

Socio-Cultural Embeddedness of Dying (Praxis) in Modernizing Chinese Communities: *All that is Solid Cremates into Ashes?*

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Why care for (Whom) those at the ending of (human) life (EOL)? The *Care* for the ending phase of human life is embedded with two contesting, sometimes contradictory, dynamic specificities which are over a long historical span from pre-modernism of cultural heritages and customs to hyper-modern high-tech in East Asia: traditional virtues of caring the others – originated from human love with the art of loving encounter the agglomerated new technologies and know-how of bio-medicine within a wider policy framework of public health and welfare services. The arguably dualistic structure / dynamics of intertwining old virtues (of Chineseness?) with (versus or against) new technologies not just pose ethical and normative choices-driven dilemma and paradox for all stakeholders, but also presenting a challenge for the state to pursue policy initiatives for enhancing social wellbeing at large.

Deriving from recent research on EOL and case studies on “hospice” care, this work-in-progress paper examines the contradictions of modernizing living and dying processes in Chinese communities (Hong Kong under colonial-capitalism and mainland China under state-nationalist-socialism), with reference to the Three-Level-Structure of Analysis on Bioethics. While taking account of socio-technological innovations -- the problems of techno-determinism, and emphasizing the socio-spirituality aspects of humanity, it highlights the manifestations of the social shaping of the end-of-life care, under the bio-medical technological care regime. Initial findings show that, due to differential modernization exposures in terms of customs, belief and knowledge, the concerned parties (professional carers and the relatives of the dying one) act differently, if not contradictory, within their own self-referential logic, belief and emotions. This is especially evident as the gate-keeping function of bio-medical regime for (diagnosis, prognosis and certificating) dying-to-death has been increasingly instrumental to define, as well as shaping, the ending process of human physical life, even without an explicit nor a well elaborated-shared ethical-normative framework. This brief ends with critical remarks on interactive-engaging processes for the dying and living life course, juxtaposing the re-constitution of old/new social relations; that have to be evolved by the people, based upon veteran and emerging social virtues and reciprocity.

Key Words : Health Care, Chinese, Dying, End of Life, Ethics, Family, Modernization

1. *The Universe of Living (dragging Dying) and Dying (dragging Living)?*

People in modern society are too busy to deal with daily struggles for survival without appreciation of life and death. It is rightly reminded us that

death and life are the intertwined bondage of (how one's) living and dying; though the subject matters are rarely studied nor understood in our present knowledge system:

If as Socrates said (Plato, 1961, Dialogues: Apology 38) “the unexamined life is not

worth living” and if death is a part of life, the final stage or the stage in between, then “an unexamined death is not a death worth dying.” In most religious traditions, this life, that is, the present life, is looked upon only as a preparatory stage for another (everlasting) life. In most traditions, there are certain rituals and ceremonies to be performed for the deceased. Yet, somehow, questioning the dying process and the necessary preparation for death has not entered, in a serious way, into our discussions and the educational system (Massoudi 2010: 198).

End of life (EOL) is a natural process of life course which everyone (homo-sapiens) has to face, none can escape this natural calling; though the critical issues are how and under what conditions will EOL process take place and perhaps, more importantly, how the interaction and separation processes between the “leaving” one with those who are still surviving but accompany their loved one’s EOL. Among others, the most dynamics of EOL perhaps are the spiritual/emotional aspects of EOL (namely, Geist) of why, under what conditions and for whom is caring for EOL.

1.1 Conceptualization of EOL: Temporal and Spatial Contours -cum- Uncertainty

But socio-familial relationships with the dying one are always a stressful, before, at and after the EOL processes; so do the relationships deriving from palliative care (Chow, et.al.2006): say the least is the emotional tensions, the ups-and-downs of psycho-somatic stress. For instance, revisiting the memories of the deceased are common experience for bereaved persons – the challenge is how to cope with these ins and outs, or ups and downs, of bereavement process.

Beyond the personal and familial nexus of emotional attachment; it is family dynamics and the unique family history which shape the process of EOL for the concerned. But at the macro level, particularly in the context of modernizing society like mainland China and Hong Kong, both societies have a highly ageing population, 10% and 13% respectively of the total population are aged 65 or above in 2011. This has strong implication for the momentum and scale of EOL, now as well as for the future – though life expectancy in Hong Kong is 85 for women and 79 for men – 2nd after Japan in the world league of longevity; mainland China has a lower life expectancy of -5 from the Hong Kong figures.

On the other hand: given the strong and continuing economic growth in the last 30 years in both economies, there is important role of pre-modernism of cultural heritages and customs on the one hand, juxtaposing socio-economic hyper-modernizing, high-tech milieu of economic development in Asia’s Economic Miracle or the rise of socialist China.

