

CASE STUDY

Lina

This case concerns an adolescent with recurrent leukaemia, and physician-parent conflicts over her treatment plan. It explores the rights of the adolescent patient and the possibility, consequences and ethics of seeking judicial intervention in the best interests of a child.

Case Description

Lina

Lina Tan has recurrent childhood chronic myeloid leukaemia. She was diagnosed three years ago, at age 11, and underwent chemotherapy and other treatments, resulting in remission. Lina was able to return to school and resume a relatively normal life for about two years. When the disease recurred one year ago, Lina underwent a second round of chemotherapy. After a short remission, the disease relapsed. Lina, who is now 14, was recently re-hospitalised for further tests.

While Lina is resting one morning, Lina's paediatric oncologist, Dr Chong, speaks with Lina's parents, recommending a stem cell transplant, telling them, 'Lina is still strong, I think this could help her.' After Dr Chong and his colleagues explain the benefits and risks of the stem cell transplant, as well as the financial cost of the procedure, Lina's parents give consent for the transplant.

That afternoon, Mr Tan expresses second thoughts to Nurse Esther, whom his family knew well from Lina's many hospital visits over the years. 'Our daughter has been through so much already! I don't know where we'll find the money.'

Nurse Esther subsequently tells Dr Chong, 'I think you should have another meeting with Lina's parents. They're not happy about the stem cell transplant.'

During evening rounds, Dr Chong stops by Lina's room. After a brief chat with his patient, Dr Chong asks Lina's parents to join him in a small conference room down the hall.

'I'm so sorry that Lina is back in the hospital, but it's always good to see her – she's one of my favourite patients. We didn't have much time to talk this morning. Do

you have any question about the next treatment – the transplant? My team and I would like to discuss it with Lina.’

Mr Tan said, ‘Thanks, Dr Chong, but I think that won’t be necessary. We’re grateful for everything you’ve done for Lina. Our family has talked about this today, and we think it’s time to try something else. We want to try TCM.’ (TCM is Traditional Chinese Medicine.)

Dr Chong says, ‘I understand you want the best for Lina – we all do. But there’s no evidence that TCM is effective in treating leukaemia.’

Mr Tan says, ‘We want to try. My brother has recommended a practitioner who can meet us soon. When can we take Lina home?’

Dr Chong calls an emergency team meeting to discuss Lina’s parents’ request.

Nurse Esther says, ‘I am so worried about this. TCM on its own is not going to help this girl at all.’

Dr Rosario, an oncology fellow working under Dr. Chong, says, ‘Well, it’s not as if there’s a study that compares TCM to stem cell transplants that we can point to.’

Nurse Esther replies, ‘Her father is worried about money – he told me that. Her mother doesn’t say anything when he’s in the room. I think the TCM is his idea.’

Dr Chong says, ‘Lina is my patient, and I’m going to have a proper talk with her directly. She’s 14, she’s had a lot of treatment, she knows what’s going on, and so she deserves a say.’

Early the next morning, before Lina’s parents arrive at the hospital, Dr Chong talks with Lina.

‘You’ve probably figured out that the last treatment didn’t work so well. I’ve told your parents that I think we should try a stem cell transplant.’

‘What do my parents say?’

‘Right now, I want to know what you think.’

‘I want to get better! I’m so tired of being sick, being in the hospital, missing school. But I’ll do whatever my parents think is best. Is that okay?’

Dr Chong is frustrated. He tells Dr Rosario: ‘Every now and then, you get a case like this – a patient who is very sick but has some chance of benefiting from further treatment, and a family that all of a sudden wants to try something ‘different’. I could push this with the family if the patient said, yes, I want the transplant – but she’s 14. Her mom and dad have been making medical decisions for her all along, so it’s easier for her to let them decide.’

Later that afternoon, Lina’s parents arrive at the hospital. On their way to Lina’s room, they meet Dr. Rosario in the corridor.

