Health Ethics in Cross-Cultural Settings

By Al-Noor Nathoo

The increasing cultural diversity in Canadian society has given rise to a range of ethical issues in the proper delivery of health services.

Avoiding Stereotyping

Perhaps the most important consideration for healthcare providers working in cross-cultural settings is to maintain a balance between stereotyping individuals as having certain beliefs or practices because they belong to a culture or tradition, while at the same time maintaining sensitivity to the particular needs of those individuals. Often ignored is the fact that there is frequently as much variation within cultures and religions as between them. Not all people born into the Muslim faith for instance, will wish their bodies to be turned towards the east at the time of death, although this may be true for some. To make a statement about the rituals surrounding the end of life for all Native peoples, as a case in point, would be about as instructive as making a statement about the birth control practices of Christians - the group is too diverse in itself and composed of too many different sub-faiths or communities to make generalization meaningful or helpful.

Treating Each Person as an Individual First

Thus each care recipient should be treated as a unique individual who may interpret the circumstances of his/her family, community, religious, cultural and racial background very differently from that of someone else with the same background. Factors such as the level of adherence or commitment to certain cultural or religious practices, the extent of his/her exposure to predominantly "Western" values and the depth of his/her connections to family and community of origin greatly influence the extent to which his/her behaviour and wishes will actually conform to "cultural norms". In fact, these "cultural norms" are themselves constantly changing in North America in the process of their interaction with other cultures. So, while health care providers would be well-advised to learn as much as possible about the differing traditions of the cultural groups with whom they interact, they should be careful to keep these in mind only as sources of potential tension or concern rather than as definitive indication of the wishes of individuals or residents, which only direct contact and communication with individuals and families will reveal.

Ethical issues that arise as a result of cultural diversity can be divided roughly into two general areas - the first involves the process of care delivery, the second deals with the content of the values in tension.

Accommodating Cultural Practices

If we take seriously the claim that health care should be equally accessible to all regardless of race, culture, religion and sexual orientation, an ethical onus exists on health care providers to take reasonable steps to accommodate any individual's particular values and customs in order to provide optimal care, equal access to care, and to allow the person to feel as comfortable as possible so as to restore or maintain health. Health care providers working in institutions may wish to consider that such settings, because they are predominantly based on Western life-styles, can be particularly alienating to users from other cultures. Where possible, accommodating preferences of diet, providing translation services, flexibility in visiting regulations and - where not counterproductive to existing treatments - consideration of preferences for complementary or alternative therapies, will go a long way towards establishing trust between health care providers and consumers, and ultimately towards improving the well-being of the users themselves.

Are We Furthering the Goals of Care?

But how far should health care workers go in accommodating individual preferences based on cultural or religious difference? This is impossible to answer as a blanket statement, but health care providers, in answering for themselves, may wish to consider the questions: Will accommodating these preferences further the ultimate goals of care for this individual? Will it compromise the care of this or other users of the health service? In answering the first question, it is important to ask what the goals of care are as seen from the perspective of the care recipient - which can often be different from those of the health care team. If the goals of life or of care for a specific individual involve maintaining honour, experiencing absolution through suffering, or dying with dignity, these may not suggest the same care plans as a purely "medical model" might. In these cases, care providers might respond in the same way they would to a client who was not a member of a minority - in a way that respected the wishes and values of the individual and their right to determine the course of their own care.

Indeed, in some cases, making accommodation for cultural difference may turn out to be a strong requirement rather than merely prudent. For instance, in cases where language is a complete barrier to communication between healthcare provider and care recipient, informed consent becomes virtually impossible. In these situations, there is an even stronger ethical obligation on the part of the health care providers to seek competent translation either through family or through other care providers.

What Ethics Can/not Achieve

Ethical issues fall into the general category of questions which rarely succumb to hard and fast rules. The fact that there is usually no one right answer to a difficult ethical question does not, however, suggest that all answers are acceptable. Ethics is the process of trying to determine which, of several possible and palatable courses of action will most likely produce the most good or be the most right This is a difficult task, and the best we can do is to ensure that we explore the various options thoroughly, that we explore the question in a systematic way, that we attempt to lay bare the values that underlie our final decision and that we provide reasonable and defensible reasons for our choices. This is what we hope to accomplish by analyzing difficult issues from the point of view of ethics.

Values in Tension

The most difficult issues that arise out of health care practice in cross-cultural settings probably involve circumstances in which a person's wishes clash with the values of the health care provider. This gives rise to the question of whether health care providers can rightly use their positions of relative power to "trump" the values of others in cases where those values are seen to be particularly objectionable. Failing this, can the provider ethically withdraw from the case?

