Chinese and U.S. Internists Adhere to Different Ethical Standards

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By nature men are alike. Through practice they have become far apart.

—Confucius

OBJECTIVE: **To determine whether internists in the United States and China have different ideas and behaviors regarding informing patients of terminal diagnoses and HIV/AIDS, the role of the family in end-of-life decision making, and assisted suicide.**

DESIGN: **Structured questionnaire of clinical vignettes followed by multiple choice questions.**

SETTING: **University and community hospitals in San Francisco and Beijing, China.**

SUBJECTS: **Forty practicing internists were interviewed, 20 in China and 20 in the United States.**

MEASUREMENTS AND MAIN RESULTS: **Of the internists surveyed, 95% of the U.S. internists and none of the Chinese internists would inform a patient with cancer of her diagnosis. However, 100% of U.S. and 90% of Chinese internists would tell a terminally ill patient who had AIDS, rather than advanced cancer, about his diagnosis. When family members' wishes conflicted with a patient's preferences regarding chemotherapy of advanced cancer, Chinese internists were more likely to follow the family's preferences rather than the patient's preferences (65%) than were the U.S. internists (5%). Thirty percent of U.S. internists and 15% of Chinese internists agreed with a terminally ill patient's request for sufficient narcotics to end her life.**

CONCLUSIONS: **We found significant differences in clinical ethical beliefs between internists in the United States and China, most evident in informing patients of a cancer diagnosis. In general, the Chinese physicians appeared to give far greater weight to family preferences in medical decision making than did the U.S. physicians.**

KEY WORDS: **ethics; cross-cultural differences; China; HIV/AIDS; family preferences.**
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There has been much speculation about and some description of cross-cultural differences in approaches to clinical ethical issues.[1–5] Most of this research suggests that clinical ethical beliefs and practices are not uniform throughout the world. For example, Seghal et al. found cross-national variation in a survey of nephrologists in the United States, Japan, and Germany in the use of advance directives,[6] and Asai et al. surveyed Japanese and Japanese-American physicians and found significant differences in their approach to life-sustaining treatment for terminally ill patients.[7] In addition, there is a burgeoning interest in bioethics research that is implicitly comparative but takes place in only one country,[8–12] or examines the attitudes and behavior of patients, not physicians.[13]

Most of the existing research in cross-cultural ethics focuses on differences in attitudes rather than clinical ethical practices. No previous study specifically compares clinical ethical beliefs and practices between physicians in China and North America. One previous study of comparative clinical ethical practices included data from Chinese nurses, not physicians.[14]

China has a long history of traditional Chinese medical ethics rooted in Confucianism. In brief, traditional Chinese medical ethics was based largely on the principles of *ren* (humaneness) and *xiao* (filial piety).[15] In medical practice, as in society at large, individuals were viewed as embedded in family and society, and social order was preserved in part through the practice of filial piety, or honoring of one's elders. Emphasis was placed on the duty of physicians to preserve life, as exemplified by these maxims: "One cannot destroy life in order to save life" and "It is impossible for a man not to fall ill, and it is impermissible for a physician not to treat a patient."[15] Patient autonomy was not a valued principle; in fact, except in cases of very powerful patients, much of the physician-patient relationship was rooted in paternalism.

Although officially out of favor, Confucianistic approaches to ethical dilemmas still permeate Chinese medicine and society. The first Chinese bioethics association was founded in 1988, in part in response to the "Han Zhong affair" in which two physicians were found guilty of murder for assisting in the death of a terminally ill patient.[16] Bioethical dilemmas involving the end of life, reproductive technology, and allocation of resources are becoming more common in China, prompting one prominent Chinese scholar to label current Chinese bioethics as "morality in flux."[17]

We sought to compare cross-cultural clinical ethical practices between Chinese and U.S. internists by presenting the physicians with clinical vignettes. We wanted to know whether internists in the United States and China have different ideas and practices regarding informing patients of serious and terminal diagnoses, the role of the family in medical decision making, and willingness to assist in suicide for a terminally ill patient. We hypothesized that we would find large differences in ethical beliefs and practices between our Chinese and U.S. subjects based on the different traditions of Western and Confucian medical ethics and on the vast sociocultural differences between China and the United States with their contrasting emphases on the roles of the individual and the family.