“Hello, Dr Rosario. As Dr Chong probably told you, Lina is going to try a different treatment. We’ve made arrangements and are just waiting for her to be discharged.”

Dr Rosario says, “Are you sure about this, Mr and Mrs Tan?”

‘We’re sure,’ said Mr Tan, firmly. “Lina is going to be okay.’

‘Well, um, if anything – I mean, if you need anything, please call Dr Chong.’

‘Thank you, Dr Rosario, we have everything we need. Thanks again.’

During evening rounds, Dr Chong again speaks with Dr Rosario: ‘I signed off on Lina’s discharge today. “Her parents were very clear that they wanted to try TCM. Lina didn’t say anything. They have their rights as parents. The stem cell treatment could save her life. So we could try to get a court order to treat the patient without the parents’ consent. But those MSF cases are so draining. I’ve been through that before. Mountains of paperwork, the parents become your enemies, and it’s very hard on the child. In this case, let’s just hope the parents get over this TCM idea and bring Lina back soon.’

Privately, Dr Rosario has a word with Nurse Esther: ‘Should we have done something differently when we talked to the family? You don’t want to get the family angry, but you do want to help the child – she’s got recurrent cancer, she’s just going to get worse.’

Nurse Esther says, ‘I don’t know what to tell you. I’m so upset – I was so sure that they would listen to Dr Chong. Maybe I should have tried to talk to them myself. It felt so wrong to be discharging her today – but what else could we do?’

Several months later, Lina is readmitted to the hospital, suffering from weakness, bruising, pain, and other symptoms of disease progression. Tests reveal that the leukaemia is spreading to her brain and central nervous system. Dr Chong breaks the bad news to Lina's parents, who are distraught. Her father says, 'We've lost all this time! How soon can she have the stem cell transplant?'

Dr Chong and Nurse Esther attempt to explain Lina's worsening condition. Dr Chong says, 'Lina's pain and symptoms can be treated, even if we're not sure if we can treat the cancer itself. I'll arrange for a consult with our palliative care team.'

'No,' says Lina's father, 'We don't need to hear about that. Just, please, save our daughter's life.'

Lina's mother finally speaks. 'And please – tell Lina that she's going to be fine. She'll believe you.'

Later that day, Dr Rosario stops by Lina's room. She is tired but awake. She says 'Dr Rosario, what's going on? Tell me the truth.'

Questions for Reflection

- The neurological capacity to make decisions, including medical decisions, begins to develop in childhood and continues to develop into early adulthood. How should medical professionals talk with patients and their parents about the patient's role in his or her medical treatment and care?
- Why is truth-telling important in patient care? How should healthcare professionals respond to parents or other family members who ask them to withhold the truth from a patient?
- When parents make a decision in the care of a child that does not appear to be in the child's best interests, what steps should physicians and other members of the healthcare team take to try to resolve the conflict?
- Under what circumstances would a doctor be obliged to seek a court order for administering treatment to a child against parental wishes?

Alternative or complementary

When parents seek alternative treatments

Commentary by Calvin W. L. Ho

In this case, the parents of Lina Tan, an adolescent with leukaemia, first agree that their daughter should receive a stem cell transplant after chemotherapy fails, then change their minds and tell the medical team, “We want to try TCM.” The reason for this change is never quite clear, although there are hints that cost, and the burden of further hospitalisation on their daughter, are factors. While the medical team did not consider TCM to be an effective intervention for leukaemia, Dr Chong, Lina’s oncologist, was reluctant to seek a court order that would allow the medical team to provide life-sustaining treatment to a minor such as Lina without parental consent, and hoped that Lina’s parents would reconsider.