To examine the dynamics at the journey of EOL in Hong Kong and mainland China, this paper attempts to delineate three empirical arenas, mirror-imaging the Beauchamp (2003; Beauchamp & Childress (2008)’s three levels of Biomedical ethics for understanding the related structure and dynamics, with specific reference to two distinctive yet inter-related mechanisms for coping with the mortality of human beings; namely, the interactions between/among the socio-familial embeddedness (of the Chineseness) and (Western) medical-health know-how, within the temporal (social timing, when and how long?) and spatial (where EOL and its derivatives take place) constrains of modernization. Obviously, in our framework, there is a strong sense for the multiple modernity on the one hand; and the rise of the varieties of second modernity (Beck & Grande 2010), on the other. In Asia’s modernization drama – the very obvious parallel or partial Westernization of Japan, China and South Korea demonstrates the thousand-year old socio-cultural structure and dynamics (Han & Shim 2010; Suzuki, et.al. 2010; Yan 2010; Chang & Song 2010) which are embedded in hyper-economic growth of the (Western?) modernization trajectories. More specific for indicative illustration is shown here (Fig.1):

Figure 1: Agencies & Dynamics of EOL's Temporal & Spatial Frames in (Asia) Modernization Trajectories

	Temporal When/How Long: Social vs. Medical Timing	Agencies of/for Development / Modernization	Spatial Where: Arena, Setting & Domains
1st Level <i>Locale</i>	Notification of “Incurable Illness... until the ending phase of EOL.	Medical Care Agents Dying Patients Surviving Family Members	From Home to (ins/out) Health Care Institution (like Hospital / Hospice): Milieu of/for EOL
2nd Level <i>Society</i>	Hyper-Modernization (since 1980s): Socio-Economic Development-driven Socio-Family Transformation	Modernizing Medical & Legal Professionals Agencies & Framework for EOL <i>versus</i> Members of Family History – cum- Cycles	City State of Hong Kong Mainland China's Urban-Rural Differences & Divides since (1911, 1978) Modernization
3rd Level <i>Cross-Cultural Philosophy</i>	Historical Processing Socio-Cultural Heritages & Legacies.... Virtues & Customs on Inter-Generation Reciprocities	Shaping from Confucianism, Buddhism and Taoism (CBT), upon “Old Age” Socio-Cultural Structure like Family, Kinship and Lineage System	Regional & Global Scales: Exchanges, Interactions and Transformation between Cultural Spheres

1.2 Socio-Cultural Differentiation versus Bio-Medical Definition for Timing EOL

Juxtaposing philosophical inquiries on the nature of life and death, cultural praxis, religions in particular, have provided a paradigm and worldview for (partial) comprehension of life and death: the origin of life, the meaning of life, life after death; as well as the rituals and practices to maintain psycho-socio adjustments. But biomedical sciences and the related technologies have been transforming the bolts and nuts of EOL, though biomedical practices rarely address to the eternal fundamental questions of/for life-cum-death. Hence, the socio-cultural timing and biomedical processing for EOL is fundamentally separated and different in domains and trajectories.

The proclamation of EOL process nowadays is mostly by biomedical definition offered by clinical evident confirmed by medical professions – the genesis of EOL usually embarks when physician's declaration of the “incurable” illness privately to the patients in question, or openly to the dying one's family members... whether the patient will left to die in misery or not is much determined by a mix of socio-familial network support and the availability of palliative care options (like hospice).

The differential timing of EOL process is an important concept to note: even the inevitability of dying process has taken place, most of us will deny, or defer, to accept the natural course of life and death – more specific, there is a generalized reluctance, and self or inter-negotiation, on the part of dying patients and their family members to consider the calling of/for EOL.

For the last two centuries, modern medicine serves a very important function of keeping human beings living longer (delaying EOL or happier?). But its success has contributed to its failure of re-addressing the fragility of human life, as well as the inevitability of EOL as a natural process of oneself. In this context, modernizing Chinese societies also “believe” the vitality (impossible mission) to keep patients cured and discharged from hospital...Hence, the hope for “recovery” and “getting well” is mystified as if the only missing or calling for medicine and health professionals. The developmental result is obvious that people have very high (unrealistic) expectations of, and dependency for, bio-medical system and expect the high-tech knowledge based health care services for keeping life forever for everyone...

In between the struggles to deal with the bad news of the beginning of EOL process; cross-cultural different should be observed here. Taking a cross-cultural perspective focusing on studies on American Chinese EOL care, Tung (2011: 68) noted that:

Family is also the gatekeeper for the critical issues, such as cancer diagnosis. Many Chinese health professionals withhold unfavorable medical information from patients at family's request to prevent patients from the psychological burden of facing death. In addition, core Chinese family members usually make treatment decisions for the terminally ill family member and physicians follow the treatment preferences of these family members over the patient's. To protect the dying patient from the burden of making difficult choices about medical care, involvement of the patient

in end-of-life decision making is very rare in Chinese culture.

Furthermore, there is always attempt to find the next possible good news (alternative diagnosis and prognosis) to delay the set off of EOL journey by patient or his/her family is the main reactionary modus operandi of those drawn into the EOL whirlpool. Without the final (last) confirmed knowledge of the diagnosis and prognosis for “no cure”, the EOL is always belatedly accepted and palliative care (like hospice) is lastly adopted or often, put off completely. Like its counterpart in other cultures, Chinese families usually object to the breaking of (bad) of EOL news to the affected (Chow, et.al. 2006).

2. Differential Timing for -Milieu of- EOL in 21st Century Chinese Communities

EOL is a critical bio-social timing concept with respect to human existence, individual’s existentialism and family historical processing of the loved one’s life course and his/her “absence” and “presence” beyond realism. And the onset of EOL is much a negotiated one; more often than not, it is a unilateral informing from the EOL gatekeeper and subsequent death certifier (the medical profession) to the patient and/or his/her family member(s)... Take a retrospective anecdotal case of the dying one saying: “Informing me about the beginning of EOL (breaking news of the medical diagnosis-prognosis of “incurable” illness) when I’m (and my Family is) ready... Okay!” As the (paradoxical) “readiness” is hardly readily available, the informative notice is

always belated served; making the limitedness of surviving time during EOL process more stringent! This rigid-shortened timing for survival is more sever in a different (place of) institutional care setting of hospitalization, away from one’s familiar home.... Similarly, the advanced sophistication of medical science (test-and-retest) is a muddle, but not through.

