Privacy in the Health Care for Adolescents of Japanese Descent: The Interface between Clinical Bioethics and Tran Cultural Nursing

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Abstract

Objectives: to describe the expectations of mothers who are Japanese or of Japanese descent regarding adolescents' requests for the prescription of contraception without the knowledge of parents and guardians, and to recognize these mothers' perceptions regarding individual privacy in the family ambit. It is an exploratory, quanti-qualitative, descriptive study. Results: 47 mothers who were Japanese or of Japanese descent who had daughters aged between 10 – 19 years old were interviewed; 48.9% chose the option "not to prescribe" and 51.1% chose the options including prescription. Discussion: Tran cultural Nursing stipulates the provision of culturally coherent and responsible care which should be reasonably adapted to the needs of the values, beliefs and realities of the patient's way of life. In attending adolescents of Japanese descent, the recognition of this culture's values is fundamental for maintaining the patient-healthcare professional bond and the healthcare.

Keywords: Bioethics, Adolescents' Health, Tran cultural Nursing

1. Introduction

Tran cultural Nursing understands that the behaviors of care and functions vary according to the characteristics of the social structure of specific cultures (Leininger, 1981). As a result of this, in order to provide therapeutic and nursing care, the nurse has to recognize the cultural values, beliefs and practices of the users of the health services (Braga, 1997). Thus, in order to ensure the child and the adolescent their right to be recognized as citizens, it is also necessary to outline their specific family and cultural characteristics. In the health area, for there to be comprehensive treatment, it is important to give the adolescents and their family members an opportunity to express themselves and their opinions about life. The adolescents have the right to speak about themselves, the others and the world, in order to guarantee comprehensiveness in the care, which includes the consideration of the cultural and family values which they experience and pass on. Clinical Bioethics is concerned with respect for the service users' autonomy, in particular when these are adolescents. The evaluation of adolescents' autonomy for decision-making regarding their health is a challenge for the health professionals who attend them. Legally, the adolescents are still conquering their autonomy, being considered individuals with reduced autonomy and dependent on their families. If the professionals take into account only the legal aspects for evaluating the adolescents' decision-making ability, the majority of them will not be able to take decisions regarding their own health (Fortes & Sacardo, 1999). The right to privacy and confidentiality derive from autonomy, this being another controversial point in adolescent health care.

Confidentiality facilitates the patient-health professional bond in the clinical relationship; it involves trust and respect for the adolescents' secrets revealed or perceived during attendance or consultations. The right to privacy and confidentiality is not a prerogative of the adult; it applies to all age ranges, albeit with distinct nuances varying from case to case (Fortes & Sacardo, 1999; Loch, 2002). Ethically speaking, any person, regardless of their age or legal rights, may enjoy conditions, both intellectual and psychological, for recognizing the nature and the consequences of an act or proposed act of assistance to their health (Fortes & Sacardo, 1999; Loch, 2002; Taquette, 2005). This is the basis for the age of majority for health; that is, the person, although legally incapable for other decisions, can take decisions regarding their health, this always being evaluated on case-by-case basis. Adolescents desire privacy in their relationships with health professionals as much as adults do, as part of the processes of developing individuality and constructing their moral autonomy. As a result of this, ensuring privacy – and in particular, confidentiality – in the clinical relationship is a basic principle for adolescent health care (Loch, 2002). Respect for autonomy, however, is not only a subjective issue, as it is also culturally determined. The culture fundamentally guides the patients' belief systems, especially in relation to the preferences in the decision making process (O'Kelly et al, 2011). Due to this, the nurses must not separate the world views and the cultural beliefs of caring; these are intimately linked (Leininger, 1981).