Traditional Chinese Medicine (TCM) is a form of complementary and alternative medicine (CAM). In general, ‘complementary’ refers to remedies, such as herbal supplements, that are integrated with standard (sometimes referred to as ‘Western’) medical treatment, while ‘alternative’ refers to the primary or exclusive use of non-standard remedies. TCM is common in Singapore, where TCM practitioners are regulated by the TCM Practitioners Board. Clinicians are generally receptive to their patients’ preferences concerning the use of TCM as a complementary remedy combined with standard medical treatment, provided there are no contraindications between, for example, a chemotherapy drug and an herbal supplement that a patient may use to counteract nausea. The use of TCM (or any other complementary remedy) as an *alternative* to standard medical treatment for a life-threatening condition raises a range of ethical concerns, including whether a decision to forgo life-sustaining treatment to pursue alternative treatment is an informed decision; whether such a decision may close off future options should the patient’s condition worsen; and whether such a decision can be made on behalf of a person who is not able to make this type of decision for himself or herself. All of these questions are present in this case.

What could this team have done differently once Lina’s parents withdrew their consent for the transplant and said, ‘We want to try TCM’ as an alternative treatment? Dr Chong and his colleagues could have tried to find out what this

statement meant to Mr and Mrs Tan, and to explore their sudden resistance to the proposed treatment plan. Does the desire to use TCM as an alternative to cancer treatment reflect a desire to alleviate suffering through the use of an approach that they may perceive as ‘gentler’? Does their decision reflect concerns about the cost of the stem cell therapy? Are the goals of the proposed treatment unclear in some way?

The medical team could also have explored the possibility of consulting with TCM practitioners among colleagues in the hospital, carefully clarifying the goals of medical treatment and collaborating on ways to incorporate TCM into the care plan, without abandoning the stem cell therapy.

Finally, this team, like any team responsible for the medical treatment of a minor, needs to be clear, among themselves and within their institution, about the circumstances that would compel them to seek a court order for treatment. The case suggests that Dr Chong has been through this process before, and that his thinking concerning the present situation is influenced by an adversarial, psychologically ‘draining’ past experience of his own, or by his colleagues’ experiences. This, too, is of ethical concern, if clinicians’ past experiences are limiting the options of their current patients. Calling for ethics consultation with the hospital’s ethics committee was an unexplored remedy in this case, and might have provided support to Dr Chong and his colleagues as they worked with Lina and her parents.

The voice of the child

The voice of the child

Commentary by Michael K. Gusmano

Lina's request to know 'the truth' about her condition puts Dr Rosario in a difficult position. Lina is an adolescent. To this point, her parents have made all of her medical decisions, and it is unclear how much information she has been given over the past three years about her diagnosis, treatment, or prognosis. She is, however, able to see that her health has deteriorated. In asking for 'the truth', she may suspect that the truth has been withheld from her in the past.

Withholding truthful information from Lina fails to respect her as a person capable of understanding her current situation. Creating false hope, by giving Lina or her parents an unrealistic picture of Lina's prognosis, is another ethical problem, as it could result in poorly-informed treatment and care decisions. Being untruthful may also create mistrust between Lina and the healthcare team.

At the same time, Dr Rosario knows that Lina's mother has asked Dr Chong, who directs the team, to tell Lina that "everything is fine." This junior doctor may wonder how to reconcile the patient's preferences, expressed to him, with the parent's instructions, expressed to his senior, and also what the law requires of him in situations like this.

This scenario might have been avoided if the medical team had talked early on with Lina and her parents about Lina's own role in her medical treatment and care, why her preferences mattered, and how a patient of Lina's age could be involved in treatment decision-making. Dr Chong did attempt to find out more about Lina's preferences after recommending stem cell therapy to her parents, but once she said, "I'll do whatever my parents think is best," he made no further efforts to understand her preferences. Cases like Lina's require clarity about professionals' responsibilities to pediatric patients, including how adolescent patients, whose capacity to make decisions began to develop in childhood, should be involved in the decision-making process.