Female Genital Mutilation or Modification

An example involves a request from a couple to have "circumcision" performed on their young daughter. Circumcision is a practice common in some areas of Africa and is often referred to as female genital mutilation. The procedure varies from an incision into the clitoris or, in its more extreme forms, the sewing together of the labia majora. Predictably, this procedure is known to be the source of a litany of future physical, sexual and psychological ailments aside from the pain caused as a result of the procedure itself. Legislation to ban the procedure has been passed in several countries, including Sweden and the Netherlands. Canada has no specific legislation dealing with female genital modification, although bodies such as the Ontario College of Physicians and Surgeons have prohibited their members from assisting with the procedure.

Author

Al-Noor Nathoo is currently the Southern Alberta Coordinator and Executive Director for the Provincial Health Ethics Network. This article is a summary of his presentation to the 17th National ORNAC Conference in Banff, Alberta, April, 2001.

Seven Things I've Learned About Ethics

1. Most of us believe we are good.
2. There is rarely ever only black and white.
3. Moral understanding and thinking makes choices even more difficult.
4. Ethics involves the search for consistency.
5. Ethics involves seeing things from the perspective of the other.
6. Never trust an ethicist - moral decision making belongs with each of us.
7. Respect for autonomy is crucial.

The Limits of Cultural Accommodation

From an ethics perspective, there are two possible approaches to this question: the first is to assert, correctly, the claim that health care providers have no ethical obligation to provide a service which they see to be morally objectionable. This response however is not always regarded as appropriate or practical, particularly in situations where no other health care providers are available to provide the requested service and a "monopoly" in health care provision exists.

The second approach, also equally valid in this case, is to claim that the harms caused by the procedure are so extensive and compelling that they provide sufficient reason for the health care provider to deny a request for assistance with the procedure on the grounds that it is always mutilation, and should be made illegal in Canada. Added to this is the valid question of whether parents requesting female genital surgery of this sort are indeed acting in the best interests of their daughters.

Four Things I've Learned About Resolving Cultural/Value Differences

- Avoiding the extremes of relativism and absolutism is often a good thing.
- Talking to the person, or finding out as much as possible about their needs and beliefs, is crucial.
- Very often there are creative ways to approach differences.
- Value differences can be blessings in disguise.

It is important to remember that even in cases where care providers refuse to assist in requested procedures such as female genital mutilation, compassion, tact and respect for other's values and lifestyles can still be practiced. Often, the language used (e.g. "female genital modification" versus "female genital mutilation") can make the difference between insensitivity to others' values and acknowledging the importance of other chosen ways of life, however incompatible with one's own.

Examples of Value Clashes

- **Truth-telling, informed consent**
- **Cessation of treatment**
- **Rejecting care due to color/race**
- **Religious beliefs**
- **Caring for family members**
- **Abortion**
- **Patient who has apparently committed a crime**

Our values reflect what we believe is important. Values fill the gap between what is the case and what ought to be the case. Because values are intimately involved with how we perceive the world, and people with different experiences and backgrounds may have different values, very often there is potential for a conflict of values. In health care practice, it is not unusual for a care recipient's values and those of the care provider to clash. The situation may become more difficult because the relationship has an unequal power dynamic. In the examples listed above, can the health care provider, being in a position less vulnerable than the patient, simply override the patient's wishes? Or, in trying circumstances, is it ethically acceptable for the provider to just withdraw from the case?

An example of a clash between the values of a person and the health care provider in a cross-cultural care setting is the case of a parent who requests that female genital modification be performed on the daughter. This procedure is common in some areas of Africa but is banned in several other countries. There are two possible approaches to seeking an ethical resolution to the conflict. First, one may claim that health care providers have no ethical obligation to provide a service which they see as morally objectionable. This approach is not always regarded as appropriate since there may be no other health care providers available to provide the requested service. This is obviously problematic if we hold as a society that members are entitled to meaningful health care. Second, one may claim (probably rightly so) that the harms caused by the procedure are so extensive as to outweigh any benefits. In addition the question arises, in requesting this kind of female genital surgery, are parents really acting in the best interests of their daughters?

Examples of Issues in the Delivery of Care

- **Food**
- **Diet**
- **Dress/Jewellery/Trinkets**
- **Alternative therapies**
- **Visiting regulations**
- **Notions of time**
- **Response to pain and suffering**
- **Language/communication/eye contact/frankness**

Promoting conditions that are conducive to restoring the health of a person unfamiliar or uncomfortable with a Western setting may include accommodating preferences regarding food or diet, dress (and others listed above). Consideration of the patient in these ways greatly facilitates a positive rapport and establishes trust between health care providers and consumers.