2.1 New Hospitalization for Human Extinction: Biomedical Modernization of EOL?

The biomedicalization of EOL, contrasting the pre-modern rituals for ending one’s physical life, is more than obvious thanks to advancement of biomedical sciences and technologies.

But paralleling the medicalization of EOL process, the so-called palliative care is emerging and mainstreaming onto biomedical regime for caring the dying ones, as well as pro-living for the surviving ones. Payne (2009: 514) delineated the development of palliative care as a progressive series of phases: (1) 1940s to 1960s as the initial developments in USA and Western Europe such as crisis intervention; (2) the UK hospice development in the 1960s (St Christopher’s Hospice in 1967, See Fig.2) led to a global movement for improving care for dying and bereaved people; (3) 1980s to 1990s: the formalization of palliative care under the medical specialty of palliative medicine; (4) the institutionalization to extending hospice work to a broader form of clinical practice and leading to acknowledgement of the right to good care for dying and bereaved people, as by the World Health Organization (WHO); (4) 2000s: mainstreaming of palliative care for EOL.

Figure 2: Saint Christopher’s Hospice (UK): EOL with Dignity



(Source: <http://www.stchristophers.org.uk/>)



In view of multi-parties involvement in the process of EOL, it becomes more expensive to complete the course of EOL: say the least is the growth of medical expenses during the last phase of EOL, especially thanks to the advanced development (costing) of medical and health care system in all advanced modernized (Westernized) economies. In other words, dying or EOL with high-tech medical setup is expensive in modern society: the last phase of EOL with assistive bio-medical devices at the Intensive Care Unit (ICU) incurred the highest cost, vis-à-vis, dying at own home or hospice. Shall we cut the cost to save more life of the others – a bio-medical ethics as well as a redistributive justice question?

Yet, it should be pointed out that the time and space in modern mobility-driven society are instrumental but contradictory for EOL medical and nursing care regime; ranging from one's own home care, ambulance care, nursing home, hospice, hospital (and its ICU)....

Even the after-care (funeral) services for EOL quest for monetary and social resources within an ageing society with the growth of “silver” (ageing population) to “gray” and subsequently to “black” (death-or after-life related business) market and its differentiation. Hence, EOL and the post-EOL proceedings and rituals are costly yet precious!

In Asia, health care development has been benefited from its economic miracle; though there is a trade-off between enhancing public (and primary) health and the advanced (tertiary) hospital development, as well as the tensions between public health care financing –cum- delivery and those funded or offered by private medical care (Wu & Ramesh 2009). Contrasting mainland China, hospital development in Hong Kong has received a preferential support from medical professions and the government; the Hong Kong Hospital Authority has almost had a monopolistic control of health care agenda, funding and delivery in the last few decades.

Since the late 1980s hospital in Hong Kong has been the institution to receive and process the early phase of EOL, with the admission (gate-keeping) of patients via accident and emergency department (AED) as the main gateway prior to EOL. This is particularly the case for aged population, which has a higher mortality rate than the rest of population cohort. In this regards, recent study found that aged 65 or above use frequent AED services three year before death, though people dying in older age groups do not use in patient hospital services more than younger age groups. More specific, the increasing numbers of elderly people occupying hospital beds is

a result of proximity to death rather than age per se. The number of admissions also followed the same pattern as for the duration of stay (Woo, et.al. 2010).

To recapitulate, the whole process of EOL has been intertwined by high-costing medical expertise-driven course of treatment (prescription following diagnosis while considering prognosis) and an array of socio-economic externalities beyond medical setting with family dynamics, history and its life cycle. One of such intertwining contradictory dynamics can be seen from the differential social-, vis-à-vis, medical timing between the dying and surviving ones and (against) the medical professionals.

What is more important is the time factor, when and how long the EOL process take place and affect whom... which is obviously shown in the differential life course of EOL – different involving parties have differential commitment in the EOL process.

2.2 Historical Timing on EOL: Socio-Familial Life Cycle -cum- Legacy

Timing of death is important to note. The temporal dimension involves at least three aspects of social timing of the concerned parties: the dying one, those have strong socio-familial with the dying one, and the bio-medical (sub, para-)professionals who are working with/for EOL process.

The acceptance of the fact of EOL (or last destiny) of the loved one has been always somewhat confusing yet negotiable, but not necessary in the bio-medical defined terms of “curable” or “incurable” illness. For instance, the temporal length of chronic illness (versus accidental death) provides more room for the mitigating and adapting process for the affected ones. Hence, there is much difference, obviously the uniqueness of, and between, the individuals (as derivatives of his/her family life cycle and history) in accepting the EOL.

The pronouncement of EOL indeed marks the end of the tasks for bio-medical intervention in medicine regime, but it does not necessarily be the case for the surviving members of the deceased – there is also a distinctive social / professional timing differentiation among the involving parties. But two major dynamics, often in tensioning condition, are in place, namely the one mostly affecting the dying-and-his/her family deriving from socio-cultural virtues and customs and the institutional defined bio-medical professionalism-driven logics. Since the under-current is much shaped by the “otherness”; tension between those suffering from EOL and those “treat” or “operation with/for” the EOL process

are experiential strong - conflicts and emotional outbursts are not uncommon!

Comparative speaking, it takes a rather long time for the deceased family to come to term with EOL process, but which might be case for bio-medical professionals who have been trained to deal with the case and presumable, business-as-usual with/after the signing of the death certificate (which is for public health reasons, becomes the modus operandi for EOL in most modern societies).

