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# ASIAN AND PACIFIC ISLANDER CULTURAL VALUES:

## *Considerations for Health Care Decision Making*

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*As the United States becomes more ethnically diverse, health care practitioners must learn about the perspectives and values of a variety of cultural groups. Of interest is how these cultural values intersect with those of the dominant culture, especially in the health care arena. This article explores the values that influence decision making among Asian and Pacific Islander cultures, with specific illustrations from six of these cultures. The literature, along with our observations as health professionals and researchers working in Hawaii, suggest potential areas of conflict between the more collectivist values of Asian and Pacific Islander cultures and the more individualist orientation of the U.S. health care system. Implications for practice and research are presented.*

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### Key words

advance directives  
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By the end of the century, almost 30 percent of U.S. residents will be people of color, that is, non-Caucasian; by the year 2050, this proportion is expected to reach almost 50 percent (Day, 1996). This high level of diversity is surpassed in Hawaii, where 71 percent of the population is of Asian or Pacific Islander ancestry, and only 27 percent of the population is white (Yatabe, Koseki, & Braun, 1996). However, the medical standards of today's health care system on the basis of Western values promulgated through such organizations as the Joint Commission for the Accreditation of Healthcare Organizations, the American Medical Association (AMA), and the American Hospital Association (AHA). Conflicts that reach hospital ethics committees are resolved based on a Western model of ethics that includes four principles: autonomy, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 1983). This article looks primarily at the principle of autonomy and the health care conflicts that can arise when it is applied to cultures that are more collectivist than individualist (Barker, 1994). In further exploration of these issues, this article discusses the individualist value base that supports current U.S. health care policies; discusses collectivist decision-making norms, with examples from six Asian and Pacific Islander cultures; discusses specific problems in health care when culture and policy clash; and presents implications for practice and research.

### HEALTH CARE DECISION MAKING IN THE UNITED STATES

It may surprise many Americans that before 1960, health care decision-making practices in the United States were often paternalistic (Novack et al., 1979). Deference to doctors' health care decisions was commonplace, although there are reports that patients were uncomfortable with their sole dependence on physicians to disclose their true diagnosis (Edge & Groves, 1994). Even when informed consent became an ethical obligation in 1957 (as articulated in the *Code of Ethics* of the AMA and the AHA), physicians were still resistant to telling patients



about serious illness, especially if the prognosis was terminal (Feifel, 1990; Novack et al., 1979). For example, Oken (1961) found that only 12 percent of physicians surveyed in 1960 said they would tell patients of a diagnosis of incurable cancer.

Originating in the consumerism movement of the 1960s and 1970s was the increased demand for the right of autonomous health care decision making in the United States. Advances in medical technology resulted in increased treatment options that provided consumers with more choices (Edge & Groves, 1994). To help judge whether they were receiving the best course of treatment, many people demanded more knowledge about their diagnosed condition, the treatment options, and the benefits and risks associated with each option. With increased discretionary spending ability, some people also exercised this demand through their pocketbooks, preferring to buy services from professionals who provided more information and options. In other cases, people sued their physicians for withholding information or not allowing patients to choose their course of treatment (Edge & Groves, 1994). It was not until 1973 that the Patient's Bill of Rights was passed; it elevated patient self-determination from an ethical concern to a legal obligation for physicians (Edge & Groves, 1994; Foster & Pearman, 1978; Hattori et al., 1991). A big change in practice resulted, as evidenced by a 1977 follow up to Oken's (1961) study. Of the physicians surveyed in 1977, 97 percent said that they would tell patients their true diagnosis, even if the prognosis was terminal (Novack et al., 1979). The Patient Self-Determination Act (PSDA) of 1990 (P.L. 101-508) furthered the individual's right to self-determination in health care decision making by requiring that health care institutions follow patient preferences for medical treatment as outlined in advance directives.

According to researchers Ewalt and Mokuau (1995), self-determination is regarded by Americans as freedom from group expectations, and self-reliance is regarded as a sign of strength. It is not surprising then, that the United States would develop moral and legal mandates for physicians to follow on the basis of individualist expectations, such as the Patient's Bill of Rights and the PSDA. In effect, individualist health care decision making in the United States is the result of dissatisfaction with medical paternalism, and the value implicit in the right to self-determination has become embedded in American health care policy.

