
Case 11—Who Should Make Treatment Decisions for a Battered Spouse?

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LF and her husband WP were born and raised in Guangdong province in China and relocated to Florida soon after their marriage. This was a second marriage for both. LF had never been accepted by her first husband's family, especially once she began complaining about her husband's bad temper and occasional violence. Continuing disagreements between LF and her in-laws were the cause of the divorce; it is not unusual for a Chinese husband to side with his parents in the case of quarrels between them and his wife, even to the point of divorce.

LF had a 12-year-old son from her previous marriage who remained in China with her extended family when she and WP moved to the United States. They settled in West Central Florida, rented a small apartment, and joined a distant cousin of WP's who owned a Chinese restaurant. Her husband soon took over as manager, and LF, now pregnant with her second child, worked from home to balance the restaurant's books and manage the payroll. LF turned all of her earnings over to her husband, and except for brief trips to the restaurant to pick up paperwork, spent her days in their apartment. LF's husband was not pleased with the news about her pregnancy, as he had hoped to achieve greater financial stability before they had a child together. He began calling LF offensive names, and closely monitored her conversations with her family in China and the few restaurant employees with whom she had become friendly. Two of the waitresses wanted to hold a small party to celebrate LF's pregnancy at the restaurant before they opened for dinner, but WP would not allow it. "Your 'friends' think we're too poor to be having another baby!" he yelled. "They are right but you have no business telling anyone what goes on in our family!" It was more likely that the waitresses only wanted to acknowledge what they assumed was the happy news about the new baby. LF was disappointed about not being able to have a small celebration, which would have been a welcome break from working on the restaurant's books and her responsibilities at home. Baby showers are not common among Chinese families, many of whom are superstitious about celebrating the baby before he or she is born. "It's just as well," LF thought to herself, "no need to create problems with my husband or tempt fate".

LF had little direct contact with her older son, and relied on infrequent telephone calls with her parents and other relatives in China who reported on his well being. Although she missed him, she believed it was in his best interest to remain in China to complete his secondary schooling, and she hoped he would choose to come to America when it was time to enroll in college. Her son had no contact with his biological father, who had also remarried and fathered another son. Although her second marriage was more stable, LF had unknowingly married another abusive man. LF did not perceive either her husband's verbal name-calling or controlling behavior as abuse, and accepted it as something she had to tolerate. She had already brought considerable shame to her parents in China when she divorced the first time, and she was not willing to risk the social and familial consequences of another failed relationship.

LF gave birth to her second son and continued to work from home to help with the restaurant. The economic downturn of 2008 drastically affected the profitability of the restaurant, which was located near a new residential community still under construction. When the housing bubble burst, new housing starts declined precipitously, along with the restaurant's business. Pressures mounted on WP to maintain a stable income for the family, especially with the addition of the new baby. He took his frustrations out on LF, and the verbal abuse that had begun when she was pregnant escalated into physical violence. Although they needed the additional income, LF was often unable to go to the restaurant to pick up paperwork or to make bank deposits, because her bruises and abrasions were increasingly difficult to explain.

LF had by this time lost almost all contact with her family in China. She tolerated her husband's abuse, possibly to prevent him from taking out his bad temper and frustrations on the new baby. In spite of the violence she increasingly experienced, LF was determined to make this second marriage a success. As the economy slowly recovered, business at the restaurant gradually improved, but her husband's abusive behavior continued to escalate. He alternated periods of kindness and remorse with increasingly violent attacks against LF. By the time their young son was 5 years old, WP was threatening LF with hits, kicks, shoves, slaps and chokes, often in full view of their son. LF knew that although her husband was not abusing their son, witnessing the violence she endured was also harmful to him. Her older son was now ready to attend college, and she encouraged him to apply to the university in the city where they lived; it had recently expanded its outreach to international students, and this included additional scholarship opportunities and extensive English language training.

LF's older son was accepted into the university program and he arrived in his new hometown the summer before classes were to begin. His English was rudimentary, and his knowledge of American customs, not to mention the norms of American family life, was almost non-existent. LF hoped that her son's arrival would signal the end of the abuse she had endured, since there would be another nearly grown man in the home to witness the violence and to protect her. Her husband was unhappy his step-son would be spending the hot summer months in their cramped apartment, as he had expected him to move directly into his dorm

room in time for fall semester classes. WP was brusque with his step-son and only spoke to him in English when he bothered to speak to him at all.