There is differential timing of EOL for the concerned / involving parties: the just-in-time medical diagnosis, prognosis -- and ending with the certification of death, is in strong contrast with the slow, time-lag and untimely emotional tensions of the surviving family members. In other words, there is individual's differential worldview-driven experience of EOL; clinically sound procedures might not be necessarily compatible to social timing of the affected: socio-familial acceptance of EOL is always through zig-zag winding and rising-and-falling trajectory of emotional reciprocities. Furthermore, there is also problems with respect to the medical institutionalization, vis-a-vis, socio-familial attached love and its negotiated externalization (of family history and lifecycle), of EOL process.

Due to differential modernization exposures in terms of customs, belief and knowledge, the concerned parties (professional carers and the relatives of the dying one) act differently, if not contradictory, within their own self-referential logic, belief and emotions.

2.3 Acceptance-EOL-driven Choreography of the Passing Away Process?

In a highly urbanized city of Hong Kong, securing a place for residence is a difficult and high-price survival game. Within the limited (crowded) living space, there is almost no possibility to have chronic illness (driven to death) care taking place at one's own home. And the only available option (in fact, no choice) is to put the sick, frail, and those for the onward journey of EOL to institutional care; hospital therefore is the final stop for EOL. There is also a legal-administrative and public health push (factor) for hospital's EOL, as stipulated by the Hong Kong law (*Hospital Ordinance*), dying at hospital is the most convenient one (no need to report to the police for investigation protocols) for Hong Kong society. The EOL other than in hospital setting requires much complicated investigation, procedures and documentations. Compared to the UK that 20% of EOL have no record of hospital admissions, but ca.

93% of Hong Kong deaths occur in hospitals (Woo, et.al. 2010: 205-6).

More specific for the caring for EOL, Hong Kong's (and mainland China alike) bio-medical prescriptive acute care regime is still a dominating one; though palliative care is emerging... But to bridging the bio-medical certification (of death) with socio-familial (emotional) attachment to during critical timing of the passing away, the use of hospice care or EOL at one's own home is still at infant stage.

In modern Hong Kong, dying to death (passing away) is no longer just a natural process as medical (hospital) regime of governance is critical. The admission to accident and emergency department (AED), with subsequent hospitalization, eventually embarks the EOL process. And most of the (certification of) death (not necessarily the whole dying process) take place at hospital, but with frequent visits of the aged (dying process towards eventually death) to AED (Woo et.al.2010); contrasting EOL at hospice (a milieu for medically (diagnosed) dying process of less than 10% of the death toll.

There is ideal case for involving all the stakeholders in the EOL process: say, regardless of socio-economic and ethnicity differences, all of them should be asked how they (alone, with family, and with the physician) prefer to make decisions regarding EOL. For example, the use of Advanced Directives (AD) – guidelines, to enhance the quality of care while respecting individual's dignity and choices about the preferred bio-medical procedures in different phases of dying, is mostly promoted by Western modern society but it is rarely articulated by health professions in Asian societies. In the case of Hong Kong and mainland China, the use of AD is minimally integrated into EOL caring process, or it comes at the very advanced, belated critical phase of dying – the suffering-avoidance procedure dictated by the critical conditions before the EOL so to speak. Here, the timing is critical, short yet quick to cope with the "expedition" the EOL in a quiet mode.

Without the AD in place for chronic illness patients towards EOL, anecdotal accounts on the experience of those involving in EOL suggest that more patients in Hong Kong and mainland China rely on physicians (the preferred proxy role) and families (supporting the medical proxy) to make decisions for them to go through EOL process (Chow et al. 2006, Chow 2010).

As there is no way to escape EOL; the logical way to face the life-death challenge is how or under what preferred option to complete this necessarily existential endeavour. Obviously, the preferred choice

for EOL is less articulated in modern society as the fundamentals of modernism are “unlimited growth”, “live longer and better”; and birth is more celebrative than death. Choice for EOL is very limited as it is more or less belatedly addressed or confirmed by medical doctor who declares the “incurability” of illness and subsequently pronouncement of death with the certification.

Comparative studies show the contextual specificities function more than cultural-ethnicity per se to define and shape the course of EOL process, as well as the options available for the preferred EOL; like the availability of monetary –cum- socio-familial capital and government-institutional resources within a broader (better?) milieu for (or against) EOL with dignity and respect (Matsui, Braun & Karel 2008).

Hence, EOL preferences are influenced by contextual factors and it is a mistake to stereotype individuals by their ethnicity; so when this paper discusses the case of the “Chineseness” in mainland China, or the East-meet-West characters in Hong Kong, we use them more as an indicative function.

3. Multiple (Pre-) Modernity: Body-and-Mind Differentiation in Socio-Medicine

The differential (Western) modernization trajectories in East Asian societies have been structurally anchored upon traditional Confucianism, Buddhism and Eco-Centrism (like Chinese Taoism or Japanese Shintoism); but the differences are somewhat more than the similarities (Tu 1996): harmony but not conform to a particular set of ideologies; pragmatism with soft (and fluid) approach for development is more than obvious (Han & Shim 2010). Yet, the dualistic, if not dialectical, structures and dynamics (between the old and the new, the West versus the East, and other dualistic (de-)coupling alike) have been crafting the socio-cultural landscape where EOL processes take place.