Families, patients, disclosure, and communication

Lina's question to Dr Rosario – 'What's going on?' – is a poignant reminder of what clinicians owe to patients: a way of framing the experience that the patient is living with. Lina knows she is sick – she is hospitalised, after all. By the end of the case, she is experiencing symptoms of worsening disease, things that are happening to her as well as showing up on tests. She knows *something* is going on; she wants 'the truth' about what it is. Lina's parents want her medical team to reassure their daughter that "she's going to be fine." The urge to protect a child from any source of distress, including distressing information, is strong. However, pretending to Lina that things will be fine would undermine Lina's trust in the people around her. That she is asking Dr Rosario for 'the truth' suggests both that the truth is important to her and that she does not trust what her parents are telling her. When Lina's mother says, "She'll believe you," she is acknowledging that her daughter trusts Dr Chong as a source of information. Dr Chong and other members of the team should take this opportunity to reinforce the importance of supporting Lina by being trustworthy, by asking *her* what she wants to know, and responding to her concerns truthfully.

Adolescents and decision-making

By the age of 14, adolescents may be as capable as adults of understanding complex medical information, even though, due to their continuing neurological development, they may not yet fully grasp the long-term consequences of a decision about life-sustaining treatment. Involving adolescents in decision-making about their own lives and healthcare (as they are willing and able) respects their developing autonomy and helps others to understand the preferences of the person who is experiencing illness and treatment. A 'shared' or 'collaborative' decision-making model, involving the adolescent patient, the parents, and medical professionals, is appropriate for these circumstances.

Integrating palliative care

According to the case, Dr Chong did not mention the palliative care team until after Lina's condition deteriorated significantly. When Dr Chong suggests involving palliative care, Lina's father resists because, to him, this represents 'giving up'.

As a consequence, Lina's pain and symptoms may be inadequately relieved as her parents try to pursue medical interventions while trying to keep palliative care out of the picture. If palliative care expertise and insights had been part of Lina's care from the start of her illness three years before, it is possible that the concerns that prompted the parents to stop standard treatment and switch to TCM, and then to try to switch back to standard treatment once Lina's condition worsened, might have been addressed more effectively. Nevertheless, in the interest of preventing harm, in the form of unneeded suffering to Lina, her doctors should be prepared to advocate for their patient, and to ensure that palliative care is part of her care plan.

A Psychiatrist's Perspective

Family styles and decision-making

Clinical perspective by Jacinta O. A. Tan

Other things may change us, but we start and end with the family. – Anthony Brandt

The treatment of children and adolescents is also the treatment of the family. In truth, almost all of us are embedded within a wider context of family, and beyond that, society. As dependents, however, children and adolescents are generally more vulnerable to their setting and may have less power to exercise personal autonomy. This brings with it certain complexities, as the case of Lina demonstrates.

Family styles of decision-making can impact on treatment decisions. Lina's father is clearly the spokesman for the family, and the clinicians have assumed that he is the family's authority figure, and the decision-maker on behalf of both his daughter and his wife. This may not be true. Different families have different family decision-making styles concerning medical decisions. In some families, one person may make the decisions for the family and patient, and all other members of the family (including the patient) are voiceless and powerless. In other families, there are pre-existing tacit agreements about family priorities and values, and one person acts as spokesman about the decisions made within the family system, with or without overt family discussion. Some families engage in full discussion between patient and other family members, but the patient makes the final determinative decision with the support of other family members. Some patients act as the sole decision-maker, with no family members involved.

In Lina's case, as in the case of most children and adolescents, it is unlikely that a patient would be the sole decision-maker, with no or limited family involvement. It is unclear how her family has been making decisions and whether Lina has had any voice in these decisions, or if she may not be as voiceless as she appears. At some level she may have tacitly or overtly agreed with or bought into the family decisions, and may have decided to allow her father to speak for her and determine her welfare. Her mother similarly may have tacitly accepted or agreed to the decisions articulated by her father. Because most adolescents are at fluctuating points between the childhood state of being heavily reliant on parental attitudes and the (ideal) adult state of having independent selves and views, Lina's apparent

passivity may reflect a developmentally appropriate reliance on the family's priorities and values to help determine healthcare decisions for her life-threatening condition. Furthermore, as treatment may have serious financial consequences for the family, certain family members have a legitimate stake in this decision.