Shortly after the older son's arrival, LF's husband shoved her into a wall in the kitchen because he was unhappy that she had brought food home from the restaurant for dinner rather than cooking something from scratch. She fell against some drinking glasses sitting on the counter, and several of them crashed to the ground. The older boy was stunned, and his step-father screamed at him to stay away. The younger boy, a terrified 5 year-old, stepped between his mother and father, who grabbed a piece of broken glass and sliced his young son's finger. He then barked at the older boy to clean up the mess and fix his brother's finger. He led his wife into their bedroom, locked the door, and proceeded to beat her to unconsciousness.

Both boys were distraught, but were largely unable to communicate since the younger boy spoke only English and the older boy mainly Chinese. Neither of the boys were prepared to call for help—they were not familiar with "911" and the family had no close friends or neighbors. In any case, the idea of airing the family's dirty laundry was unthinkable. After 45 min of terror, WP carried his unconscious wife to their car, and shouted at the boys to remain in the house and instructed them to talk to no one.

Upon arriving at the Emergency Department of the nearest hospital, WP told a story about coming home from the restaurant and finding his wife unconscious and his younger son injured, and he made some vague references to the fact his stepson was in the apartment at the time and appeared uninjured. The medical team informed WP that his wife's condition was extremely serious; she had severe bleeding from the brain and a broken wrist. Within a few hours LF became comatose and never regained consciousness. Despite the fact that the lapses in WP's story rendered him a less than reliable narrator, he had no criminal record since LF had never reported his abuse to the police. Although LF's injuries were consistent with abuse, the hospital personnel had no immediate choice but to rely on WP to make medical decisions for his wife. As her condition continued to deteriorate over the next few weeks, WP insisted on continuing life support, and LF was kept on a ventilator and feeding tube even though the medical team all agreed her prognosis was extremely poor.

Meanwhile, the older son was able to communicate with his new University about the troubled state of his family life. With the administration's help, he filed a police report detailing the events of that tumultuous night. As a result, the younger boy was removed from the home and placed in foster care, and the older boy was allowed to move into his dorm room earlier than planned. The physicians in charge of LF's care knew that continuing to rely on her abusive husband's decisions about her medical care was a grievous error, but they were told by the court that until the sheriff's office arrested WP, there was nothing they could do to remove him as her legal proxy. WP did not want his wife to die, since then he would likely be charged with murder in addition to child endangerment and domestic abuse. The doctors now knew of LF's older son's existence, and attempted to contact him and convince him that he was the better proxy decision maker.

LF's older son, although extremely distressed about his troubled introduction to American life, his mother's poor condition, and his step-father's violence, had no knowledge of what his mother would have wanted in terms of medical care. He pleaded through a translator that he did not want to make any decision that would look as though he was the cause of his mother's death, and also that he did not know her well enough to know what she would have wanted. LF remained on life support, and the hospital petitioned the court to appoint a guardian. Before one could be appointed, LF succumbed to her life-threatening injuries and was pronounced brain dead after 6 weeks in the Intensive Care Unit. WP was arrested and eventually charged with murder, child endangerment, and domestic violence, and he was ultimately sentenced to life in prison. LF's older son withdrew from the University and returned to China, and he was distraught that he could not bring his younger half-brother with him, who remained in foster care.

Discussion Questions

1. Law and ethics should work together, but are sometimes at odds. What are some of the ways in which what was legal and what was ethical were problematic in this case?
2. Who should make medical decisions for a family member when criminal behavior is suspected but before criminal charges are filed?
3. Can other family members who appear to be more suitable decision makers for incapacitated family members be pressed into service in spite of language and cultural differences?

A Bioethicist Responds

The preceding narrative bears a major characteristic often found in case reviews, that is, it lacks information that might obviate questions such as: What was the dynamic between the hospital, the court, and the sheriff's office that permitted WP to act as his wife's proxy, despite suspicions that he was the cause of her injuries? And what resources, if any, were brought in to help LF's older son understand his decision making options, or to help stabilize the living situation of both of LF's sons during her hospitalization? Although one could always wish for more information than might be given in a particular case report, much can still be said about how the frustrating issues in this situation might have been approached differently.

