Relationships between Cancer Characteristics and Culture in Singapore

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Introduction

Culture refers to a set of shared attitudes, values, goals and practices that characterize a group. Cancers are known to be a result of both genetics and lifestyle factors. Lifestyles emanate from cultural beliefs, values and practices. Thus culture affects both the risk factors for cancers and the meaning of the disease by influencing the behavior responding emotionally, cognitively and socially to this disease. Culture will determine approaches to prevention, early detection, treatment choices, and management of side effects such as pain, appropriate psychosocial support, rehabilitation efforts, survivorship issues, hospice use and effective end of life care.

Confucianism forms the core of Chinese culture. Confucianism was born during the Warring states era in China, which began after the fall of the Zhou dynasty. Yearning to the social and political stability of the earlier Zhou era, Confucius set out to expound a set of values that would govern society. The basic tenets of Confucian philosophy are *li* (decorum), *yi* (righteousness), *ren* (kindness) and *ci* (knowing shame)[1]. The roles and obligations of an individual in the familial, communal and political order are coterminous and mutually entailing and their fulfillment leads to personal fulfillment. Indeed, the role of family dominates Chinese cultural influence in cancer care. While Confucianism is not a religion, its influence can be found in much of Asian culture.

The West, defined as that of European origin, has a strong tradition of individualism and autonomy. The roots of Western thought can be traced back to ancient Greece where democracy offered all citizens legalized freedoms. In 1225, the Magna Carter required King John of England to proclaim certain rights, respect certain legal procedures, and accept that his will could be bound by law. It explicitly protected the rights of his subjects, and implicitly supported what became the writ of *Habeas Corpus*, allowing appeal against unlawful imprisonment. The first record of Human rights in Europe appeared in 1525 (Twelve Articles of the Black Forest) and the momentum of enlightenment driven by the Lutheran reformation would later lead to the American Declaration of Independence in 1776, the United State Bill of Rights and the French Revolution of 1789. Later on, after World War II, the Western ideals of human rights would be enshrined in the Universal Declaration of Human Rights. Indeed, as the authority of decision making has moved from political and religious authority to the individual, Western Medicine has seen the rise of patient autonomy as a key concept in the doctor-patient relationship. This is evident in the role of cancer care.

Industrial revolution has its roots in the West. Many modern aspects of scientific approaches to the modern world also stems from the West, e.g. astronomy, physics and chemistry. This however is by no means affirmation that western culture is either modern or exclusively scientific. With better education, every community has access to

a modern scientific culture that can also be rooted in the community's distinct traditional culture. This transition taking place creates tension between old and new; between local and international, and sometimes between religion and science.

Cultural influence in Cancer Screening

There has been much debate regarding cultural influence on cancer screening, especially that regarding culturally sensitive regions of the body such as the breasts, cervix and colon. Cervical cancer screening has been widely implemented and has been subject to much study[2]. A study of 100 Chinese-American immigrants showed that the odds of Pap test use and adherence decreased with increasing age, increased age at time of immigration and increased modesty[3]. Women with insurance or a regular healthcare provider had better odds of Pap test use and adherence. While it is true that modesty remains a concern among Chinese women[4], these results may be confounded by the inherent biases relating to an immigrant population. Indeed, while China has yet to implement a national cervical cancer screening program[5], the rates of overall attendance of screening for cervical cancer (target population who had had at least one Pap smear) in the United States (59.3% in 2003)[6], Singapore (70% in 2004), Hong Kong (63% in 2006) and Taiwan (61% in 2004)[7] do not differ greatly.

In a study examining the health belief model of 23 married, educated, Chinese women living in the United States (mean age 30.4) attending a university clinic, it was found that cultural beliefs about modesty, husband's involvement, self-care, relationship between health and body functions, and use of preventive health behaviours in the absence of disease influenced participation in early detection programs. 80% of them believed in monthly breast self-examination and 70% believed that receiving annual Pap smears would reduce the risk of cancer[8].

While part of Confucian belief (shame) emphasizes modesty, increasing education and public awareness play an important role in modifying individual health beliefs in early cancer detection. What may be crucial, is the setting of a public education program in a broad population of the same culture (i.e. among Chinese women in Singapore or Hong Kong) such that the act of attending screening itself becomes accepted as part of the culture. This may also explain the limitations that are observed in acceptance of early cancer detection in Chinese migrant populations.

Among the Muslims, there is a prevalence of a certain concept of fatalism, "God's will or destiny". Sometimes they believe that cancer is 'inevitable and thus taking preventive measures may be moot' This may influence the active participation in screening and preventive measures.

Cultural influence in Cancer Diagnosis and Disclosure

Confucius teaches that in a society, every person has a role and obligations to fulfill. In the context of cancer diagnosis, this phenomenon is particularly acute. To a parent of a young family, a diagnosis of cancer immediately brings the burden of the possibility of being unable to fulfill his or her duties to raise the young and provide for the family. This may produce intense feelings of guilt, shame and anger. These reactions must be taken into consideration by the healthcare provider in relating to the patient. While a patient raised in Western culture is no less responsible compared to the Chinese counterpart, these feelings may be less intense. In the West, children often leave the home at a younger age, and many of them are expected to provide for their own university education. To a Chinese parent, there is often great regret at being unable to put a child through university.

On the other hand, a more elderly Chinese who perceives that he has discharged his or her duties and obligations may be more accepting towards the diagnosis and prognostic implications.