Being very ill bestows particular vulnerabilities; being an ill dependent minor more so. In times of family crisis, as is occurring with Lina's health, there may be a retreat into a belief that a 'good' child should defer to his or her parents, who hold parental responsibility and authority. In turn, 'good' parents may take what they consider a protective and caring stance towards their child and may attempt to relieve her of what they consider the burdens of full disclosure/knowledge and the responsibilities of decision-making. Is this bad? It is certainly problematic when these notions of protection and care arising in families collide with professional obligations concerning disclosure, privacy, confidentiality, and informed consent, and also with the patient's explicit concerns, expressed by Lina: "Tell me the truth."

The parents who are trying to be 'good' parents are not morally 'bad' because they want to shield their daughter. And yet Lina is owed an honest answer to her question: "What's going on?" What are the options beyond agreeing with the family spokesman and ignoring the voice of the child, or forcing a family to act in a child's best interests by taking the case to court? These questions can only be answered if the healthcare team explores how the family works, what the values and motivations of each member of the family are, and how the family makes decisions; through a process of ongoing conversations with the parents alone, with Lina alone, and with the family together. When a patient has been relatively disempowered within her family, the ongoing task for clinicians may be to guide Lina (and her family) in developing and articulating her views and attitudes towards the issues at hand, in order to optimise her autonomy and input into the family's decisions.

Ideally, this style of engaging families in talking about – and walking with them through – making decisions should be part of a style of routine healthcare. Just as families have styles, teams have their own styles; and teams should be reflective about their own values and practices. They should consider consciously adopting a normal working style where they learn about how individual families work from a position alongside them. Team practices, which are as value-laden as family

priorities, should be transparent and form a supportive culture where families know what to expect and can navigate their way.

A learning point from Lina's case is that it would be helpful for teams to start with ground rules about openness where there is an expectation that adolescents are participants in, rather than subjects of, healthcare decisions. At the same time, family styles should be identified and respected, with appropriate levels of support and disclosure then negotiated and agreed by all and tailored to developmental need and family style. If this is the case, the family's apparent reluctance to involve Lina would be examined and discussed from the start, rather than being colluded with or tolerated and subsequently becoming an issue in a crisis. Furthermore, there can be a policy of assigning each significant family member – such as Lina, her mother, and her father – different team members who can be their advocates to support them from their own perspectives as well as give them the space to develop their views and attitudes. Finally, families need to be supported in the process of making decisions, and where possible, given enough time and space to decide.

BACKGROUNDER

Communication with patients, families, and other caregivers:

Why is this ethically important?

Nancy Berlinger

Saying the right thing, doing the right thing

‘Difficult’ decisions in healthcare are not always technically difficult, although sometimes they are. They are difficult as personal, family, and professional experiences. It is hard to face a life-threatening diagnosis, a painful course of treatment, or an uncertain prognosis. It is hard to witness the suffering of a family member, or of a patient under one’s care. It is hard to face death, or to endure grief and loss. It is hard to worry about how to pay for medical care. Resolving disagreements, whether with families or among colleagues, can also be difficult. It can be difficult for people with less authority, such as nurses, or junior physicians, or home care workers, to bring problems to the attention of people with more authority.

Ethical healthcare is based on communication that is truthful, respectful, clear, and compassionate. Ethical communication supports and advances the patient’s goals of care, while inattention to communication may result in confusion, conflict, failure to address suffering, and even error and harm. Ethical communication can also be challenging. This backgrounder describes some of the common challenges clinicians may face when communicating with patients and others.