LF and her children faced many obvious problems, such as spousal abuse; psychological trauma; fear (of reprisals, of authorities in a strange land, etc.); and familial embarrassment, shame, and dishonor. LF, the other members of her family, and everyone attempting to help her medically or to resolve the attendant social problems were operating in a zone to which two cultures—Chinese culture and the culture of American medicine—both laid claim. Culture is a set of shared patterns of behaviors, interactions, and cognitive constructs learned by members of a social group through exposure and socialization. Cultures and subcultures have defining ideals and norms that are unique. For example, our American medical/ethical focus

on autonomy can be seen as a logical extension of our reverence for individualism, self-determination, independence, and freedom. Broadly speaking, Asian cultures favor a communitarian way of being in the world, and view the family as more important than any individual's desires or aspirations; filial piety is prized above the ability to make one's own way.

There are many instances of the culture clash between patients and the medical professionals attempting to provide care that have been documented. One excellent example is Anne Fadiman's book that explored the clash between doctors at a small county hospital in California and a Hmong refugee family from Laos over the care of Lia Lee, a child diagnosed with severe epilepsy (1997). Lia's parents and her doctors both wanted what was best for Lia, but the lack of understanding between them led to tragedy. Lia's illiterate parents were not able to give her the medicine prescribed for her condition, and could not accept the idea that she would need to take medication for the rest of her life. They also saw her seizures as evidence of her special connection to the sacred. The case of Lia Lee and the case presented here of LF—and many others—ask us to consider whether there are human ideals that transcend culture. Must we allow an epileptic child to be grievously injured because her parents' cultural beliefs see epilepsy as a divine blessing? Can we stand by and ignore an immigrant woman's suffering and abuse because to witness it or to intervene brings shame to her family?

The ethical issue with LF centers on the potential disconnect between Western medical views of autonomy and the Chinese cultural value of family and community. In the United States, we attempt to act ethically by honoring an individual's autonomy, operationalized in a medical context as his or her preferences for medical treatment. In LF's case, her cultural values placed the needs of her family ahead of what might best support her individually. Her willingness to stay with her abusive spouse speaks to this cultural value, as well as to more practical issues such as how she perceived her options for seeking assistance. Does honoring LF's autonomy and preference for self-sacrifice mean her abuse should be allowed to continue? We must ask whether it makes sense to hold fast to this relatively narrow view of autonomy, especially when the person's life has been endangered by someone usually identified as the proxy decision maker most able and willing to support the incapacitated person's notion of autonomy.

The principle of autonomy is a subset of a more inclusive ethical principle usually called "respect for persons" (Veatch 2003). Respect for persons is an ethic that derives in large part from the work of the philosopher Immanuel Kant. Kant affirmed the intrinsic value of human life and that humans deserve respect, demonstrated in the duties we have toward one another. The duty-based principle of "respect for persons" usually includes autonomy, fidelity, veracity and avoidance of killing. "Avoidance of killing" can be interpreted as a medical act—not participating in euthanasia for example—as well as literally not killing one another. Surely one of our most basic duties toward one another is the assurance of one another's personal safety and bodily integrity.¹ Our most basic ethical commitment must be to safeguard LF's life, even if such actions run counter to the patient's and family's cultural values. Culture is tricky. We need to explore the damage we do when we

insist on the superior humanity of our own preferred cultural practices and ethical principles. And we must ask ourselves what harm we inflict when we look the other way from cultural beliefs or practices that injure, demean and sometimes kill.

While this case did not occur in an area with a sizeable Chinese population, it did occur in a very large, culturally diverse, highly educated, metropolitan area containing a number of colleges and universities, including a major state research institution. The area in which it is located is one where speakers of major dialects of Chinese could undoubtedly be found, where certified interpreters would no doubt also be available, and where there would surely be persons capable of serving as informants about Chinese culture and customs for Americans working in health care, social work, legal and law enforcement activities. At this point it may be unfair to judge those persons directly involved in this case (e.g., physicians, nurses, social workers, police), but in the absence of other information one cannot help wondering why there was no attempt to better understand LF's domestic situation, and the cultural values that kept it invisible before her untimely and tragic death.