## TWO INDIVIDUALIST HEALTH CARE CONCEPTS

### Informed Consent

Two health care concepts that specifically reflect this individualist value base are medical informed consent and advance directives. The medical informed consent process requires physicians to communicate to patients their diagnosis, prognosis, and alternatives for treatment. Information must be communicated in a way that patients can understand, even if it requires the use of an interpreter. Patients must then make a decision about how to proceed with treatment. From a legal perspective, informed consent can be viewed as a mechanism for adjusting a historically uneven relationship, with a shift in authority from physician to patient (Cotsonas, 1991).

### Advance Directives

How does the right to self-determination work for people who are no longer able to make decisions for themselves? Advance directives allow individuals to influence their course of treatment when incapacitated and unable to express their wishes directly (DeSpelder & Strickland, 1996). The two most common types of advance directives are the living will and the durable power of attorney for health care decisions. A *living will* is a document in which an individual states the kinds of medical treatment he or she wants or does not want in case of disability so severe that the individual cannot communicate his or her desires. The *durable power of attorney for health care decisions* is a written document in which an individual designates another person to make crucial health care decisions in the event of incapacitation. According to the PSDA, health care providers who receive federal Medicare funds must ask patients if they have an advance directive and if the patient does, must request a copy for the medical record or, if the patient does not, must offer the patient information about advance directives and how they can be completed (Miles, Koeppe, & Weber, 1996).

## COLLECTIVE DECISION MAKING IN ASIAN AND PACIFIC ISLANDER CULTURES

When discussing Asian and Pacific Islander (API) Americans, it is important to remember that this label encompasses over 30 distinct cultural and linguistic groups (Tanjasi, Wallace, & Shibata, 1995). The largest Asian American groups are Japanese, Chinese, Filipino, Korean, and East Indian, and the



largest Pacific Islander groups are Native Hawaiian, Samoan, Guamanian, and Micronesian (Zane, Takeuchi, & Young, 1994). Although each group has its own language, culture, and history in the United States, there is a growing literature that suggests that the API cultures are more collectivist than individualist (that is, these cultures tend to downplay the goals of individuals in favor of those of the group) (Hattori et al., 1991; Hofstede, 1980; Kitano & Kimura, 1980; Long & Long, 1982). A number of concepts emerge in the literature that are relevant to understanding decision making in collectivist societies.

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#### **Shared or Deferred Decision Making within Families**

In collectivist societies, many decisions are not made by individuals, but by families and groups, presumably with the larger good in mind; for example, in focus groups in Hawaii, physicians said they modified their approach to families on the basis of their understanding of cultural decision-making norms. Unlike the custom among white people, for whom the individual patient is the decision maker, many Japanese and Chinese families assign decision-making duties to the eldest son. In Pacific Islander families, it may be less obvious who the decision maker is. A member may be designated as decision maker, and others are assigned to other duties (for example, bringing food, telling stories, and running errands). Regardless of role, all family members customarily receive the same level of detail about the patient's diagnosis, prognosis, and treatment options (Braun, Mokuau, & Tsark, 1997).

#### **Filial Piety**

Filial piety refers to the obligation of family members to care for each other, with a particular obligation for the younger generation to care for the older generation and family ancestors. Thus, children must ensure that parents are well cared for in old age, and the family feels great shame if they

cannot. In a health care context, decisions about placing an elderly patient in a nursing home, for example, may be somewhat simplified by the cultural norm to keep the elderly relative at home (Long & Long, 1982). On the other hand, it can cause conflict in families that are unable to arrange schedules, finances, and assistance to provide home-based care. This value may also result in a reluctance to tell an older family member his or her true diagnosis and prognosis, as the younger person has an obligation to protect the older person from upsetting news (Tamura, 1994).

#### **Silent Communication**

A collectivist style of silent communication relies on an implied understanding between people of that culture. Because of cultural norms, implicit concerns are not allowed to be expressed verbally. For example, it would be improper for a son or daughter to discuss issues of death and dying with parents, yet concern by either party may be expressed by nonverbal cues such as bowing of the head or eye contact. When dealing with Western health care workers, implicit understandings are not overtly stated. Unless the health care provider understands the culture so well that he or she can address the unspoken, this valuable information is lost and can lead to a misunderstanding about family-patient dynamics and agreement with the plan of care (Marsella, 1993).