Communicating with patients

Disclosure

Telling the truth is one of the earliest moral lessons taught to very young children, and is consistent with most people’s understanding of what it means to act ethically. Truth-telling is also constructive: truthfulness builds trust between people or groups, while lying or evasion undermines trust and makes it hard for different parties to work towards common goals. Truth-telling is fundamental to medical ethics. Healthcare professionals have a duty to deal honestly with their patients, and

the concept of informed decision-making is premised on the provision of accurate information that is clearly presented.

The duty of disclosure is a duty owed directly to the patient. Even when family members wish to ‘protect’ the ill person from medical information, the healthcare professional should explain that it is the patient’s right to receive this information. It is also the patient’s right to decide whether another person (such as a ‘donee’ appointed under a Lasting Power of Attorney) should receive some or all medical information. Other care planning measures, such as the documentation of the patients’ preferences for end-of-life care through an Advance Care Plan, also involve direct communication with the patient.

All patients are not alike in how they prefer to receive medical information. When a patient has been determined, following clinical evaluation, to have decision-making capacity, the healthcare professional responsible for this patient’s care should talk directly with the patient about what level of medical detail the patient wants, and what information the patient may want the professional to share with family members. One patient may express a general preference for treatment and may also ask that detailed information about his or her diagnosis be provided to a specific family member. Another patient may want detailed information.

Talking directly with the patient also demonstrates respect for the patient as a person. In some cases, a patient may disclose information to a healthcare professional that he or she has never shared with family members. For example, some elderly Singaporean patients may never have talked about painful wartime or other early experiences, and yet knowing something about these experiences may be helpful to a professional who wants to understand what a patient may find particularly stressful.

Dealing truthfully with patients about their health, appropriate to their level of understanding, also helps the professional to elicit information about a patient’s preferences, which may include non-medical aspects of life. Learning from an adult or child about what he or she likes to do, and what experiences he or she prefers to avoid, may provide immense insight into this person’s best interests.

Communicating with the patient who lacks decision-making capacity

Patients who lack the capacity to make informed decisions about their own healthcare include those who temporarily lack capacity (for example, because they are undergoing short-term sedation as part of a medical treatment, or because they have a thought disorder that periodically impairs their capacity), who have irrevocably lost capacity (for example, because they have dementia), who have not yet attained capacity (for example, because they are young children), and who will never attain capacity (for example, because they have a lifelong cognitive impairment). In all of these cases, communication should proceed in a way that respects the patient, even though the patient is incapable of making informed choices and may not be capable of full understanding in other respects. Patients who lack decision-making capacity may have and be able to communicate preferences about their healthcare and their lives, and they should have opportunities to share these preferences with others.

Communicating with the patient whose capacity is developing or whose ability to communicate is impaired

Communication with older children and adolescents whose decision-making capacity is still developing, and with patients with conditions that affect their ability to communicate, requires special attention. In these situations, a patient's ability to understand and express preferences about their own healthcare is at risk of being overlooked. Healthcare professionals may need to clarify the patient's current decision-making capacity, and to explain to family members why it is important to try to include the patient's preferences, even if another decision-maker (typically but not always a family member) will be needed to make medical decisions.

Communicating with families

Relationships

It is common in Singapore (and in many other societies) to use the term 'the family' to represent a large number of individuals with some relationship to a patient: spouse, siblings, young children, adult children, nieces and nephews, grandchildren. Those whom a patient considers part of his or her family may also include people who are not biologically or legally related to the patient. These

relationships should be respected, although not every family member can (or should) be involved in medical decision-making.

Patients are members of their own families, and their preferences for their own lives and healthcare may reflect their concern for their own families. For example, a healthcare professional may perceive that a patient knows or suspects his or her diagnosis and is worried about burdening family members with this information. These same family members may also know or suspect the patient's diagnosis and worry about burdening the patient with this information. Situations like these, in which people who care about each other are understandably trying to protect each other, can lead to confusion about how (and with whom) to communicate when treatment decisions must be made or a patient's condition is changing.