Limits to meeting specific individual preferences may be necessary when considered in relation to broader issues of care. Focusing on what could be more narrow care issues may impede the realization of the ultimate care goals for the individual or, compromise others' ability to use the health service. Here, no line may be clearly drawn.

It may be helpful to ask what the goals of care are as seen from the perspective of the patient. These may be quite different than those seen from the perspective of the health care team. In those cases, just as for the client who is not a member of a minority, the response of the care team might be in such a manner as to respect both the wishes and values of the individual and the right of the individual to determine the course of his or her own health care.

Autonomy and the Role of Family/Community

A commonly noted difference between Anglo-Saxon cultures and others is the emphasis placed on individual autonomy, independence and self-control. In many non-Anglo traditions, the family and larger community to which the individual belongs plays a much greater role in decisions about care. These underlying differences may take different forms in health care settings. A family may request that a person not be told the full extent of his/her poor prognosis (in which case it might be prudent to attempt to diplomatically determine whether the person wishes to know the prognosis). Some cultural groups may have low utilization rates of advance directives -not unexpected in peoples for whom decision-making is made by family members and for whom written instructions by care recipients about future care may be unnecessary. Health care providers should recognize that the decision to allow family members or community elders to make health care decisions on one's behalf is in itself an exercise in personal autonomy. In such a case, the individual may have made an autonomous decision, either actively or passively, to allow others to decide on their behalf.

Six Things I've Learned About Cultural/Value Differences

1. The idea of human equality must be the starting point.
2. An attitude of respect and sensitivity is the result.
3. The attitude must translate into action.
4. Clashes in value (and thus ethical issues) are happening everywhere, all the time.
5. Avoiding ethnocentricity and stereotyping is a delicate balancing act.
6. The role of individuals, families and communities is an important difference to be aware of and maintain respect for.

"The ethical system of any culture is morally defensible because it is grounded in truths which transcend that culture; it is not morally defensible simply because it is the product of a particular culture. Respect for culture and ethics other than our own is the beginning of any intercultural dialogue, not its ending".
(Edmund Pellegrino)

Recognition of the differences in value placed on individual decision-making between cultures is therefore an important part of the ethical provision of health services. Most conflicts of value arising out of cultural differences, as might be expected, are extremely complex and difficult to resolve. The greatest danger lies in assuming that certain cultural practices, because they are unfamiliar, uncommon or generally unacceptable in this part of the world, are necessarily unethical.

The flip side of the coin is the danger involved in assuming that because each culture or geographical region has its own customs (including Canada, of course), those customs must necessarily be ethical. This is the misguided idea that all values are culturally relative, and that members of one culture or nation can never judge the actions of others. Murder and rape, for instance, are everywhere murder and rape, and it is difficult to argue that they could be less morally repugnant anywhere else in the world than they are in Canada, even though various cultures may perceive the acts differently from each other.

Balancing Sensitivity and Integrity

What are health care professionals to do then, given the need to strike a balance between being culturally sensitive on the one hand, and abstaining from assisting in cultural practices that seem clearly morally objectionable on the other? While there can be no easy answer of course, there is much to be said for taking the route of greatest sensitivity and dialogue. Taking time to get to know the recipients of one's care, learning about their cultural practices and the explanations behind the refusal of certain treatment or unusual requests may go a long way to finding courses of action that are mutually acceptable. Along the way, what may have appeared to be difficult either/or situations may emerge as having various acceptable alternatives compatible with the goals of care.

Guidelines in Cross-Cultural Encounters

- Assess the language used to discuss the patient's illness, e.g. degree of openness in discussing diagnosis, prognosis, and death.
- Determine whether decisions are made by the patient or a larger social unit.
- Consider relevance of religious beliefs.
- Consider issues of generation/age, gender and power relationships, both within the patient's family and with hcp's.
- Take into account the political and historical context, particularly past discrimination and access to care.
- Make use of available resources, including community or religious leaders, family, translators.

Decision-Making Approach

(A) Identify goals of care

- central aims that hcp and patient bring to encounter
- requires gathering information about values and culture.

(B) Search for mutually agreeable strategies

- consistent with both care provider and patient's beliefs.

(C) Re-examine personal values

-consider reinterpreting, reordering or changing them in light of the case.

(D) Engage in formal dialogue/discussional adjudication

- Ethics committee, care team and patient meeting.

(Based on Framework developed by Jecker, Carrese & Pearlman)

The Basis for Discussing Cross-Cultural Ethics:

All individuals are equally entitled to care regardless of:

- **skin colour**
- **culture**
- **ethnicity**
- **mother tongue**
- **gender**

We begin with an important question: Why should we be concerned about issues that arise when the health system involves people of diverse cultures or beliefs? Why is this an ethical issue?