A Health Communication Scholar Responds

The individuals in this case cannot literally communicate with one another, either because they do not speak the same language, or because their cultural values are so disparate as to be nearly unbridgeable. The husband and sons will not talk to hospital personnel or to law enforcement. LF can no longer speak for herself because of her severe injuries. Law enforcement personnel are not communicating effectively with hospital administrators. The two half-brothers barely know one another and do not share either a common native language or culture. WP and LF did not communicate effectively in their lives together, and WP used his cultural privilege as head of the household to abuse his wife and step-son, without any legal repercussions (at least initially). The legal right of a spouse to act as his or her partner's proxy decision maker is based on the assumption that they will act to support one another's best interests, which also assumes adequate communication between husband and wife. The patient's older son has some rudimentary English language skills, but is a world away from embracing his role as an adult son who can (and probably should) question his step-father's actions and decisions. The entire family is thrust into a specialized subset of American culture—that of Western medicine—which further stresses their ability to communicate. Even more complicated, perhaps, are the multiple roles that each must enact. Chinese culture might describe the role of the dutiful step-son, the powerful patriarch, the humble wife and mother, but American culture, law, ethics, and medicine require a decisive step-son, an apologetic husband, and an autonomous patient. Under the most stressful circumstances imaginable, this family is attempting to manage multiple identities, play multiple roles, and satisfy multiple audiences. And the health care team members caring for this dying woman are also attempting to understand the culture that this family carries with them, respect the law that governs medical

decision making for incapacitated patients, and provide the best medical care possible. It is not clear from the case description how clearly and consistently the medical team documented the futility of continued life support for LF and pushed for a resolution to her medical condition, or how actively they advocated for more information about the cause of her injuries, so the areas in which communication gaps occur are multiplied.

In addition to the interpersonal and institutional communication difficulties these individuals faced, there are communication difficulties at a systems level between this immigrant family and the community in which they lived, worked, and raised their family. The communication discipline is particularly attuned to issues of context at multiple levels, and trying to understand some of the cultural differences Chinese immigrants face in adjusting to American culture might shed some light on this unfortunate set of circumstances.

The Pew Research Center reports that Asian Americans are the fastest growing racial group in the United States, comprising 36% of all immigrants who arrived in 2010; Latinos were second at 31% (2013). At 23%, Chinese Americans constitute the largest portion of the Asian American population. Nearly 2.4 million ethnic Chinese are living in the United States, and 2.2 million speak Chinese as a first language. Many reportedly have no intention of remaining in the U.S. permanently, and they work hard to maintain cultural ties and Chinese language fluency. Historically the primary immigrants from China have been men, with female immigrants entering the U.S. legally dependent on men as their wives, daughters, mothers, or sisters (Dasgupta 2000). Legal dependency often translates into financial and emotional dependency in South Asian families. Chinese men generally control the family finances regardless of a woman's employment status, and women who work outside the home are often perceived to be doing so as part of their domestic duties rather than for personal or professional reasons.

The image of South Asian femininity includes submissiveness and putting one's husband and family ahead of one's own needs. A woman may be educated, but that accomplishment brings status for her parents and future in-laws rather than for herself or her financial or emotional independence. Sons are valued more highly than daughters because they carry the family name, as well as whatever money, power, and status are handed from father to son. The importance of lineage is a distinct feature of Chinese culture. Daughters are seen as a financial burden to their families since they are expected to marry and become members of their husband's families. Chinese girls are taught from an early age that great harm will be inflicted on the family should they fail to be good wives. Even so, the marital relationship between a husband and wife is seen as secondary to the relationship between a son and his parents.

While often regarded as a model minority, domestic violence is a pervasive problem among Asians residing in the United States (Midlarsky et al. 2006). It is difficult to report accurate assessments of the prevalence of domestic violence in the Chinese immigrant community. The data available reveal between 10 and 25% of Chinese Americans are physically abused by a partner. But such behaviors as

having one's earnings taken, being confined to one's home when not at work, or being belittled by one's husband are not always considered forms of abuse or violence. Among Chinese people, one is rarely seen as independent or separate from one's family or community, and this is especially true for women. Domestic abuse is viewed as a family issue, and the priority is to spare the family public humiliation or legal repercussions as opposed to protecting the victim (Ahmed et al. 2001). Chinese Americans largely agree that making domestic violence public violates family privacy and brings shame to the family. In addition to informational and language barriers, these cultural values impose additional obstacles to immigrant Chinese women who seek protection from violent partners.