3.1 Modernizing Western Medical Care embedded into Eastern Cultural Legacies

In China, there is large difference in terms of both quality and quantity of medical care provision, ranging from village-based primitive health (check) care to the sophisticated bio-medicine in metropolitan areas around Beijing, Shanghai, Guangzhou, and in Hong Kong – mostly led by university-teaching hospitals. In our case study focusing on Hong Kong, a high developed economy with much health care assets; medical care for acute illness-based EOL

and chronic illness-embedded EOL is differential “streaming” (or triage like in emergency medicine) into EOL at teaching hospital (the main gate-keeping for patients admission), palliative care at secondary convalescent – nursing home like regional hospital, and the novice hospice care for EOL.

In spite of a modern medical system in Hong Kong, a city state, the concept of EOL is still a contesting one; so do socio-cultural -cum- emotional aspects of the deceasing one’s family and relatives and, in some case, contradictory against, bio-medical science rationality-based diagnosis and prognosis which bear different epistemology and ontological implications. For instance, the ideas of “Euthansia” have not been fully articulated among medical professionals, or among citizens. The infancy of bio-medical ethics within (contrasting) a highly developed medical system in Hong Kong can be shown by anecdotes; the underdevelopment or the delaying (forgetfulness?) of the policy discussion is highlighted when testing out the reliability and validity of the Euthanasia Attitude Scale (EAS) in Hong Kong medical doctors:

In Hong Kong, where Chinese culture meeting the western influences, introduction of “passive euthanasia” into the code of conduct for doctors was proposed in 2000. Two years later, guidelines on the withholding and withdrawal of therapy were available in Hong Kong.

In 2004, a desperate patient of paralysis of limbs demanded the authority for his right to euthanasia. This not only has aroused again the discussions of end-of-life decision in local society but also harped echoes internationally (Tang et al. 2010: 320).

In other words, the bio-medical ethics in Hong Kong’s health care system is belatedly developing, but the development is embedded within Chinese socio-cultural foundation. Hence, there are tensions (if not contradiction) between modern Western bio-medical technologies and Eastern (traditionalism) cultural embeddedness.... This contextual specificity has been defining and shaping the courses, contours and trajectories of EOL at individual, family, social groups and (particularly medical care) institutional levels.

Embedded in Chinese socio-cultural foundation with fault-lines drawn by three major influences from the trilogy of Confucianism, Buddhism and Taoism (CBT), the highly modernized (Westernized) medical and health system has become a site, place or milieu to exemplify the differences or contradictions of the under-development of bioethics in general, those coupled with EOL process in particular: budgeting

and funding for medical and health services are not compatible the respect and dignity for those undergoing (suffering from) EOL process, say the least.

3.2 Three Level of EOL Bioethics: Structural Tensions & Matrices of Value-based Belief

Clinically defined dying process, and subsequently death, is embedded in structural tensions between the clinical in the social and the social in bio-medicine, as shown in our previous indicative framework. Three levels or arenas of interaction can be identified; namely, the clinical ward level, the society level and cross-cultural philosophies in historical time frame of modernization.

At the venue of/for EOL, like hospital, nursing home or hospice, there is a reframing of the concept –cum- nursing care practice for the dying one and the concerned family members: between the binary coding of EOL (life-and-death) and social timing of life (after-life) at people's social reciprocity.

But institutional setting where EOL takes place defines under what conditions and by whom (health care agencies) the dying (and surviving) one will be taking care of. In modern society like Hong Kong and modernizing cities in China, the setting likely to be at hospital or related medical and health care institution; namely, the modern milieu of EOL process is mostly in health care institutions, ranging from hospital to hospice (Lo, et.al. 2010).

In Hong Kong the palliative care for EOL is still an emerging / novice one, as indicated in a recent study that the palliative care concept is only recently adopted in old age homes, it is perhaps not surprising that many would find deficiencies in their knowledge of palliative care (Lo, et.al. 2010: 269).

Different from (dying at) home care for EOL in pre-modern era, modern institutional care defines, and some instances limits, the choice for care for the dying (and his/her surviving members); and the adjustment process from acute care to chronic care for EOL, and the journey from home to institutional requires much adjustment. This can be seen from the major issues during the early phase of EOL institutional care: adjustments problem for both the dying people and their family are usually coupled with physical conditions decline of the former and mis-communication between the affected family members, and between the client-patient and health professionals (Lo, et.al. 2010: 268)

Socio-familial engagement with health care professional for the benefits of, and with, the dying

one is critical important for an adaptive-evolutionary appropriate adjustments for EOL.

Due to under-provision of health care services, there is a seemingly paradoxical contradiction regarding the time spent on, and tasks for, the dying one against the authority-hierarchy of decision-making for EOL: health care (sub- and para-)professionals' time and tasks spent with the dying one is inversely proportion to the rank and status: more tasks are carried out, and more time is spent on, for the EOL by the rank-and-file frontline health care assistants, followed by nursing staff and medical physician – but medical physician (followed by nursing gatekeeper, the so-called nursing care ward manager) controls most of the key decision, prescription and daily routines for the dying and the survival one (say, the visiting time and the curfews). All these exacerbate unnecessarily tensions and conflicts!

The paradoxical hierarchy of power-time-tasks matrix has structured the milieu where EOL takes place and problems evolves; in most cases, medical guidelines over-power socio-familial reciprocities which aggregate mis-communication of the concerned parties in general, and the social (versus professional) time differentiation and divides for the caring of EOL: medical timely decision is working against the temporal needs of the affected family members and the dying one to cope with the crisis of EOL. In other words, the hierarchy of power-time-tasks constituting the institutional setting, and the time-lag or conflicting experience on the way to EOL process, reinforce the temporal and “adjustment trap” (without enough time for digesting and resolving emotional happenings, those [except the task-specific health professionals] in the EOL process are likely trapped in the unknown and mis-communicated temporal-spatial lost) – this could be partly reflected from high anxiety –cum-uncertainty of all involving parties who have less power and authority like medical physician who can determine (when to call and certify) the clinically death (cf. Lo, et.al. 2010; Woo, et.al.2010).