METHODS

The study was conducted in two large urban areas, San Francisco, Calif, in the United States and Beijing, China. In San Francisco, we interviewed a convenience sample of practicing internists in the Department of Medicine at the University of California, San Francisco, and at two randomly selected community hospitals. In China, a convenience sample of practicing internists was interviewed from three large hospitals in the Beijing metropolitan area. The Chinese internists surveyed practice predominantly Western medicine, so they are unlikely to represent the beliefs and practices of traditional Chinese medicine physicians. We interviewed both academic and community internists in China and the United States to seek a more heterogeneous sample. Physicians were initially contacted by telephone and asked about their potential interest in participating in the study; this was followed by a letter describing the purpose of the study and the general content of the survey. The study was approved by the Committee on Human Subjects at the University of California, San Francisco.

The survey instrument consisted of seven brief clinical vignettes followed by multiple choice questions that explored potential differences in clinical practice between Chinese and U.S. internists in the areas of informing patients of their diagnoses, the role of family in decision making, and end-of-life issues. The survey was translated into Chinese and then back-translated into English to ensure accuracy. It was pretested in the United States and China and revised before being used for the study. Actual doctor-patient interactions were not observed.

Responses to each question were collapsed into one of two responses, yes or no/other. We present data as proportions answering yes and provide confidence intervals and *p* values by Fisher's Exact Test for the differences in those proportions. Fisher's Exact Test was used because of the small numbers in each of the cells.

RESULTS

Forty clinicians were interviewed (20 each in China and the United States) by one of the authors (MDF in the United States and JZ in China). Only one physician in the United States refused participation in the study, owing to time considerations; all of the physicians in China asked to participate agreed.

The mean age of the Chinese physicians was 43 years; the U.S. physicians' mean age was 42 years. All 40 physicians identified themselves as internists. Twelve of the Chinese physicians were women in contrast to three of the U.S. physicians. We were unable to adjust our analysis for differing numbers of women in the two groups owing to the small overall numbers.

The subjects were asked to respond to one or more multiple choice questions after seven vignettes. In total, there were 12 questions; we selected 9 to discuss in more detail and have reported these in Tables 1–3. Responses to the other 3 questions are summarized below.

We found striking differences between the U.S. and Chinese internists in their practice of informing patients of cancer (see Table 1). In the first vignette, we asked

Table 1. Chinese and U.S. Internists Who Would Inform Patients of Cancer, HIV, and AIDS Diagnoses

Question	U.S., *n* (%)	China, *n* (%)	Difference in Yes Answer, % (95% Confidence Interval)	*p* Value
Should the doctor tell the patient she has cancer?				
Yes	19 (95)	0 (0)	95 (85, 100)	<.001
No	0 (0)	7 (35)		
Other	1 (5)	13 (65)		
Should the doctor tell the patient he is HIV positive?				
Yes	19 (95)	17 (85)	10 (−8, 28)	.29
No	1 (5)	1 (5)		
Other	0 (0)	2 (10)		
Should the doctor tell the patient he has AIDS?				
Yes	20 (100)	18 (90)	10 (−3, 23)	.49
No	0 (0)	1 (5)		
Other	0 (0)	1 (5)		

whether the doctor should tell a patient that she has cancer. None of the Chinese internists and 19 (95%) of the U.S. internists answered that they would inform the patient of her diagnosis (Fisher's Exact $p < .001$). The one abstaining U.S. physician stated that although he intended to inform the patient eventually, he "preferred to break the bad news gradually." Most U.S. physicians focused on the rights of the individual patient in justifying their decision to inform her. For example, one physician said: "I make it a point of telling . . . patients have a right to know what their true diagnosis is." Chinese doctors, however, worried about the potential negative impact of a cancer diagnosis on the patient and her family.

In contrast to cancer, Chinese and U.S. physicians answered questions about ethical decision making in HIV infection in the same way. When asked if they would inform a patient that he tested positive for HIV, 17 (85%) of the Chinese and 19 (95%) of the U.S. internists responded that they would inform the patient ($p = .29$, not significant). Similarly, when asked if they would tell a patient not expected to survive for more than 6 months that he has AIDS, 18 (90%) of the Chinese and all 20 (100%) of the U.S. internists responded that they would.