This issue is especially true when the topic is a specific foreign culture present in Brazil, seeking attendance in the health services: the Japanese culture. Japanese culture has defied history, as it has lasted thousands of years and arrived at modernity still maintaining its own identity (Rubio, 2000). In cultures rich in family values, such as Oriental cultures, the interdependence of family members is emphasized; highly independent 'selfs' are not valued; there are hierarchical family relationships; and members are expected to show loyalty in relation to the family and respect and obedience to the older members. The adolescents, in these societies, spend more time with their families than they do alone with their groups of friends. Acceptance by the group of friends is more important in those societies which emphasize the family members' independence, such as North American society, in which group co-existence is an essential element for the adolescents' individuation. In cultures with strong family values, coexistence with the groups has, rather, the function of adapting the adolescents to cultural and social forms which emphasize family values, rather than promoting individuation (Schwarz et al, 2011).

Given that ethical conflicts related to confidentiality (Taquette, 2005). are among the principal ethical conflicts relating to attending adolescents, what is the cultural influence in the recognition of, and respect to the privacy for, this age group? In order to explore this question, the following was investigated: how do mothers from the Japanese culture face their daughter's autonomy for attendance in sexual and reproductive health? The researchers sought the view of mothers who are Japanese or of Japanese descent regarding the attitude which they expected of health professionals regarding their daughters requesting to be prescribed contraception without parental knowledge. Understanding the adolescents' families' expectations contributes to broadening the circumstantial context involved in this moral conflict, requiring greater prudence in the deliberations of Clinical Bioethics. It contributes through the construction of evidence such that the professionals who work in adolescent health care can include in their decisions the cultural value of the adolescent's autonomy in the family ambit and in the dynamic of the parent-adolescent daughter relationship. In this, it also contributes to improving the quality of the relationship in the attention to the family's health.

2. Method

An exploratory, quanti-qualitative, descriptive study was carried out. The qualitative methods are important for establishing meanings and accurate cultural knowledge (Welch & Leininger, 2004). In the data collection, the inclusion criteria to participate in the study was to be a Japanese woman, or a woman of Japanese descent, with a daughter aged between 10 and 19 years old, at the time of the interview. The interview used a form describing a hypothetical situation involving providing a female adolescent with sexual and reproductive health care. After the description of the situation, alternatives were presented with three possible conducts for the professionals regarding the adolescent's request (Chart 1). The interviewees were asked to choose the alternative containing the behavior which they expected of the health team, and also to explain their choice, if they wished to. If the alternatives included did not include the interviewee's opinion, there was a space on the form where she could write the behavior which she expected of the team.

Chart 1: Hypothetical Situation - São Paulo – 2012

B, 15 years old, attends the Family Health team with which she is registered and explains that she recently fell in love with a 16-year-old boy. Her parents think she is too young and forbid her from seeing him romantically. She states that she is not yet sexually active, but asks to be prescribed oral contraceptives. She also asks the team not to tell anything to her parents. Would you recommend to the health professionals involved in this case any of the alternatives below? Which? Why? a. Prescribe the contraception without saying anything to the parents and without encouraging the adolescent to do so. b. Prescribe the contraception without telling the parents, but encouraging the adolescent to do so. c. Not to prescribe the contraception and to encourage the adolescent to speak with her parents.

The results relating to the choices of the alternatives were treated using descriptive statistics. The responses explaining the choices were organized through the construction of a Discourse of the Collective Subjective (DCS) (Lefévre et al, 2000) for each one of the alternatives presented on the form. The DCS is a way of organizing and tabulating qualitative data of verbal nature obtained through statements. It is based on Social Representation Theory, with its sociological assumptions. DCS allows the presentation of results of qualitative studies in the form of one or various discourses-syntheses, written in the first person singular, so as to express the thinking of a collectivity, as if it were the issuer of a single discourse (Lefévre et al, 2000). Data collection started in April 2012, in Japanese cultural festivals held in a variety of places on different dates. These festivals aims to disseminate Japanese culture to those who do not know about it, and to maintain the tradition for the Japanese or persons of Japanese descent who live in Brazil. In the festivals, one finds presentations, exhibitions, songs, typical foods and workshops.