A fundamental claim of secular ethics is that every person is morally equal and worthy of respect and dignity. This implies that every person has entitlement to care that is equal to that of someone else in the same position. In other words, if someone is entitled to care, we must be careful not to restrict care to that person for reasons based on their language spoken, color of skin, ability to communicate, etc. In fact, in some cases, where language or other barriers create "difficulties" for care providers, there is special onus on those providers to take positive steps to ensure that these barriers are overcome, as much as possible, so that clients or patients receive the same level of care as someone else who does not experience such barriers. Care providers, then, have an ethical obligation, within reason, to accommodate individual requests for care.

Opportunities for Growth

Difficult ethical questions arising out of culturally diverse healthcare settings, rather than being seen as a burden which further complicate already-difficult situations, can also be approached as opportunities for learning. Cultural groups have much to learn from each other. Human beings, like cultures, are not static in time or always attached to specific sets of beliefs. The kinds of intense interaction that take place within health settings provide opportunity for personal growth for both providers and recipients of care. Seen in this light, ethical dilemmas arising from cultural differences may begin to lose some of their more onerous undertones. ❐

"For every human problem there is a solution that is simple, neat and wrong." (H. L. Mencken)

Reading List

Adeney, Bernard T., *Strange Virtues: Ethics in a Multicultural World*, InterVarsity Press, Illinois, 1995.

Brownlee, Ann Templeton, *Community, Culture, and Care: A cross-cultural guide for health workers.*, The C.V. Mosby Company, Saint Louis, 1978.

Crigger, Berte-Jane, *Cases in Bioethics: Selections from The Hastings Center Report, Second Edition,* St. Martin's Press. Inc., New York, 1993.

Galanti, Geri-Ann, *Caring for Patients from Different Cultures: Case Studies from American Hospitals,* University of Pennsylvania Press, Philadelphia, 1991.

Gostin, Lawrence O., Informed Consent, Cultural Sensitivity, and Respect for Persons, *JAMA*, September 13,1995,Vol 274, No. 10, 844-845.

Griepp, Mary Elizabeth, Culture and Ethics: A Tool for Analysing the Effects of Biases on the Nurse-Patient Relationship, from *Nursing Ethics* 1995 2 (3), 211-221.

Ishiwata, Ryuji, and Sakai, Akio, The Physician-Patient Relationship and Medical Ethics in Japan, *Cambridge Quarterly of Healthcare Ethics* (1994), 3, 60-66.

Jecker, Nancy S.; Carrese, Joseph A.; Pearlman, Robert A., Caring for Patients in Cross-Cultural Settings, *Hastings Center Report 25*, No. 1 (1995): 6-14

Jenriings, Bruce, Cultural diversity meets end-of-life decision making, *Hospitals and Health Networks,* September 20,1994, 72.

Klessig, Jill, The Effect of Values and Culture on Life-Support Decisions, from *The Nature and Context of Health Care Ethics* (Part One), 3749.

Koenig, Barbara A., and Gates-Williams, Jan, Understanding Cultural Difference in Caring for Dying Patients, in *Caring for Patients at the End of Life* [Special Issue]. West J. Med 1995; 163: 244-249.

Lane, Sandra D., and Rubinstein, Robert A, Judging the Other: Responding to Traditional Female Genital Surgeries, *Hastings Center Report 26*, No: 3, (1996): 31-40.

May, Larry, and Sharratt, Shari Collins, *Applied Ethics: A Multicultural Approach,*Prentice-Hall, Inc., New Jersey, 1994.

Orr, Robert D.; Marshall, Patricia A.; and Osborn, Jamie, Cross-cultural Considerations in Clinical Ethics Consultations, *Arch Fam Med.* 1995; 4: 159-164.

Pellegrino, Edmund; Mazzarella, Patricia; and Corsi, Pietro, Transcultural Dimensions in Medical Ethics, University Publishing Group, Inc., Maryland, 1992.

Pellegrino, Edmund D., Is Truth Telling to the Patient a Cultural Artifact?, from *The Nature and Context of Health Care Ethics (Part One)*, 55-57.

Surbone, Antonella, Truth Telling to the Patient, from *The Nature and Context of Health Care Ethics (Part One)*, 50-54.

Taylor, Charles, and Gutmann, Amy, *Multiculturalism and The Politics of Recognition* , Princeton University Press, New Jersey, 1992.

Taylor, Charles, Two Theories of Modernity, *Hastings Center Report 25, No. 2* (1995): 24-33.

Veatch, Robert M., *Cross Cultural Perspectives in Medical Ethics: Readings,* Jones and Bartlett Publishers, Boston, 1989.