There were significant differences between the opinions of Chinese and U.S. internists as to the role of family members in medical decision making. In a vignette in which a patient's spouse asks the physician not to inform his wife of her cancer diagnosis, only 2 (10%) of U.S. physicians reported that they would comply with this request as compared with 16 (80%) of Chinese physicians (Table 2; $p < .001$). When asked if they would inform a patient of a terminal cancer diagnosis, 9 (45%) of the Chinese physicians reported that "it depends on what the patient's family wants." Some U.S. doctors attempted to walk a fine line between the patient's rights and the family's wishes. For example, one U.S. doctor stated: "If the patient's husband disagrees, I will tell her she has a 'tumor' and ask if she has any questions. If she asks directly about the diagnosis, I will not lie to her."

When the internists were presented with a vignette in which a patient's family disagrees with her decision to discontinue chemotherapy (Table 2), 13 (65%) of the Chinese internists and only 1 (5%) of the U.S. physicians chose to side with the family and continue the chemotherapy despite the patient's wishes ($p < .001$). Again, the U.S. physicians seemed to be influenced by their notions of individual rights: "It is up to the patient, not the family, to decide on treatment," while the Chinese doctors often expressed concern about the "harmony of the family." Fourteen (70%) of Chinese internists but only 9 (45%) of U.S. internists would comply with the family's request to stop tube feedings of an elderly man in a persistent vegetative state ($p = .20$).

A few of the vignettes reflected issues with which clinicians often grapple at the end of life, such as assisted suicide and withholding treatment from terminally ill patients (Table 3). In one vignette in which the family agrees with a terminally ill patient's request that her doctor provide her with medication to end her life, 6 (30%) of U.S. internists and 3 (15%) of Chinese internists agreed that the doctor should comply with this request ($p < .05$). When the same vignette was presented but this time with discordance between family and patient wishes (i.e., the patient's family asks the doctor *not* to assist the patient in ending her life), only 4 (20%) of U.S. internists were willing to assist the patient, while the number of Chinese internists who were willing to assist remained at 3 (15%; $p = 1.0$).

We also asked the subjects if they would be willing to withhold treatment from a terminally ill AIDS patient who is requesting to "die with dignity." The U.S. internists were significantly more willing to withhold treatment from a terminal patient than were the Chinese internists (18 [90%] vs 9 [45%]; $p = .006$). Far more of the Chinese

Table 2. Chinese and U.S. Internists Who Would Follow Family's Wishes

Question	U.S., *n* (%)	China, *n* (%)	Difference in Yes Answer, % (95% Confidence Interval)	*p* Value
In accordance with the family's wishes:				
Would *not* disclose cancer diagnosis				
Yes	12 (60)	2 (10)	50 (24, 75)	<.001
No	2 (10)	16 (80)		
Other	6 (30)	2 (10)		
Would continue chemotherapy against patient's wishes				
Yes	1 (5)	13 (65)	−60 (−83, −37)	<.001
No	14 (70)	3 (15)		
Other	5 (25)	4 (20)		
Would continue futile treatment for patient in persistent vegetative state				
Yes	9 (45)	14 (70)	−25 (−54, −4)	.20
No	4 (20)	3 (15)		
Other	7 (35)	3 (15)		

Table 3. Chinese and U.S. Internists Willing to Assist in Suicide or Withhold Treatment

Question	U.S., *n* (%)	China, *n* (%)	Difference in Yes Answer, % (95% Confidence Interval)	*p* Value
Should the doctor help the patient end her life? (family consents)				
Yes	6 (30)	3 (15)	15 (−10, 40)	<.05
No	7 (35)	14 (70)		
Other	7 (35)	3 (15)		
Should the doctor help the patient end her life? (without family consent)				
Yes	4 (20)	3 (15)	5 (−18, 28)	1.0
No	9 (45)	15 (75)		
Other	7 (0)	2 (10)		
Should the doctor withhold treatment in patient with AIDS?				
Yes	18 (90)	9 (45)	45 (19, 70)	.006
No	2 (10)	9 (45)		
Other	0 (0)	2 (10)		

physicians were willing to withhold treatment from terminally ill patients than were willing to participate in assisted suicide.