#### **Preservation of Harmony**

The concept of preservation of harmony affects health care decision making in several ways. People from collectivist societies may be less willing to share bad news within the group, because it may disrupt the harmony of the group. They may also be less likely to question the decisions made by the family, feeling that the decision was made for the overall good of the family. As revealed in Honolulu-based focus groups, families may also be less inclined to question decisions made by health care professionals who have the harmony of the health system to maintain. Finally, they may be more likely to endure hardship and pain, and they are more likely to keep their wishes silent, especially if they believe their true desires would inconvenience another person or disturb the group (Saldivo, Kakai, & McLaughlin, 1997).

#### **Health Care: Delayed Access but Great Respect**

Societies with a high reliance on their own social group or community for care may delay their use



of Western medicine, especially preventive services. Rather there is an expectation that minor ailments will be cared for within the family or social unit, and Western medicine will be used only if emergency care is needed. Once inside the health care system, however, those from collectivist cultures may abdicate decision making to the physician, who is seen as a wise and benevolent authority figure. This approach to decision making does not allow for individual choice in medical care. Instead, physicians are expected to make decisions that are in the best interest of the greatest number of people involved with the patient. The physician also serves as a buffer so that individual family members are not at risk of being blamed for poor decisions (Feldman, 1985).

### **SPECIFIC CULTURAL NORMS**

#### **Japanese**

In Japan the concept "amae" refers to four principles that guide decision making in traditional Japanese families: (1) collective family interests take priority over the interests of individuals; (2) harmony must be preserved; (3) the family is responsible for caring for its elders; and (4) family members are interdependent (Hattori et al., 1991). Caring for parents must be done with feelings of deep gratitude and happiness that the children are able to return the caring that they had been provided by their parents. Not acting accordingly brings great shame to the family name (Takamura, 1991). In terms of help seeking, there is an expectation that all help would be provided from within the family and there would be resistance to obligating oneself to an outside provider of help (Fujita, Ito, Abe, & Takeuchi, 1991).

In the traditional culture, Japanese people attach stigma to emotional and mental problems, which are attributed to genetics, punishment for past behavior (karma), or poor guidance from the family unit (Shon & Ja, 1982). Such problems are often denied and the affected family member hidden. Talking to an outsider would make the person stand out even more and would cause the family to "lose face." Once in the health care system, however physicians' decisions are respected, and lawsuits for wrongful health care decisions are extremely rare in Japan (Long & Long, 1982).

An analysis of the Japanese saying "born Shinto, die Buddhist," exemplifies a way in which the effect of religion influences collectivist decision making. The significance of this phrase is that Shinto believe in life and light, and consider mention of

death taboo (Freund & Ikeuchi, 1996). Therefore, Shintoism does not deal with death and dying, and its followers believe that even speaking words related to terminal illness can cause *kegare*, which translates as contamination or spiritual pollution (Long & Long, 1982). Buddhism, on the other hand, regards death as a natural life process, and Buddhists believe that the soul continues beyond death (Braun & Nichols, 1997). Thus, many traditional Japanese turn to Buddhism in later life. The continuation of life after death comes in the form of rebirth, determined by good or bad karma accrued during life. These two beliefs, *kegare* and karma, allow for an interpretation of health care issues that is often contrary to Western medicine. First, *kegare* creates a situation in which it is not advisable to discuss terminal illness, death, or dying. This precept conflicts with informed consent procedures in the United States that mandate that diagnosis and prognosis be discussed by patient and physician. Second, the idea of karma adds to the collectivist concept of continuation of life after death, implying that present actions will affect what happens to the individual in another lifetime. Therefore, it is prudent to make decisions that serve society. For example, a person may decide to take care of elderly or sick individuals, believing that he or she will be well cared for when needed. Or one might decide to take an action that would relieve one's family or society of a burden. The idea of making a decision on the basis of personal desires may seem unnecessary or unethical to traditional Japanese people.

#### **Chinese**

Based on centuries of Confucian thought and an agrarian lifestyle, traditional Chinese beliefs center around the harmony, unity, and survival of the family. Hierarchical family relationships take priority over spousal relationships and friendships; family members have prescribed roles according to gender, age, and birth order; for example, women are subordinate to men, children obey and care for their parents without question or resentment, and the first-born son has the greatest authority and responsibility. Elder care usually is provided by the wife of the first-born son, but all children are expected to "repay parental sacrifice via filial piety" (Huang, 1991, p. 84) (see also, Char, Tseng, Lum, & Hsu, 1980).