To promote a good system for EOL, there are seemingly not just some anxiety, worries and concerns on the lack of palliative care knowledge, manpower and supportive resources, but strong marked difference for the concept of “palliative care” along the hierarchy of service providers (gatekeepers, assuming) even with a somewhat shared (?) motivation for better EOL (Lo, et.al. 2010). Perhaps, this complex view on the palliative care is a direct reflection of the shortcomings, shortfall, and missing communications in the caring landscape and

“adjustment trap” where hierarchical fault-lines of power-knowledge and the divided social (individual –cum- family emotional versus professional-task) timing anchor.

Having a differential, if not divided, social timing between the contracted health caring agencies and the dying –cum- family one; it is almost impossible to accomplish a decent EOL with respect to and dignity for the dying (and his/her family) – not even close to the mostly used, but rarely articulated nor agreeable, holistic (conceptualization of) health for EOL. And it is not uncommonly experienced, and sometimes found, that when health care professionals’ timing for the dying is stopped for clinically death with the death certificate signed and issued by medical doctor, the surviving members’ differential timing with the dying (not yet death in terms of socio-familial time) is still wandering and muddling but not through....

All socio-cultural institutional – socio-familial differences, their differentiation, or their divides make the uniqueness of EOL process in modern institutional regime of health care – this is further exacerbating with a mix of Chinese socio-cultural practices (at the socio-family relationship networks) but without corresponding structure or echoing spaces in Western modern medicine-driven institutional care for EOL process.

More specific, it is especially evident in our field observation that the gate-keeping function of bio-medical regime for (diagnosis, prognosis and certificating) dying-to-death has been increasingly instrumental to define, as well as shaping, the ending process of human physical life, even without an explicit nor a well elaborated-shared ethical-normative framework. In short, responding and echoing between medical regime and socio-familial concerns are rarely met!

3.3 Binary Coding of Life & Death in Socio-Historical Time Frame: Trilogy of Chinese Culture

Confronting nursing care for EOL, experiences of ethical dilemmas and workplace distress pose challenge for health care professional in different cultures and even within the same society with multi-culturalism (Wadensten, et al. 2008).

In Chinese historical time frame, the foundation of Confucianism, Buddhism and Taoism (CBT) is more than solid and substantial! Hence, the extension or the externalities of life (-after life?) and the historical good calling from CBT are embedded in every social practices regarding EOL in Chinese societies (Tu 1996).

The so-called Chinese cultural practices

embrace the influences from CBT. Yet, there is different preferential integration of matrix among them: say, the differential prioritized matrix of CBT, CTB, BCT, BTC, TBC and TCB. More importantly, it is the critical different matrix encounters with bio-medical regime of health care in (Westernized) modern society; and these built-in tensions and dynamic (de-)coupling condition the risk and uncertainty of human life course – say, the Buddhist normality (life-after-life cycles) of Birth, Aged, Sick and Death. But against this backdrop, under hyper-modernizing forces, Chinese worldview on death and dying is changing too; though majority of the ageing population tend to consider EOL as a taboo (Tung 2010; cf. Tu 1996). To recapitulate the multiple self-referential sub-systems of socio-culture and bio-medical (determinism?), the extent of the Chineseness with different CBT philosophical underpinning and their matrix contradiction-dynamics in hyper-modernism originated from the West(ernization) should be highlighted here.

The ideas, ideal or virtue, of life-after-life is the foundation of all human religions from the East and the West. Cultures, customs and folklores define social life in any community. More specific, religions and folk religions in Chinese context (Yang 1961) have provided an epistemological and ontological framework related to the genesis, course and termination of life, the means of (pre-and-post)- life.... Western philosophies since the *Enlightenment* have been in pursuit of the discovery of the meaning of life (forms), but Western modern bio-medical sciences, since their several-century departure from religions, have limitation to understand, or comprehend, life as socio-cultural agencies (human beings and social institutions at large) do; and this posts the fundamental contradictions when EOL, a more than bio-physical condition of ending the life(?), is under a medical regime of governance. More problematic when life form changes (into) towards the spirituality aspects of the existence of human (and otherness), as shown in the case when Buddhism and Buddhist praxis develop in Chinese societies and shaping their socio-cultural life (cf. Massoudi 2010).

Chinese praxis of religious rituals, as a form of folklores and folk-religions, is more flexible, vis-à-vis, organized religions like Judaism and Christianity: the multiple worship of God and Goddess (mostly from human turned saints derived from good endeavours [*Karma*] during life time) is normal in many folklore worships in temple and monasteries. For Chinese, folk religions through their flexible, contextual-specific and less dogmatic, view

and stance on what constitutes a (meaningful) life and how one should prepare for death and afterlife sometimes have open the gateway to fundamental enquiries and interpretations – this has been making EOL a rather complex mix of differential matrices of, involving different yet contradictory, social (folk religious) practices. Obviously, this flexible structure and fluid dynamics define a differential matrix of confusions, for all involving parties, particularly for the dying, the surviving ones but less for health care professionals (Tung 2010; Yang 1961).