Chart 2: Events Participated in for Data Collection – São Paulo, State of São Paulo (SP), Brazil 2012

Date	Event	Place
04.14.2012	Akimatsuri	Mogi das Cruzes
05.19.2012	Temaki Night	Santo André
06.02.2012	Japan Matsuri	Osasco
06.10.2012	Ikoinosono June Party	Arujá
07.01.2012	Kodomonosono Fête	Itaquera
07.14.2012	Festival of Japan	Bandeirantes

The project and the terms of free and informed consent, administered to the subjects, were approved by the Research Ethics Committee (REC) of the University of São Paulo's School of Nursing (EEUSP) under Process N. 1111/2011/CEP-EEUSP.

3. Results

A total of 47 mothers was interviewed, of whom three (6.3%) were Japanese (issei), and 44 (93.7%) of Japanese descent. Of the latter, 32 (72.7% were the first generation descendants (nissei) and 12 (27.3%) were second-generation (sansei). Two interviewees (4.3%) did not state which condition of Japanese descent they had. In the total of the alternatives, 48.9% of the interviewees chose C, which was not to prescribe the contraception, and to encourage the adolescent to speak with her parents. The two alternatives which included the prescription of the contraception were chosen by 24 interviewees (51.1%). Alternative A ('Prescribe the contraception without saying anything to the parents and without encouraging the adolescent to do so') was chosen only by 10.6% of the interviewees. Alternative B ('Prescribe the contraception without telling the parents, but encouraging the adolescent to do so') obtained 40.4% of the responses (Table 1).

Table 1- Alternatives Chosen – São Paulo, SP, Brazil 2012

Alternative	Quantity
A	5
B	19
C	23

Regarding the distribution of the mothers' choices in accordance with their degree of descendance, the alternative of not prescribing (C) was found most among those born in Japan (issei). Among the third-generation Japanese (sansei) 75% chose prescription, without telling the parents, but encouraging the adolescent to do so (Table 2).

Table 2- Mothers' Degree of Descendance and the Alternatives Chosen – São Paulo, SP, Brazil 2012

Degree	Quantity	Alternatives Chosen %		
		A	B	C
Issei	3	33	-	67
Nissei	32	10	31	59
Sansei	12	8	75	17

In order to clarify the cultural values implied by the choices it was decided to construct a DCS for each one of the three alternatives presented to the interviewees in the form. Through this, we were able to recognize the contradictions and the values present in the explanations for the choices, explaining the movement of the discourses' dialectic, without isolating them in categories. The statements were grouped by alternative chosen, constructing the DCS in each grouping (Chart 3).

Chart 3: Discourses of the Collective Subjective for the Alternatives A, B and C, Respectively – São Paulo, SP, Brazil 2012

"For sure she is young, she should take precautions and the parents should have a dialog with the girl. But, being an adolescent, probably, she won't accept the advice to tell her parents, and to avoid worse consequences, it's better to prevent [pregnancy], considering that the girl herself took the initiative of seeking the medical team and protecting herself on her own." (Alternative A)

"Sexual activity is a delicate topic. The majority of young people today begin their sex life too early, without their parents knowing. Autonomy and responsibility are values to be passed on. If the girl sought advice, that's a positive point, as it means that she is preparing herself for when it happens. Girls don't always talk about this subject with their parents, and if they are against the relationship to begin with, the girl isn't going to seek them for guidance about the use of condoms or oral contraception, even if the health team asks her to talk to their parents . Because of that, in order to protect the minor, it is better to prevent sexually transmitted diseases and unwanted pregnancies, but even so it is worth advising her to tell her parents and ask her to come to our next consultation with her mother." (Alternative B)