Specific to decision making, elders must be treated with respect, which may result in protecting them from bad news about diagnosis and



prognosis, as well as reluctance to place them in a nursing home. The concept of karma is also important in the Chinese culture and affects views of death, dying, and decision making. For example, many traditional Chinese people feel that it is bad luck to talk about illness or death because talking about it can cause it to happen. An early death is often interpreted as punishment for bad deeds performed in this lifetime or in a past lifetime (Braun & Nichols, 1997).

Traditional Chinese people believe that spirits and fate influence health, as well as self-control. Thus, moderation is a common practice to avoid the excesses that cause illness, including moderation in eating and drinking and suppression of strong negative feelings like anger and expressions of pain (Lasky & Martz, 1993). The traditional culture also believes that personal mistakes or outcries can reflect badly on the entire family and cause shame. Thus, traditional Chinese families may keep private concerns within the family, rather than talking about them with outsiders (Lin, 1985; Ryan, 1985). Instead, they might rely on more passive forms of coping, such as keeping busy, looking the other way, and not thinking too much (Huang, 1991). They may also treat themselves and family members with herbs and other Chinese approaches to healing (Char et al., 1980). Barker (1994) found that some Chinese patients have been labeled "noncompliant" as a result. Although use of traditional remedies does not specifically represent a collectivist means of decision making, it does affect Chinese willingness to make use of Western health care. If traditional Chinese people are not using Western health care, they will be less knowledgeable of policies designed to enhance individual rights in these settings. However, once in the health care system, physicians are seen as authority figures, and traditional Chinese families are likely to defer to the physician about treatment recommendations.

### **Vietnamese**

The Vietnamese have been influenced by several sets of religious beliefs that reflect on end of life and health care decision making. With strong emphasis on Buddhism, the concept of karma can lead to fatalistic attitudes toward illness and death (Lasky & Martz, 1993). Among Vietnamese in Hawaii, there is a notion that karma determines longevity (Braun & Nichols, 1997). Thus, there is little sense in completing advance directives as they imply that the individual can have control over his

or her life span. Family unity and filial piety are also important, requiring that children care for their elders and ancestors who, in turn, watch over the family. These notions work in tandem; as interviews in Hawaii suggested, when children take good care of the parents, both parents and children will be reborn at a higher level in the next lifetime (Braun & Nichols, 1997).

Taoism is also a prevalent religion among Vietnamese (and Chinese) people. This philosophy stresses that when things are permitted to assume their natural course, they move toward perfection and harmony (Hoang, 1985). To facilitate harmony, Vietnamese will frequently use traditional healing medicines, either before seeking Western medicine, or while being treated by physicians. Like the Chinese, the Vietnamese are hesitant to allow any procedure that cuts the flesh because of a fear of disrupting harmony (Nguyen, 1985). They may also be reluctant to say "no" to a physician or health care worker because this would be disrespectful and may also create disharmony (Nguyen, 1985). However, Nguyen found that Vietnamese families want to be involved in major decisions concerning the health care of an individual family member, which is in line with a collectivist culture.

### **Filipino**

Although there are limited studies available on Filipino decision making about health care, filial piety is clearly an influence. Barker (1994) cited an example of an elderly Filipino man who had inoperable cancer. The hospital staff wanted to make a referral to hospice. Although the daughter concurred, she insisted that the doctor tell the patient that it was the hospital's decision to have her father admitted to a hospice rather than her decision. The shame experienced by the daughter in needing help to care for the father was more than she could bear.

Many in the traditional Filipino culture believe that illness is caused by an imbalance in spirit or morals. Baysa, Cabrera, Camilon, and Torres (1980) found that many Filipinos believe that most people get what they deserve and that if people behave badly, bad things will happen to them. Filipinos may delay seeking treatment and attempt to care for themselves until there are signs of bleeding or extreme weight loss and then present at a hospital emergency room as a last resort. Filipinos are similar to the Chinese and Vietnamese in that they believe invasive medical procedures that puncture the skin can cause "bad things" to happen to the body.



