

# Patient autonomy in an East-Asian cultural milieu: a critique of the individualism-collectivism model

Max Ying Hao Lim 

## Correspondence to

Mr Max Ying Hao Lim, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Hong Kong, People's Republic of China; maxlim@hku.hk

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## ABSTRACT

The practice of medicine—and especially the patient-doctor relationship—has seen exceptional shifts in ethical standards of care over the past few years, which by and large originate in occidental countries and are then extrapolated worldwide. However, this phenomenon is blind to the fact that an ethical practice of medicine remains hugely dependent on prevailing cultural and societal expectations of the community in which it serves. One model aiming to conceptualise the dichotomous efforts for global standardisation of medical care against differing sociocultural expectations is the individualism-collectivism model, with the ‘West’ being seen as individualistic and the ‘East’ being seen as collectivistic. This has been used by many academics to explain differences in approach towards ethical practice on key concepts such as informed consent and patient autonomy. However, I argue that this characterisation is incomplete and lacks nuance into the complexities surrounding cross-cultural ethics in practice, and I propose an alternative model based on the ethics of clinical care in Hong Kong, China. Core ethical principles need not be culture-bound—indeed, their very existence mandates for them to be universal and non-derogable—but instead cultural alignment occurs in the particular implementation of these principles, insofar as they respect the general spirit of contemporary ethical standards.

## INTRODUCTION

Contemporary discussions regarding the patient-doctor relationship have repeatedly emphasised increasing standards for patient autonomy from a moralist, ethical and legal perspective, as seen through the Montgomery decision<sup>1</sup> for informed consent in 2015. The current standard for patient autonomy seeks to enshrine the power of the patient vis-à-vis clinicians regarding decisions over their own care—that is, patients retain the fundamental decision-making power over their own care even if it contradicts professional medical judgement.<sup>2</sup> Within this, privacy is seen as fundamental and a prerequisite for trust within the patient-doctor relationship, with modern ethical standards calling for physicians to protect patient privacy and confidentiality to the greatest extent possible.<sup>3–5</sup>

However, with the reasonable standard of care being predominantly developed in a Western context, problems arise as we seek to globalise standards across different cultures and societies—especially since there currently exists a worldwide variety of bioethical practices based on vastly different sociocultural contexts, value systems and moralistic assumptions.<sup>6</sup> Modern standards for patient autonomy continue to be based on the

Western cultural milieu but are then extrapolated globally (the Montgomery decision was judged in the UK but carries landmark status in common law jurisdictions globally); the majority of patient-doctor communication studies continue to be based on the Western medical context.<sup>7</sup>

How, then, do we conceptualise the effect of cultural influences when seeking to apply ethical standards across different societies? One sociological-anthropological model is the individualism-collectivism argument, which frames different societies into ‘individualistic’ societies emphasising the ‘self’ as an autonomous unit in contrast with ‘collectivistic’ societies where subordination to group demands and the view of the ‘self-in-relation-to-others’ is desired.<sup>8</sup> This is the main argument underpinning the ‘East-West’ split, with the West seen as ‘individualistic’ and the East as ‘collectivistic’. Using this model, academics have argued that the conceptualisation of patient autonomy in individualistic countries focuses excessively on individual autonomy, choice and participation<sup>9</sup> which may not necessarily fit in an East-Asian collectivistic context.<sup>10</sup> This ultimately culminated during the late 1990s in the ‘Asian values’ debate championed by several Asian political leaders as a means of characterising an essentially unique ‘Asian’ value system centred around shared cultural, political and social ideologies fundamentally distinct from pre-existing ‘Western’ conceptions of so-called universal values including human rights.<sup>11</sup> If we are to accept this premise, then the logical conclusion will be ethical relativism: that different societies have fundamentally distinct ethical values due to their cultural differences, and that there exists no essential commonality between Western and Eastern principles of autonomy.<sup>12</sup> This exploratory essay aims to offer an in-depth critique of the arguments made.

## COMPARING THE EAST AND WEST USING THE INDIVIDUALISM-COLLECTIVISM MODEL

A contemporary ethical perspective views patients themselves as being best positioned to make decisions over the management they receive; this means the patient’s individual right to autonomy and privacy must be protected in order to allow them to participate fully in the decision-making process. From an East-Asian perspective, this is judged against cultural differences centred on collectivism, Confucianism and the family unit, where group autonomy and shared decision-making are emphasised over personal privacy.<sup>13</sup> Under such a cultural milieu, families may choose not to inform and involve the patient with discussions pertaining



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to his/her medical condition as a manifestation of their duty to fulfil familial obligations within the family unit, for example by protecting the patient from potential suffering. This is in direct contradiction with the core tenets of patient autonomy and informed consent.