"It's better to know [that the girl is initiating sexual activities] and for the doctor not to prescribe oral contraception without the mother's consent, as mothers must be aware of their daughters' activities, know everything that is going on with her, be present and advised regarding medication. The girl isn't old enough yet to make a sensible judgement on the issue, she is too young for that, a minor must have consent, authorization from her parents, through a letter from them or their presence. The parents need to be kept aware, as the doctors don't know her health processes. There must always be trust within the family, and for that, the doctor must advise the parents and try to encourage openness with the daughters, as through this there will be a better life, without drugs, without losing her way, a truly familial coexistence. The omission of the facts is the worst path to take in these cases, an open dialog and a good conversation is always the best option." (Alternative C)

4. Discussion

Tran cultural Nursing stipulates the provision of culturally coherent and responsible care which should be reasonably adjusted to the needs of values, beliefs and realities of the client's life (Welch & Leininger, 2004). These knowledges are imperative for guiding all the nursing decisions and actions for successful and efficacious results (Leininger, 1981). In the DCS for alternative A, what stands out are the values of protecting the adolescent to avoid an unwanted pregnancy and sexually transmitted diseases. The lesser of two evils is sought, considering that the adolescent would not accept the advice to tell her parents or not to initiate a sex life. In the DCS for alternative B, the importance is emphasized of the values of autonomy and responsibility, which the adolescent shows in seeking the service on her own initiative. The issue of the lesser of two evils is raised, it being better to hide what is happening from the parents than for there to be an unplanned pregnancy or for the adolescent to fall ill, given that the adolescent would not tell anything to the family even if the team recommended her to do so.

A contradiction also appears in the DCS regarding the adolescent's autonomy and confidentiality, as it is proposed that the professionals should ask the young woman to come to her next consultation accompanied by her mother. The DCS for alternative C reveals values relating to the hierarchy, both of the daughters in relation to the parents, and of the parents in relation to the medical team. Obedience to, and respect for, the hierarchy are strong and typical elements of a traditional Japanese family. As respect for the hierarchy is a striking feature of the culture, it is found also in the other social environments (Hoga, 2001), among them the family. The present study's results clarify that even with the women having passed through the process of enculturation, in which the person gradually internalizes the beliefs and values of the society in which she lives (Helman, 2006), many values typical of Japanese culture still persist. These remain evident in the communities of Japanese descendants, regardless of the degree of descendance to which they belong. In relation to daughters' sexual and reproductive health, the mothers who are more distant in their degree of descendance tend to respect the adolescent's autonomy and confidentiality, but the DCS expressed the contradiction and ambiguity of this choice.

In the DCS, one can perceive the conflict between Western individual values and Oriental family values. Congruent and beneficial nursing care can only occur when the individual and family, or the values, expressions or standards of cultural care are known and used appropriately and meaningfully (Leininger, 1981). That is to say, one can offer better nursing care when one knows the culture, dealing more prudently with the conflicts of privacy and confidentiality in the adolescent's health. Prudency equates to a responsible attitude. Contributing to the understanding of the influence of culture in health care, the DCS made it possible to clarify, in the present study, the basic characteristics of the concept of culture described by Herberg (1995): the culture is incorporated in a long process of socialization and learning, in which the person gradually acquires the knowledge necessary to live in accordance with the way of life of her group; the groups share the culture through the experience of beliefs and norms of the group itself and thus constitute a group identity; culture is a process of adaptation of environmental and technological conditions to viabilize natural resources and the group's survival; because of this, it is dynamic and is in a constant process of evolution and transformation. These characteristics of the culture and its movements were experienced during the development of the project, and were evidenced in the results.