Filipinos expect family members to care for them in the event of illness, and within the family, it is quite common to freely express pain and suffering (Frank-Stromborg & Olsen, 1993). However, Filipinos are hesitant to express signs of suffering in front of strangers or to discuss emotions with health care workers (Baysa et al., 1980). They also may avoid seeking help because they do not want to be a burden. Once health care is obtained, Filipinos tend to be compliant because of deference toward physicians. The exception is cases in which the patient or family do not understand what is being said but are reluctant to ask for clarification. Our personal experience working with members of this group in Honolulu suggests that patients may not be compliant if a health care worker disregards other family member's opinions.

### **Hawaiian**

In traditional Hawaiian culture, there was a tendency to accept medical conditions and adjust to unpleasant symptomatology without complaint. This is, in part, a result of the fact that traditionally health practices were integrated with daily religious and social practices and emphasized the spiritual unity of the individual with the environment. Added to this is a Hawaiian view of Western medicine as autocratic and in conflict with their culture's more holistic approach (Braun et al., 1997; Frank-Stromborg & Olsen, 1993). Given these traditions, it is not surprising that Hawaiians may avoid Western medical services or use them only when experiencing severe conditions or advanced stages of illness (Native Hawaiian Health Research Consortium, 1985).

Families provide care for sick or disabled members, and this caregiving is regarded with spiritual significance and importance (Braun et al., 1997). This practice may lead to a seeming lack of concern about performing preventive health behaviors; Hawaiians know that their families will care for them and that there is significant value attached to this caregiving. Hawaiians also may not feel a need to plan for future functional incapacitation by completing personal advance directives. One of the best examples of collectivism in Hawaiian culture is a frequently used term, *kokua*, defined as mutual support and interdependence (Braun et al., 1997). Implied in *kokua* is a collectivist belief that family members are expected to anticipate each other's needs and help each other without being asked.

Hawaiians also believe in a continuation between this life and the next (Nichols & Braun,

1996). People in this life are expected to have cared for those who have died, and those who have died watch over the currently living. In hospice, Hawaiian patients are calmed by the notion that spirits of the dead are present to help them move to the other world when it is time. Again, a collectivist theme emerges. If an individual adheres to this belief, he or she is less likely to use medical care or to assert individual desires about health care. Rather, the person is apt to take the path that will result in the greatest harmony with family members (living and dead), society, and nature.

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### **Samoan**

According to Markoff and Bond (1980), who studied Samoans residing in Hawaii, traditional social structure in Samoan society is hierarchical, yet collectivist. The extended family is responsible for mutual support, and communities care for their members. As in the Hawaiian culture, a specific decision maker may be designated; for example, the first author was working with a Samoan patient in hospice who was the widow of a former chief. All questions about treatment had to be presented to a designated person within the extended family, who then discussed them privately with the patient's sons. Once a decision was made, this decision maker relayed it to the social worker. Although this arrangement was time consuming and led to delays in treatment, the family insisted on it. For major decisions, the chief may be asked to listen to the case and make a judgment.

Gaining access to Western medical care appears to be problematic for Samoans living in Hawaii. Not only is it expected that injured or ill family members will be cared for at home, but also there appears to be a mistrust of Western medical care (Fiatoa & Palafox, 1980). The exception is when a loved one is in need of emergency care, at which time Western health care is sought. Western health care workers, with their emphasis on prevention, often have difficulty coping effectively with Samoans in a health care setting because of what they



may perceive as a lack of regard for preventive health care. However, Samoans tend to regard the authority of a doctor with great respect and do not want their doctor to waiver on treatment decisions. Traditional Samoans also do not want to be asked what their preferences for health care might be (Fiatoa & Palafox, 1980). They want their physician to be directive, and if trust is established, compliance will follow. Young female physicians may have the most difficult time in establishing trust and achieving compliance with Samoan patients, because of paternalistic views of the physician-patient relationship.

### **CONFLICTS WITH U.S. HEALTH CARE POLICIES**

Because of cultural differences in decision making, conflict or misunderstanding can result when non-Western patients are asked to make independent health care decisions. In many cases, the patient's dilemma goes unnoticed by health care workers, and the patient who has difficulty making independent decisions is labeled as "noncompliant."