This raises a number of ethical dilemmas pertaining to informed consent, privacy and the role of the family in the patient-doctor relationship. Can informing family members first while bypassing the patients themselves be considered acceptable practice? What about withholding information from patients and seeking ‘informed consent’ from relatives instead (assuming the patient is fully competent and willing to be involved in the decision-making process)? In a collectivistic cultural milieu, the patient-doctor relationship is much more influenced by family opinions as compared with that in the West; for example, Cong found that most doctors in mainland China prefer to discuss with family members first on how much to inform the patient before informing the patient,<sup>14</sup> while a proportion of doctors in Hong Kong found it ‘morally permissible’ to release bad news to family members without the prior consent of the patient.<sup>6</sup> Such an approach would be seen as a gross violation of patient autonomy and right to privacy in a Western context. However, the individualism-collectivism model characterises this dilemma as a fundamentally sociocultural issue, and Fan makes the argument that a Western medicoethical model emphasising *individual* autonomy is ethically relativist and incompatible with an East-Asian environment.<sup>12</sup>

This perspective is, however, an incomplete characterisation. The individual-collectivistic model does not delineate the extent to which cultural factors modify ‘universal’ standards defining good ethical conduct (if they exist at all), and where the line lies between cultural sensitivities and what Macklin describes as ‘universal character flaws’—arrogance, corruption, greed and indifference.<sup>15</sup> Moreover, other influences continue to shape the patient-doctor relationship beyond a purely transcultural perspective; Macklin argues that the act of withholding information from patients, instead of being explained through a collectivistic lens of family determinism over the individual, may instead occur as a result of medical tradition (historical conduct of practice), class (doctors are better educated and occupy a privileged social strata) and paternalism (doctors command power over patients). In a similar vein, Ma notes that patients in Hong Kong are ‘submissive’ not because of the collectivistic culture, but because they are ‘less able to express themselves in front of powerful doctors’.<sup>16</sup> We see that the presumption of the ‘family-unit’ *modus operandi* in an East-Asian context might not be as intrinsically linked with a sociocultural collectivistic perspective as is argued.

Similarly, the presumption that the individualistic interpretation of patient autonomy reflects fundamentally from the Western value system is also not entirely correct. The modern Anglo-American push for self-determination only originated in the 1950s precisely because of the *lack* of self-determination that existed previously (prior to this era, patients in the USA had little autonomy over the treatments they received) and after the horrors recounted in the Nuremberg trials after World War II.<sup>2</sup> Macklin notes that

*‘it is a mere 40 years since the concept of informed consent to treatment was introduced into the legal domain (in the United States) and probably only about 25 years since the practice of obtaining informed consent took root’.*<sup>15</sup>

She further argues that autonomy and family input are not mutually exclusive even in a Western conceptualisation, and there exists growing calls for change from within the Western

cultural milieu for families to become equally relevant in the decision-making process.<sup>17</sup>

Finally, the fundamental argument of a distinctly ‘Asian’ sociocultural-political ideology has been hugely contested by various scholars including Amartya Sen, who has roundly disputed a ‘grand contrast between Asian and European values’<sup>18</sup> and warns that such ideas are instead conceptualised to advance dogmatic political ideologies—in other words, there exists nothing particularly ‘Asian’ about ‘Asian values’.

It is clear that the individualist-collectivist perspective does not adequately explain the nuances shaping the standards underpinning patient autonomy within the patient-doctor relationship globally. However, we must not reject the argument that culture plays an integral role in defining the patient-doctor relationship.<sup>19</sup> Thus, it is critical to tease apart the ‘culture’ aspect; culture-bound differences must be distinguished from grossly unethical practices less to do with intractable cultural differences and more to do with ‘universal character flaws’. In this view, Macklin argues the USA is simply better able to control these bad practices through laws, ethical norms and professional oversight of practice—in other words, good governance and regulatory control, aspects which can hardly be considered culture-bound.