The bio-medical regime for EOL is somewhat clear-cut with binary coding of live or death, whilst Chinese social timing for life (after-life?) is yet less rigid and soft.... But there is obviously a societal and familial processing for re-configuration of, and re-addressing to, the contradictions of life-and-death; in Buddhist terms, Karma within and beyond the life cycle of birth, aged, sick and death....This process can be seen from the historical change of the venue (space) for EOL process in the last 100-years: the mid-1970s marked the watershed (crossed the 50% threshold) from a family home EOL towards institutionalized hospital-based EOL in Japan. In this regards, Hong Kong and other Asia's newly modernizing economies like China have been catch-up very fast to institutionalize EOL into public health policy framework; and the venue of/for EOL is by default now in hospital. And the challenge is how to enable love and care for human dying process, and in the future, whether back to family home or to the intermediaries like hospice and nursing home with palliative care.

The challenge for respecting humanity dignity while caring for EOL is how to mediate the contingent dynamics within the dualistic structure of the medical and the social; intertwining old virtues (of Chineseness?) with (versus or against) new bio-medical technologies – enhancing not just pose ethical and normative choices-driven dilemma and paradox for all stakeholders, but also presenting a new worldview for the state to pursue initiatives for enhancing social wellbeing for the living, dying and death.

Learning from retrospective or after-death opinion obtained from the proxies, usually the bereaved family members can be a reliable and feasible alternative to understand the ups and downs with emotional attachments for the dying one. Furthermore, EOL has a gender dimension, in actuality, the (en-)gendering process for/against coping ability for EOL. Regarding which gender is at the EOL. For widows, most of them actually viewed that good relationship with the deceased

husband enabled them to cope with the challenge of EOL (Chow, et.al. 2006). Here love is important force to enable the surviving ones to re-learn the meaning of life and strengthening human spirituality. Hence, love and care in high-tech milieu are the ideal state of EOL: traditional virtues and the art of love enhance the quality of living and EOL process, but with a compatible health care system of bio-medical technologies.

4. De-Mystify the Modernized EoL: Rejuvenation of Hope & Bioethics for Life?

Faith, hope and love are the trilogy of the post-Judaism Christianity.... Contrary to the calling for love as articulated in biblical text *1 Corinthians* 13:13 that “And now these three remain: faith, hope and love. But the greatest of these is love”, the more important aspect for the rejuvenation of living spirits and humanity after the EOL phase is hope:

For bereavement counselors or carers of bereaved persons, talking about goals and plans for the future is insufficient to work through the emotional and physical outcomes of bereavement. It is more important to find ways to motivate, as well as support, the implementation of actions towards these goals (Chow 2010: 344).

The survivors' perception, or remembrance, of physical conditions and (versus) mental-image (spirit) of the deceased one before, during and after EOL is contingent upon various dynamics involving in the (not) EOL process of socio-familial experience in different milieu – but the least account on is usually when the EOL process taking place, or the dying one, is institutionalized in hospital setting in general, the worst is at the intensive care unit, where inter-personal reciprocity is minimally shaped by bio-medical routines and procedures of medical care. Hope has critical important role for the individual's bodily lost in EOL but gaining spirits for continuation, rejuvenation of socio-family life course....

4.1 Re-Positioning Life in Hyper-Modernizing Chinese Societies

Juxtaposing hyper-modernization in Asia, the advanced rapid ageing in Chinese societies (aged 65 or above out of the total population: 13% Hong Kong, 11% Taiwan, 10% mainland China, in 2012) has been, and will be, a critical issue for all concerned; more challenge will come as ageing take faster momentum in the coming decades (Lai 2007, 2008). The challenge is manifested in the fast-track (or the

new institutionalizing cost-cutting) processing of EOL, against the slow yet high emotional valued passing away processes for the dying and living as well.....

In modern society and under public health governance, where, how and when is the EOL process is much shaped by legal and medical governance, as indicated in the Hong Kong study above (- “dying at home will making trouble to your family to report to police for investigation....”). Most of nursing care institutions (old age homes, care-and-attention homes) for frail elderly are not ready for EOL taking place; so does any private residence and personal home. Any death outside the hospital will have many police, public health and legal (very inconvenient and trouble-making) procedures to follow – and this conditions the very complex matrices of the hierarchies of professional-power versus family’s emotions, medical decision timing over the bereavement span....All these make EOL a conditional cul-de-se for legal-medical proceedings without humanity concerns; unnecessarily tensions, with conflicts, between and among the involving partners of EOL are unfolding in the critical phase(s) of life and death!

Contrasting the problematic modern medical system, the nostalgic pre-modern EOL at home with family and community members’ harmonious farewell for EOL is being re-discovered.... Some of these can be seen in the use of Advance Directive (AD): the US Patient Self-Determination Act (1991), the United Kingdom Mental Capacity Act (2005), Australia and Singapore enact similar AD legislation. But Hong Kong (and mainland China) is a belated one in considering such AD rights for their citizens as their last social rights in their life, though there is growing concern for decent EOL – the Law Reform Commission only confirms the promotion of advance directives but not legislation was recommended (Chu, et.al. 2011: 144).

For the past, present and future, to foster a more humane vision for EOL is an ontological endeavour.... As indicated that many frail elderly on the journey of EOL prefer a more control-able and involving regime for their last phase of life – say the use of Advance Directive (AD). A recent study in Hong Kong discovered that most of the studied Chinese old-frail people living in nursing home prefer having an AD, and one-third of them would prefer to die in nursing homes (Chu, et.al. 2011).