#### **Medical Informed Consent**

An aspect of collectivist cultures is to maintain harmony and further the goals of the group; therefore, it is not difficult to envision cases in which patients may sign documents because they feel it is expected by the doctor or family members. It is also easy to understand that these patients would be uncomfortable telling their physician what they want to have done medically. A study in Hawaii that investigated problems with obtaining informed consent from elderly Japanese oncology patients illustrates these problems. Preliminary findings suggest that these patients have internal conflicts about signing consents but that the health care workers are largely unaware that their Japanese elderly patients are in conflict. The hesitancy in signing the consent form results in treatment delays, but the delays are not attributed to value conflicts. Rather, health care workers attribute delays to the patient being elderly or noncompliant or having a language barrier (Saldov et al., 1997).

Another difficult culturally based problem is that of disclosure of the true diagnosis to the patient, particularly if the diagnosis is terminal (Blackhall, Murphy, Frank, Michel, & Azen, 1995). In many API traditions, a terminal diagnosis is withheld. Reasons for this may be that the family does not want the patient to become disheartened and give up on living, that the family feels it is dis-

respectful to speak of such things to an elder, or that talking about death is "polluting" or will cause bad luck. Family members, however, are generally told of the terminal diagnosis by the physician. If the patient is aware of his or her fate, the patient does not let family members know it. Therefore, medical informed consent practice, which is required in the United States, poses ethical dilemmas for physicians when family members ask them not to disclose the true diagnosis to the patient. How can the physician obtain consent to proceed with treatment if the patient is not told his or her true diagnosis and treatment options? To insist that the patient be told, however, causes conflict within the family and between patient and family.

#### **Advance Directives**

Advance directives are another area where conflict often occurs between Asian and Pacific Islander and Western cultures. Health care facilities are required by law to approach patients for copies of advance directives. However, it is well documented in the literature on traditional Hawaiian, Chinese, and Japanese cultures that if you talk about death, you may bring on death or, at least, spiritual pollution. It may also seem pointless to have written instructions about what to do after death because, in collectivist cultures, decisions about property and funeral services are already known within families (Nichols & Braun, 1996).

A Buddhist belief in fate and karma also adds to the dilemma for some API patients. If a patient adheres to a belief that illness and death can occur because of the way in which he or she has lived (either in this life or a past life), then there is little to be gained from trying to interfere with the course life and death may take. If patients and family members from collectivist cultures do not see a need for asserting health care directives in advance of incapacitation, there would also be little need to designate a person to make those decisions. The Western rationale for assigning someone to make decisions for an incapacitated individual is based on a mistrust of the health care system (Cotsonas, 1991). From a collectivist view point, individuals feel secure that in the event of incapacitation, family members and physicians will make the best possible decision for everyone concerned.

#### **Decisions about Nursing Home Placement**

When individuals can no longer live independently because of impairments and disabilities, they may need to be moved to institutional settings that



provide 24-hour assistance with daily living. For API families, stress associated with caregiving is unlikely to be expressed to health care workers. In line with the concept of filial piety, a female family member (often the daughter-in-law) is expected to accept the burden of caregiving without complaint. In Hawaii, where two incomes are often needed to make financial ends meet, the stress associated with caregiving for elderly parents, working a full-time job, and caring for one's own family are more than can be tolerated. On the other hand, to express distress or need for help would trigger feelings of shame and failure. Thus, whereas a Western family may make a decision for nursing home placement quite early in the stress cycle, a traditional API family may wait until the situation is extremely difficult before seeking assistance and placement.

In addition, there are cultural variations as to the acceptability of family members dying at home, which also influence placement decisions. Westerners tend to be more reluctant to have a death take place in the home and may make a decision about nursing home placement early enough to avoid this occurrence. In contrast, many traditional API cultures expect death to occur at home and have mourning traditions that involve keeping the body at home for a number of days before burial (Nichols & Braun, 1996). The possibility of a death occurring in the home in a traditional household may not even be an issue in terms of making a decision for nursing home placement.

## DISCUSSION

When considering health care options, there are always decisions to be made. The answer to the question "who decides" is based largely on cultural values. In the United States, the individual patient is empowered to make his or her own health care decisions. This value has been codified into a number of documents that are standard in American health care institutions, including medical informed consent and the advance directive. Alternatively, in many API cultural traditions, the individual may have (and want) little input into the decision-making process; rather health care decisions may be decided by the family as a whole or relegated to the patient's doctor (Hattori et al., 1991; Long & Long, 1982).