Another factor relates to the phenomenon of reciprocity and filial piety (righteousness) in Confucian teaching. As the parents grow old and the children come to maturity, the role of the provider is gradually passed to the children and in the twilight years, it often comes to pass that the family will make most of the decisions for the elderly ones. It is widely observed in local medical practice that in Chinese families, the children often wish to conceal

the diagnosis of cancer from the patient. At times, the diagnosis is explained to the children who stay behind in the consultation room after the patient leaves. This is entirely opposite to the grain of Western bioethics of medical confidentiality and patient disclosure. Indeed, this practice is not usually seen in clinics in the West where the very opposite occurs: the patient attends the consultation alone and certainly would hold the confidentiality of his medical information dear.

In a study of 617 dyads of patient-designated caregivers across 21 hospitals in Taiwan, it was found that there were substantial discrepancies in the knowledge and experiences of being informed about the diagnosis and prognosis between Taiwanese terminally-ill cancer patients and their family caregivers (kappa values ranged from 0.08 to 0.44). However, it was also found that cancer patients strongly proclaimed their superior rights to be informed about their disease over their family and preferred their physicians to inform themselves before releasing any information to their family caregivers[9]. While the family in the traditional Confucian system intends well for the patient, terminally-ill cancer patients may have better opportunities to make end-of-life care decisions that are in accord with their wishes. This may have to be assessed on a case-by-case basis, but in the event of a disagreement it is clear that physicians need to respect patients' preferences rather than routinely taking the family's opinions into consideration.

Amongst the Muslims, again the concept of God's will influence the willingness to accept bad news and even mishaps and regard it as fate and thus may be more forgiving to the carers.

A physician operating within the Chinese culture faces much tension while providing care for an elderly Chinese patient as he has to reconcile the wishes of the family and the patient's autonomy and right. A doctor operating in a population of predominantly Western belief would find this even more troubling. In a Norweigian empirical study of intercultural healthcare, Hanssen recognized that to confront a patient who is socio-culturally unprepared with a serious diagnosis may be tactless and unforgivable[10].

Cultural influence in Therapeutic Decisions

In accordance with the theme of the family, a parent of a young Chinese family would be more likely to seek appropriate treatment if the family could afford it. This would provide the best chance of cure and to allow them to fulfill their responsibilities toward the family. An elderly patient would feel that he or she has completed his or her obligations and would opt for treatments based on cost to the family.

Western bioethics centers treatment decisions on patient autonomy and informed consent. The American Medical Association Code of Medical Ethics states that 'The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.'[11]

With the family as the basic unit, Confucian views often result in the main decision maker being the head of the household. Parents of young families would make decisions for their offspring as well as their own elderly parents. In relation to their offspring, they feel that it is their duty to care for them and this extends to selecting the best treatment. While this approach has worked, there have been conflicts, particularly with adolescent patients. Hui et al in Hong Kong reported that the tendency to hierarchism and parental authoritarianism in traditional Confucianism has at times led to refusal of treatment and deprivation of rights, leading to conflict with physicians who see themselves as 'parens patriae' attempting to fulfill professional and moral obligations[12]. On the other hand, Hanssen in Norway recognized that to force a person to make independent choices who is socio-culturally unprepared to do so, may violate his or her integrity.

Adhering to the principle of beneficence, in dealing with adolescents, Hui suggests the solution would be to persuade the decision-maker to re-interpret parental authority in the light of parental responsibility and enhancement

of the patient's interest. In dealing with elderly parents, the physician would have to balance patient desires and autonomy with that of the family, again being clear that in event of disagreement, patient's preferences would be paramount.

Cultural Influences in Cancer Palliation

It is often perceived in the West that informational and emotional supports are equally important in helping cancer patients deal with disease. In a study of 253 liver cancer and 334 lung cancer patients who were Chinese, Wong et al showed that general emotional support from health professionals (ChPSQ-9) was a more effective predictor of quality of life than was a measure of informational support (MISS-Cog)[13].

Chui et al showed in a study of 11 Chinese-Australian patients suffering from advanced cancer showed that while struggling to accept the diagnosis, the five culturally specific coping mechanisms employed were traditional Chinese medicine, traditional Chinese beliefs on the use of food for health maintenance, qi gong, feng shui and the worship of ancestors and gods[14]. Accommodation to and negotiation about these cultural practices would be important for the health care provider.

Kohler discussed the needs of 27 terminally ill French patients in 'spiritual distress'[15]. He suggested that patients may not need religious representatives or psychologists as much as active listening and help with the rereading of life by the nurses caring for them. Interviewing 33 terminally ill hospice care patients in Hong Kong, Mak found that awareness of dying was the foremost element in the meaning of a good death. However, only a third of them would use the words 'death' in their speech and speak openly of it.

All patients probably undergo the stages of acceptance of terminal cancer in the same fashion. The difference between Chinese and Western cultural practices would likely be in the culturally specific coping strategies. Ultimately, the physician and other healthcare providers have to assess the patient in his cultural context and find out what would help the patient the most to go through the terminal phase of the disease.

The community bond amongst Muslims is very strong, most end of life issues are preferably taken care at home amongst family members rather than in hospice facilities.

Conclusion

In this article, we have examined the tenets of Confucian beliefs and Western bioethics. The populations used in the discussion include immigrant Chinese to predominantly Western populations such as the United States and Australia and Chinese populations in increasingly Westernizing cultures with large conservative base (Singapore, Hong Kong and Taiwan).

It is important to take into account existing trends in the influence of Chinese culture on Western bioethics in the planning of screening programs, attitudes towards disclosure and treatment selection, as well as coping with terminal disease.

In dealing with a patient, a physician must take into account the degree of his cultural inclinations as well as that of his family in order to communicate and provide best medical treatment effectively. Invariably, communication and empathy are indispensable in achieving this. In an increasingly westernizing society, a physician should be wary of imposing generalized belief models on patients without first understanding their background and preferences.

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