The mothers' difficulties in exteriorizing their opinions during the interviews seemed to arise more from feelings such as shame, anxiety and embarrassment regarding the situation. Supporting this, we record that the interviewees were not reluctant to justify their responses, even though this was optional. As the justification for the choice was the last item in the interview, the mothers' feeling of being ill-at-ease due to this being the first contact with the interviewer had probably passed. The majority of the women participating were second or third generation Japanese, and had therefore received influences from both the Japanese and Brazilian cultures. They were born and grew up in a sociocultural context in which they assimilated the culture transmitted by their forebears in their families and in environments in which the Japanese community comes together, and the Brazilian culture in the social environment in general (Chubasi, 2004). The great challenge in education is, at the same time, to promote autonomy and establish limits and a safe haven for the young. These two aspects are clear to the parents; autonomy is negotiated, but the difficulties with limits – which, in any social strata, mean protection against risks – can lead to authoritarianism. This resource is one of the ways of educating, but it can end in failing to achieve the effect desired by the parents. Western cultural ideals, in their turn, exalt the liberty of the young, strongly defended by them. The parents, however, may neither understand nor accept the relativization of values, especially if the youngsters choose their lifestyles without paying attention to the consequences. In this case, it is difficult to establish dialog to resolve the issue (Macedo et al, 2006). The Japanese culture, from generation to generation, has passed through changes and processes of adaptation. Nevertheless, ancestors' cultural baggage still exercises strong influence on the actions and the way of thinking of their descendants who experience the traditions maintained within the Japanese communities in São Paulo, through cultural festivals and other socialization initiatives of the group. Nursing acts as a bridge between the everyday life of society and the professional system. In Transcultural Nursing, three types of care are stipulated: 1) preservation and maintenance of the cultural care, 2) accommodation and/or negotiation of cultural care and 3) remodelling and/or restructuring of the cultural care (Leininger, 1981). In this study, one can observe the cultural influence of the hypothetical situation, based on accommodation and/or negotiation of the cultural care. This type of care entails creative professional actions and decisions of assistance, support, facilitation or empowerment in the assistance to persons from a specified culture, so as to adapt or negotiate with others, in order to achieve a beneficial or satisfactory health result (Leininger, 1981).

If nursing practices fail to recognize the aspects of cultural care of the human needs, as in the negotiation of sexual and reproductive health of the adolescent who experiences the Japanese family dynamic, the care will be less beneficial and efficacious, potentially creating dissatisfaction with the health services. The transformation of the health care will not be successful unless the cultural values, beliefs and practices are clearly known and used (Leininger, 1981). This transformation requires a responsible attitude, that is, to deal with the ethical conflicts bearing in mind the vision of those affected and the foreseeable consequences. This entails careful consideration of the clinical and legal data, and the cultures' values and peculiarities.

5. Conclusions

In attending adolescents of Japanese descent, it is essential to respectfully recognize the peculiarities of the identity of this community's members: it is family values and hierarchical values that structure this culture. One must consider that in the adolescent's relationship with the health professional the latter is seen as somebody hierarchically superior. Furthermore, during the attendance, the nurse should evaluate and carefully consider how difficult it can be for an adolescent of Japanese descent to seek the health services alone without her parents' knowledge, given the strength of family values in her culture. Due to this, the link with, and trust of, the adolescent regarding her confidentiality and culture are especially important for ensuring that the continuity of the care should be undertaken with quality and responsibility. Little by little, the adolescent's relationship with her family must be improved. If the mother is a third-generation Japanese, this question may be easier than for a first-generation mother, as superseding cultural issues causes contradictions, as the DCS showed. This process requires nursing actions for supporting the family and the adolescent at this delicate time of transition they are experiencing. For example, meetings which allow therapeutic conversation for the mothers and their daughters can be useful, especially if undertaken separately, to ensure confidentiality and freedom to express fears and expectations for both parties. In collective health, the nursing action can take advantage of times when the Japanese community comes together, such as the festivals, to encourage educational activities relating to specific characteristics of adolescence and adolescents' sexual and reproductive health. It is necessary, in the training of nurses, to value teaching activities and courses which show the influence of cultural values on health and in ethical conflicts, emphasizing the importance of respectful care, responding to each group's peculiarities and differences of tradition, based in the three types of care proposed in Transcultural Nursing.

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