The primary recommendation for cross-cultural practice is for increased sensitivity on the part of health care workers (see, for example, Brislin, 1993; Koenig, 1997; Mokuau & Shimizu,

1991). With this we agree and encourage universities and health care settings to provide education and training that promote understanding and appreciation of diverse cultures. On the basis of our work in Honolulu, we suggest the following strategies for helping professionals who work cross-culturally:

1. Learn about the cultural traditions of the groups you are working with.
2. Pay close attention to body language, lack of response, or feelings of tension that may signify that the patient or family is in conflict but are perhaps hesitant to tell you.
3. Ask the patient and family open-ended questions to elicit more information about their assumptions and expectations.
4. Remain nonjudgmental when provided with information that reflects values that differ from your own.
5. Follow the advice given to you by your clients about appropriate ways to facilitate communication within families and between families and other health care providers.

Although we support an increased understanding of ethnically diverse cultures, we also realize that the study of cultural variations and health care decision making is in its infancy. More research is needed on how illness and death are perceived and discussed in different cultures, how and when help is sought, and how decision making may be delegated or shared (Koenig, 1997). For API Americans, some of the same values outlined in this article may complicate research in this area; for example, if the culture places a high value on harmony, respondents may tell you what they believe you want to hear. Severity of pain and suffering may be underreported for similar reasons or because it may not be thought appropriate to share feelings with strangers. Fears of contamination and bringing bad luck on the self also create problems for health care professionals and researchers who want to ask questions about personal health and advance planning. A way to overcome these problems in data collection is to use projective-type questioning (for example, reading a scenario about a hypothetical family and asking respondents how they think that family would respond).

At both the practice and policy levels, our findings tend to support the notion that the current U.S. system of using advance directives to determine how patients want to be treated in end-of-life situations is, in itself, biased and ineffective. As



other researchers have found, it appears that advance directives have more appeal to educated, insured, middle-class white people than to the country's various populations of color (Eleazer et al., 1996; Hanson & Rodgman, 1996; Randall, 1994; Sulmasy, Song, Marx, & Mitchell, 1996). Other researchers have found that, even when advance directives have been made available to health care professionals, they may have little effect on use of life-sustaining treatment at the end of life (Jacobson et al., 1996; Johnson, Baranowski-Birkmeier, & O'Donnell, 1995; Teno et al., 1997). Thus, there is a call to begin addressing end-of-life planning issues with whole families (not just individual patients), earlier in the life course (rather than waiting until the end), and in nonhospital venues (Braun & Kayashima, in press; Heffner, Fahy, & Barbieri, 1996; Johnston, Pfeifer, & McNutt, 1995; Teno et al., 1997).

These findings also support further exploration into family-centered, rather than patient-centered, models of medical decision making (Blackhall et al., 1995). In fact, the law on informed consent currently gives physicians some leeway in their interpretation of how to obtain informed consent and does not negate use of a family-centered model (Cotsonas, 1991). Support for shared decision-making mechanisms comes from DeSpelder and Strickland (1996) as well, who argued that many health care decisions are too big for any single person to make, regardless of their ethnicity. Moody (1992) concurred and called for further exploration of the concept and practice of "negotiated consent" as a middle ground between paternalist and autonomous decision making in nursing homes. A process to obtain a negotiated consent recognizes the legitimacy of multiple views (for example, of the resident, family, health care providers, and the institution) and supports open communication and increased understanding as the parties move toward fair decisions.

## CONCLUSION

The United States is becoming more ethnically and culturally diverse. To help health care workers increase their awareness of different cultures and to reduce potential conflict, more research is needed on how different cultural groups approach end-of-life decision making. The study of more collectivist cultures may also shed light on the use and usefulness of shared or negotiated decision-making models. Given that our current system of health care decision making, which is based on

patient autonomy, does not appeal to all Americans (Koenig, 1997) and may not work well in the context of long-term care and end-of-life care (Moody, 1992), study of collectivist cultures may help the U.S. medical community develop a more effective model for decision making in these situations.

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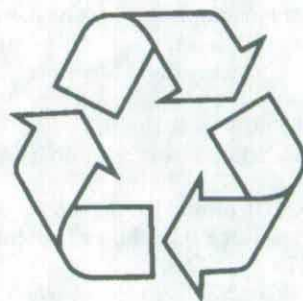
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