Despite the limited bio-medical regime for caring (though sometimes torturing) and all the confusions and tension between two sub-systems drawn into EOL process (the slow social timing for family of

the dying one, vis-à-vis the fast-track processing of medical and health care institution), some of the negotiated yet resolving outcomes are the initiatives for AD and/or hospice regime for EOL. But the question is timing again: when is the contractual agreement for AD signed – recent South Korean initiative has been embattled by all concerned in deciding when or the (ir-)reversibility of the AD....

To rejuvenate life course and spirituality of EOL; the so-called holistic appreciation and realization of one’s (and his/her family’s) accomplishment within and beyond the life course; there is urgency to call for humanization of EOL with respect and dignity, without and beyond Western modernizing legal and medical- bondages.

4.2 Beyond Binary Code of Life-&-Death: Rejuvenation of Social Timing in the Universe?

Historical processing of social time: memory and remembrance, constitutes the fundamental dynamics of socio-cultural experience and the very existence, or the existentiality of, human beings within the wider universe.... Here, in the context of Chinese communities, the very social praxis of CBT (and their derivative) learning in the locale, society and cross-and-inter-cultural arena and scales define the roles, and scripts, for EOL process; say, in the funeral ceremony and post-funeral practices (ancestor worship!) and the related established institutional arrangement for the deceased and the surviving ones. All these socio-cultural structure and praxis are both providing the preparatory steps for, and the extended social reciprocities after, the EOL process.

In modern (and urban) Asia, though majority of the praxis and processes for the last phase of EOL are likely be situated within a confined spatial and temporal institutional structure of hospital, nursing home and/or hospice setting: ca. 90% of EOL are in these institution in Asia cities!. Socio-cultural praxis within and beyond health institutional setting at this temporal frame or conjuncture is confronting with new (Western?) medical science practices in daily institutional life towards the EOL.

Confusions, tensions and contradictions between the medical and the social, new and old practices, professionals to family members within such a confined space and time are normal. But the real life experiential learning for the surviving (family members) group is hardly conveyable to those professional institutions as the social timing for the former is historical and long-lasting, while the latter group merely follows the objective evidence or material outcome-based “scientific” discovery of

bio-medical rationality. By default the contradictions are fundamental in three arenas. First, it is almost the impossibility to derive anything from the linear path to the EOL: the dead cannot give further evidence or outcome for scientific acknowledgement of the soft “variable” like quality of life, happiness and being respect during EOL, or the eternity or infinity of (spirituality of) life beyond the EOL. Second, the highly differentiated social, vis-à-vis, medical, timing between the (will be) surviving family members, the dying one, and medical caring (sub-or-para-) professionals is structurally embedded in, but also beyond, the institutional setting. Here, each of the sub-system in the EOL process has its own referential logic, self-organization and sphere therefore it is testament that the sub-system cannot make functional exchange and learning with other sub-systems – a state as succinctly described in social system differentiation terms as “*autopoiesis*” (Luhmann 1990). And the power hierarchy and mis-communication are detrimental to the EOL course without respect and dignity in modern urban life.

To recapitulate the problematique of EOL in modernizing East Asia – a lesson everyone perhaps can learn for his/her (family) destiny. The manifested shaping of the end-of-life care is clearly under the bio-medical technological care regime. The above findings show that, due to differential modernization exposures in terms of customs, belief and knowledge, the concerned parties (professional carers and the relatives of the dying one) act differently, if not contradictory, within their own self-referential logic, belief and emotions.

All that is Solid Cremates into Ashes? The care for the ending phase of human life is embedded with two contesting, sometimes contradictory, dynamic specificities which are over a long historical span from pre-modernism of cultural heritages and customs to hyper-modern high-tech in East Asia: traditional virtues of caring the others – originated from human love with the art of loving encounter the agglomerated new technologies and know-how of bio-medicine within a wider policy framework of public health and welfare services. The arguably dualistic structure / dynamics of intertwining old virtues (of Chineseness?) with (versus or against) new technologies not just pose ethical and normative choices-driven dilemma and paradox for all stakeholders, but also presenting a challenge for the state to pursue policy initiatives for enhancing social wellbeing at large.

To comprehend EOL, to be more accurate, we

must study life and living (Massoudi 2010: 198):

The Dalai Lama (1997) says: One of the principal factors that will help us to remain calm and undisturbed at the time of death is the way we have lived our lives. The more we have made our lives meaningful, the less we will regret at the time of death. The way we feel when we come to die is thus very much dependent on the way we have lived. (p. 26).

To re-address this functional deficits and differential (conflicting?) social (versus medical) timing of EOL, while respecting each human being’s existence (extinction) and re-celebrating the humanity at large – the ethic-normative calling for life’s eternity, we need to moot for, or bring back, socio-cultural (CBT appeals) sensitive co-determination governance for the dying one – cum- surviving members centred (spirituality) life care in the EOL settings – respecting human dignity at the very least, particularly in those nursing home and hospital settings which have not been assuming the task of spirituality support at the last phase of EOL process. Obviously, this can be a very difficult task given the temporal, spatial and resources constraints within/beyond health care sector; but this has to be endeavoured for observing socio-cultural virtues and customs. If these basics can be initiated, there will be possibility for the project to rejuvenate and revitalize the holism and spirituality of human civilization(s): EOL is an embracing, celebrating and integral part for the eternity of life and beyond! In actuality, some rejuvenated EOL social praxis is evolving in urban Taiwan and Hong Kong: back-tracking funeral service (殯葬) to socio-familial etiquette (禮儀)....

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