We found no substantial differences between the U.S. and Chinese physicians' responses to some of our survey questions. When asked whether the doctor, patient, or family should decide about feeding tube placement for a severely neurologically impaired patient, both American and Chinese doctors felt that this decision was best left primarily to the doctor. In addition, there were no statistically significant differences in answers of the two groups to some of the questions related to HIV testing. All subjects agreed that doctors should "insist upon" or "recommend" an HIV test to an at-risk patient (none felt that they should make "no recommendation"), and there was no significant difference in response to the question of whether the doctor should "insist" that an HIV-seropositive patient inform his wife of the diagnosis.

DISCUSSION

We found large differences in clinical ethical practices between internists in the United States and China. First, the Chinese physicians gave far greater weight to family preferences than did U.S. physicians. In some situations, the Chinese subjects were more willing to follow the family's wishes rather than those of the patient. This was true even when the treatment offered was of little benefit or potentially harmful. Our U.S. subjects heavily emphasized the rights of individuals in health care decision making, while the Chinese subjects elevated the role of family members or extended family networks as primary decision makers.

Second, the U.S. internists virtually always, and the Chinese internists almost never, would inform cancer patients of their diagnosis. Chinese physicians are not unique in this regard; physicians from other Asian countries such as Japan may also withhold information about potentially terminal diagnoses from patients or their families, or both,[18,19] and this practice may be the *norm* in many other nations.[20–23]

Given the large differences between the groups with regard to diagnostic disclosure about cancer, it is intriguing that the Chinese internists, like their counterparts from the United States, would generally inform patients of an HIV and AIDS diagnosis. This finding may reflect the fact that most Chinese internists have had less experience with HIV/AIDS, or that they are aware of public health imperatives that obligate them to inform patients of an HIV/AIDS diagnosis, or both.

Third, the U.S. physicians were much more willing than their Chinese counterparts to assist in ending the life of terminally ill patients with cancer, but only somewhat more willing to withhold treatment from a terminally ill patient with AIDS. One third of the U.S. internists reported a willingness to assist a patient with cancer obtain sufficient narcotics to hasten her death, and almost half of the Chinese internists were willing to withhold care from a terminally ill AIDS patient. The readiness of many U.S. internists to assist in a terminally ill patient's death reflects the growing acceptance of assisted suicide among some in the United States.

The percentage of U.S. internists willing to be involved in assisted suicide was reduced when the patient's family asked the doctor not to comply with the request, but the percentage of Chinese internists who reported a willingness to help remained stable. In this case, it is the U.S. physicians who seem more influenced by family wishes than their Chinese counterparts. This may reflect the more litigious nature of American society, or perhaps in a difficult moral area, U.S. physicians are more influenced by a dissenting observer.

Awareness of the striking differences in cross-cultural ethics should inform the care of patients from

different cultural backgrounds. Physicians should enhance their skills in cross-cultural communication, including effective use of translators, so they can elicit patients' and families' health beliefs and values and negotiate a mutually acceptable treatment plan.[24] One useful framework for addressing the ethical predicaments that cross-cultural medical encounters often raise has been offered by Jecker et al.[25] They suggest an approach that consists of three distinct steps. First, the clinician must elicit from patients information about their ethical values and cultural orientation in order to identify the main *goals* that both clinician and patient bring to the medical encounter. Second, once the goals have been clarified, they must identify mutually agreeable *strategies* to meet these goals. Third, the clinician and patient must be willing to reexamine their own values and reinterpret them in light of the stated goals and strategies of the case. If disagreements persist, these can be adjudicated through a fair, nonjudgmental process. Whenever possible, clinicians should strive to accept the strategies put forth by the patient, recognizing that their own ethical values do not represent universal truths.

This study has several limitations. Random sampling techniques were not used, leading to potential selection biases that may limit the generalizability of our findings. In particular, the internists in both countries had urban practices; most were affiliated with academic centers. Our use of scenarios rather than directly observed behaviors may limit the validity of our results. The small sample sizes precluded analysis of effects of physicians' characteristics or their ethical views.

This direct comparison of clinical ethical beliefs and practices of internists from the United States and China suggests that there are important differences in these two cultures even among physicians who all practice Western medicine. We should recognize that although there may be some values or principles that are universal, many of what we consider to be basic bioethical principles are not universal.

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