key values necessary to maintaining social stability (Unschuld, 1978), and children are seen to have a duty to assist parents and other family members in protecting their health, safety and general well being, so they may reach an advanced age. According to a traditional Confucian interpretation, a child who agrees to a parent’s refusal of treatment would be violating the principle of filial piety (Unschuld, 1978). Another aspect of interdependence in Chinese culture is that of inter-generational responsibility. In the early years of the parent–child relationship, parents are the providers of care, but later, the parents are likely to be the recipients of their children’s care (Kleinman, 1980). Consistent with these cultural norms, the majority of respondents believed that their adult children, who best understood their wishes, would be the most appropriate decision makers. Furthermore, in Chinese culture, the individual is considered an integral part of the family, and the family, in turn, is seen as an entity that exists before one was born, and shall continue to exist after one has died. Thus, the accomplishments and choices of individuals are not theirs alone, but belong to the family. In a culture that values the interdependence of family members to such a great extent, it could reasonably be assumed that a proxy format of advance care planning would be seen as desirable. Many respondents, however, perceived the naming of a proxy as creating an obstacle to the collective decision-making process, as it would necessarily limit the influence of those not named. It appears that proxy decision making is too circumscribed a method of family decision making for respondents.

**Implications for practice**

**Advance directives rejected**

Our initial objective was to develop a culturally appropriate advance directive document, but this proved to be a fruitless endeavour. Advance directives, as traditionally conceived, were met with indifference and negativity by the majority of respondents, many of whom felt it was impossible, unnecessary, and even unwise, to predict and anticipate future hypothetical situations. Although Chinese culture places great value on the interdependence of family members, the proxy decision-making feature of the advance directive document was not generally valued, largely because to identify a proxy (or proxies) was seen to limit the opinions of family members not so named, and thereby impede collective family decision making. Advance care planning in the absence of an actual illness seemed to create a hypothetical scenario that was at once too abstract, and too circumscribed for many respondents. However, many respondents acknowledged that they would consider advance care planning if they were facing a serious illness at some time in the future. Thus, it would seem to follow that the onset of a clearly identified illness, when patients are still capable, is probably the best time for health care workers to assess the interest of patients and their families in advance care planning. Given the serious reservations expressed by the respondents on the subject of proxies, it is probably advisable that the entire family is involved in advance care planning. Such an approach would be more consistent with collective decision making at the time of illness. New, family-centred models of advance care planning (Singer et al., 1998; Martin, Thiel, & Singer, 1999) may find greater resonance cross-culturally. It must be recognized, however, that in any culture a polarization of attitudes within a family can and does occur. In this event, emotional support and family mediation skills are required.
Limitations of autonomy

In the practice of Western health care, autonomy reflects a belief in the importance, uniqueness, dignity and sovereignty of each person, and the sanctity of each individual life. Accordingly, every person is entitled to self-determination. Adhering to such beliefs, health care teams may assume that the patient is always the best person to make health care decisions. This stands in contrast to non-Western cultures in which greater social interdependence, which overrides self-determination (Harwood, 1981; Hahn & Kleinman, 1983; Gaines, 1979). Consequently, many non-Western cultures vest in the family or community the right to receive and disclose information, to make decisions and to organize patient care (Barker, 1992). These differences in perspective, when unacknowledged, can lead to a complete breakdown in communication. Applying the notion of autonomy cross-culturally may therefore warrant accepting 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.

Approach to culture

We do not aim to stereotype Chinese patients based on the values we identify here. Rather, we hope to sensitize physicians to the importance of understanding the values of patients from different cultures. When working cross-culturally, the first step is to understand the perspective of the patient and family, especially their treatment goals (Jecker, Carrese, & Pearlman, 1995). The next step is to identify a treatment plan that is acceptable both to the patient and family, and to the health care team. The most effective way to address cultural difference is through open and balanced communication. The clinical situation is perhaps best conceptualized as a negotiation. When health care workers are unsure of how a patient or family perceive a situation, it is best to simply ask. The mere acknowledgement of such differences frequently leads to improved communication. Cross-cultural interpreters can help the health care team (Kaufert & Putsch, 1997). Some things worth considering in cross-cultural interactions are: Do patients value individuality and personal choice or, do they focus more on family and collective choices? Do they value open communication or do they tend to draw cues from the context of the situation? Do they believe a person can and should influence their health? Do they believe in a Western biomedical view of illness or do they hold an alternative, or blended view of illness? Models for the cross-cultural clinical encounter have been developed (Carillo, Green, Betancourt, 1999).

Limitations of the study

This study has several limitations. First, some might argue that the attitudes we describe could easily have come from “Western” respondents. We agree. In accordance with usual practice in ethnographic research, we did not include a “Western” comparison group. Nor are we particularly interested in contrasting the views of our respondents with “Western” attitudes. Our goal is simply to describe in depth the attitudes of a small sample of Chinese seniors, show that these attitudes are understandable through the lens of Chinese cultural values, and trace the implications for practice. Whether the description overlaps with attitudes one might expect to elicit from “Western” respondents, or the analysis sheds light on “Western” attitudes, is not central to our work but may offer insights for future research.

Second, one might rightly question whether there is such a thing as “Western” or “Chinese” culture. We agree. It would be a mistake to treat cultures as homogenous blocks of different values. We do not claim there is a monolithic Chinese culture, but rather analyse the attitudes we observed through the lens of particular cultural values from Confucianist, Buddhist, and Taoist traditions. In relation to “Western” culture, we do not even use the term. Rather, where necessary, we refer to Western health care practices. As noted above, we are not interested in comparing the attitudes from Chinese seniors with an imagined set of “Western” attitudes.

Third, some might question the relationship between cultural values and attitudes. We do not claim that the Confucianist, Buddhist, or Taoist values we describe caused the respondents to express the attitudes we observed. Rather, our claim is that the observed attitudes can be understood through the lens of these cultural values.

Fourth, some might argue that the attitudes expressed reflect the experience of respondents in Canada. We cannot exclude that encounters with the Canadian health care system have shaped to some degree the attitudes of respondents. However, we purposefully chose a non-assimilated group of respondents to minimize this effect. The mean score of respondents on the Marin acculturation scale (see Table 1), which places the group in the “low acculturation” category, shows that we were successful.

Finally, some might argue that the attitudes of 40 Chinese seniors in a Canadian long-term care facility do not represent Chinese culture generally. We agree. The sample size is small by quantitative standards but large for a qualitative study. As in all qualitative research, it is difficult to generalize the findings beyond our respondent group. Our goal was not to make generalizable statements about Chinese culture but rather to describe attitudes in depth so that we might analyze them through the lens of Chinese cultural values.
Conclusion

Quality end-of-life care necessitates understanding and addressing cultural differences between physicians and their patients. Respondents based their end-of-life decision making on the following factors: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the family. These attitudes can be understood through the lens of cultural values from Confucianist, Buddhist and Taoist traditions. A key finding was that they are not favourably disposed to advance directives. Health care workers should be aware that many of the assumptions implicit in an autonomy-based approach to decision making may not be shared by Chinese seniors and their families. The best way to address cultural differences is therefore to foster open and balanced communication in the process of making end-of-life decisions. This can be as simple as asking questions of patients and their families, and making a concerted effort to understand the patient’s perspective on a variety of issues. Only then can end-of-life care reach the quality that all patients deserve.

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