### RECHARACTERISING PATIENT AUTONOMY: ‘RESPECT FOR PERSONS’ FIRST AND FOREMOST

Can we propose an alternative conceptual framework to reconcile the dichotomy between cultural relativism and the quest for some form of commonality in patient autonomy? Macklin argues for a more fundamental approach: she believes that while values such as ‘privacy’ (as part of patient autonomy) might be culture-bound, the first-level moral principles which *underpin* these values are far less culturally relative—what Macklin refers to as ‘respect for persons’, the fundamental respect for the wishes and values of the *individual* patient.

If the conceptualisation of patient autonomy is realigned instead as a *means* through which we maximise ‘respect for persons’ rather than as an end in itself, what would such an interpretation look like in an East-Asian ‘collectivistic’ setting? First of all, respect for *individual* privacy within the family context need not be absolute—indeed, many patients themselves would *prefer* that their family take over significant portions of what is traditionally constituted as under the domain of ‘patient autonomy’ in an individualistic setting (it should be noted, however, that *family* privacy remains a different matter entirely). This does not contradict the best interest of the patient, nor does it indicate a violation of ‘respect for persons’ *if and only if this aligns with the patient’s individual wishes*. ‘Respect of persons’ must entail a minimum standard of *individual* patient autonomy, including the right to make *informed* decisions over their own care: this is logical as it may be impossible to know what a patient truly wants without discussing medical care issues with them directly, and in order for the patient to then make decisions in accordance with their wishes, they must be adequately knowledgeable of their own clinical condition.

An example of such an approach is found in Hong Kong, which Chan argues lies in the middle of a cultural continuum between the USA and mainland China, by retaining a strong family presence with aspects of individual autonomy in what Chan refers to as ‘moderate familism’.<sup>6</sup> Within the context of breaking bad news, he delineates the ‘special role’ of family in ‘vetting information and preparing the patient’, while abiding by several core principles:

- ▶ All patients have the right to be informed of bad news

- ▶ Not lying to the patient
- ▶ Telling the truth to the patient eventually.

We see that in this conceptualisation, respect to patient autonomy is enshrined even though the family maintains a significant role in information-sharing and patient care and could even be notified of medical developments *before* the patient him/herself. The 'respect for persons' is protected as the patient remains adequately informed of his/her medical condition, and thus is able to exercise a minimum degree of self-determination. In such a scenario, while the family plays a highly involved role in patient care, family insistence cannot override the individual right to information and autonomy. Indeed, Chan argues that the principal issue is not *whether* bad news is delivered to the patient (depriving patients of their autonomy), but rather *who* is best positioned to deliver the news, *how* it is done and *when* it is most appropriate to do so (maximising beneficence).

With the family's role clearly acknowledged within the patient-doctor relationship in a collectivistic culture, doctors acting in the best interest of patients may choose to involve family consultation within the decision-making process, including *disclosing information to family members without the patient's consent*, so long as this is believed to be in the spirit of 'respect for persons' and in the patient's best interest. If the patient objects to family participation (reasserting his/her right to autonomy), or if the doctor views such an approach as not in the patient's best interest (protecting his/her right to beneficence), this assumption of family oriented care immediately ceases and is instead replaced with a more Western model emphasising individual consent and autonomy. This fundamentally places the gold standard of the patient-doctor relationship on the *patient's best interest*, safeguarding the first-level principle of 'respect for persons'.

The Hong Kong approach does not contradict the individualistic approach; rather, it proposes a context-specific characterisation of the patient-doctor relationship fundamentally compatible with modern standards of medical ethics, rebuffing the argument for ethical relativism. This conceptualisation grants the culturally aligned freedom for a collectivistic interpretation of patient autonomy, maximising beneficence and trust within the patient-doctor relationship while preserving the original spirit of patient autonomy as the Western model was originally conceptualised to protect. It is not within the scope of this essay to argue about the practical challenges of applying this approach in clinical practice or even to arrive at a normative judgement as to whether any particular approach claims moral superiority—rather, it is simply a demonstration that the central principles underlying a bioethical concept as fundamental as patient autonomy can be applied in cross-cultural settings. So long as the patient-doctor relationship upholds fundamental respect for the patient's best interests, additional cultural modification that takes into account the importance of family input in collectivistic cultures based on the patient's value system should not be seen as contradictory to a Western interpretation of the practice of medical ethics, but instead as an opportunity to further strengthen the

patient-doctor relationship in different socio-cultural milieus in being simultaneously morally ethical and culturally aligned.

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#### ORCID iD

Max Ying Hao Lim <http://orcid.org/0000-0002-1830-7073>

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