Helping families to understand patients' rights

When family members are present, in the hospital or during medical appointments, the professional should always address the patient. It may be necessary to explain to family members why a physician and patient should be able to communicate with one another, to share information and to build trust. Because the healthcare professional's first obligation is to the patient, the professional should not avoid speaking directly with a patient simply because a family member objects.

Working with families as part of best-interests decision-making

Healthcare professionals should expect to work closely with families, including those family members who are knowledgeable about the values and preferences of a patient who currently lacks decision-making capacity. In many cases, it will quickly become clear whether a particular family member has been serving as the patient's primary caregiver. Professionals should keep in mind that the family member who is responsible for paying for a patient's care may or may not be knowledgeable about the patient's own values and preferences. They should avoid deferring to the opinion of 'the payer'. Rather, they should help this family member (and others) to understand both what is known about the patient's preferences for care, and what treatment options are consistent with these preferences or, if these are unknown, with the patient's best interests. Professionals should also be prepared

to deal with disagreements between family members who may hold different views on how a patient should be cared for.

Communicating with foreign domestic workers as caregivers

In Singapore, many families employ foreign domestic workers, often known as 'domestic helpers' or 'maids'. The typical foreign domestic worker is female, and may or may not share a common language with her employer. Healthcare professionals may meet foreign domestic workers when a patient is hospitalised, or during discharge planning. They may also meet foreign workers when the workers themselves are in need of healthcare.

When it is clear that a patient's care plan will involve a foreign domestic worker in addition to family members (and may, in fact, depend heavily on the domestic helper), the professional should make every effort to include her in communication about the care plan. In some cases, a foreign domestic worker who has been caring for a chronically-ill patient may have insights into a patient's preferences or into how a non-verbal patient communicates, and should have opportunities to share these insights.

Some foreign domestic workers have been trained to provide home care, or more specialised care for post-stroke patients or patients with dementia, while others have not. Healthcare professionals responsible for discharge planning or involved in the care of patients at home should be familiar with training opportunities available to foreign domestic workers, so that these caregivers are well-prepared to follow a care plan and to bring problems with the care plan (perhaps due to the patient's changing condition) to the attention of family members and healthcare professionals.

Communicating about culture and language

Cultural values and practices concerning illness and health may shape how, or whether, people tend to talk directly about issues such as death and dying. A healthcare professional in Singapore may, for example, take notice of Chinese customs concerning death. These customs may include the belief that talking about death is inauspicious for the living. This should not mean that talking about medical decisions, or the prospect of dying, is impolite or impossible with Chinese

Singaporean patients or their families. Rather, it means that the professional should be attentive to how the individual patient may prefer to talk about these issues in the context of other values (including cultural values) that are meaningful to him or her. A Chinese-speaking healthcare professional who is aware of these beliefs, and also knows that these traditional beliefs form part of a patient's values, may, for example, ask a Chinese elder, 'What instructions will you have for us when you have lived to a hundred years?', as this phrase may be an acceptable and welcome way for this patient to talk about end-of-life preferences.

Many different cultural factors shape individuals and families in Singapore. Healthcare professionals should aim both to be attentive to cultural values in the lives of their patients, and to keep an open mind, so as to avoid myths and stereotypes. Giving each patient an opportunity to talk about cultural, religious, or other personal needs and concerns that are relevant to their healthcare is a good practice. Some patients may want to talk with a counsellor from a particular faith tradition, while others prefer to talk about these issues with family members or with social workers or other professionals. Some patients may prefer not to discuss these matters.

In Singapore, patients may not have a common language with healthcare professionals. For example, Chinese elders may speak Cantonese or a different dialect, rather than Mandarin or English. In these cases, it is preferable to involve a professional interpreter or another healthcare professional, rather than to rely on family members as interpreters. This better assures the patient's privacy and confidentiality and avoids inaccurate translation of medical information.