LF was fluent in English, but she was also likely prevented from seeking help in part by these cultural norms. The shame of another failed relationship likely discouraged her from acknowledging the extent of the abuse she was tolerating. Perhaps she was waiting for her older son to arrive and hoping that his presence would lessen the violence directed at her. Calling attention to her plight might have prevented her son from coming to the United States for college, for which she had long planned and prepared. Perhaps, as is common in the Chinese immigrant community, she did not perceive her husband's verbal abuse and controlling behavior as abusive. It may be that only when her husband's actions became physical that LF perceived her husband as an abuser and felt her well-being was in danger. Like many immigrant women, LF may have lacked knowledge about her rights in the United States, or feared police insensitivity toward immigrant communities. In fact, law enforcement personnel are sometimes "super-sensitive" to cultural issues, and fail to respond in standard ways for fear of being accused of not respecting cultural norms.

Cultural norms about family life are also embedded in Florida statute 765 that regulates end-of-life issues, including the identification of who may serve as a proxy decision maker for an incapacitated individual.² The hierarchical list of proxies begins with the judicially appointed guardian of the patient, followed by the patient's spouse. These top choices are followed by an adult child of the patient, or a majority of the adult children; a parent of the patient; the adult sibling of the patient or a majority of one's adult siblings; an adult relative of the patient; a close friend of the patient; or lastly, a licensed clinical social worker. Embedded in this hierarchy is the assumption that one's spouse (since most formally competent adults lack oversight by a guardian) has one's best interests at heart and is in the best position to make medical decisions. For anyone who is a member of a non-traditional or dysfunctional family system, the hazards of this legal structure become immediately apparent. A homosexual couple unable until recently to marry, for example, would not be able to make medical decisions for one another. The case of Terri Schiavo also revealed the vast difficulties of assuming that individuals on this list with close ties to the patient would agree about the appropriate course of action. Terri Schiavo's husband and parents spent 15 years embroiled in litigation about whether or not to discontinue artificial nutrition and hydration after she was diagnosed as being in a permanent vegetative state.³

Laws and ethical principles should ideally reinforce one another. The Florida statute aims to support the extension of a patient's autonomy beyond their capacity to make their own decisions by specifying a hierarchical list of proxy decision makers, standards of evidence about a person's medical treatment preferences, and provisions for writing a living will or advance directive. But clearly in this case, both ethics and law failed to protect the rights of LF. She chose not to pursue her legal right to protection from her violent husband, and inadvertently allowed him to remain in a position of power over her even after he was the cause of her incapacity. Ironically, her husband's right to be seen as innocent until proven guilty, and to be named as his wife's medical decision maker, were better protected under the current legal and ethical structure than were LF's rights to autonomy and protection from bodily harm.

Justice was served when WP was arrested, convicted of murder, and sentenced to life in prison, but it came far too late for LF. The law also made victims of her sons—one who remains in foster care and one who returned to China without the benefit of an American university degree, and likely with a good measure of guilt for his inability to protect his mother from fatal harm. It is difficult to fault the hospital personnel who followed the letter of the law, but unfortunately such diligence does not always lead to an ethical outcome. Court-appointed guardians serve a useful and necessary function, but the process is burdensome—law does not move at the pace sometimes required in medicine. The standards of evidence for a criminal investigation are also cumbersome to apply to medicine and to ethics. The law protected WP's rights, but failed to protect the interests of his battered spouse or embattled sons. The ideals of open communication—to ask the pertinent question, to question standard operating procedure, to voice concern about another person's life and liberty—must also be safeguarded and held as sacred.

Notes

¹The ethical principle of beneficence requires us to do good things for one another, but it does not obligate us to put ourselves in harm's way, unless we have a professional obligation to do so. For example, an average person need not stop to assist a stranded motorist in a dangerous neighborhood, which might reasonably put their well-being at risk; however, a police officer, who has taken an oath to protect the public, must do so.

²Florida Statute 765—Health Care Advance Directives. http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0765/0765.html.

³For more information on the Terri Schiavo case, see Caplan, A., McCartney, J. J., & Sisti, D. A. (2006). *The case of Terri Schiavo: Ethics at the end of life*. Amherst, NY: Prometheus Books.

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