The challenge of cultural and ethical pluralism to medical practice

Rob Irvine, John McPhee and Ian H Kerridge

Mr T is a 74-year-old non-English-speaking Vietnamese man who was initially brought in to your surgery by his family for investigation of symptoms of prostatism. Subsequent investigations have confirmed a diagnosis of prostate cancer with skeletal metastases. You have organised for Mr T to come in and see you to discuss treatment options, including orchidectomy, gonadotropin-releasing hormone (GnRH) agonists and radiotherapy. Before calling Mr T in to your rooms you are approached by his eldest son, a 46-year-old architect. He requests that all decisions be directed primarily through him rather than his father. He also tells you that it would be best if the word "cancer" was not used, as this would cause his father unnecessary fear and may actually hasten his death.

ABSTRACT

- "Culture" can be understood as the way in which people make sense of the world by deploying shared meanings, attitudes, assumptions and values.
- Doctors will frequently encounter patients whose lives are guided by ethical systems and values that are different from their own.
- Individuals may differ in their beliefs about decision-making, regardless of their cultural background.
- Doctors should be willing to examine and test their own moral systems and cultural assumptions and be open to alternative traditions and beliefs.
- Engaging with other cultures does not imply that all cultural norms should be accepted uncritically, as there may not always be room for compromise.
- Failure to engage with issues of culture can erode the trust on which the doctor–patient relationship depends.
- Tensions can only be resolved through rigorous attention to a person's story.

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IN THE COURSE OF EVERYDAY practice doctors frequently encounter patients whose lives are guided by ethical systems and values very different from their own. It has also long been apparent that conflicts between doctors and patients over judgements about what is good or bad, right or wrong, have important implications for the delivery of healthcare services to individuals and to communities. Disputes over ethics and values can interfere with the process of healthcare delivery and the success of medical care. Ethical issues and dilemmas can also erode the trust upon which professional relationships depend.

The growth of a pluralist society has intensified pressures to take account of culture (ie, the ways in which people make sense of the world by deploying shared meanings, attitudes, assumptions and values).[1] More specifically, this requires consideration of moral and ethical diversity and an attempt to understand "what a person's world is".[2] Today, doctors see patients who speak numerous different languages and dialects and who embody cultures very different from their own. In the past, ethicists have attempted to mediate this inherently untidy pluralist culture by formulating a "universal" medical ethics.[3] But it is questionable whether a universal medical ethics based on a set of a priori principles can adequately deal with moral and ethical complexity.[4] Principle-based approaches may be too simplistic, and a duties (deontic) approach too rigid, for culturally complex societies. Doubts have also been expressed about the adequacy of familiar models of ethics for dealing with a "globalised" world and about the imposition of Western moral systems on non-Western people.[5,6]

We believe that, with a few exceptions, contemporary biomedical ethics has not adequately engaged with indigenous and non-Western ethical frameworks and modes of moral thought.[7,8] This is a critical failure, as it is indisputable that another set of "voices" would bring something additional and distinctive to the ongoing debate over ethics, values and morality in the clinical context. An appreciation of different cultures and an understanding of different approaches to ethics would not necessarily result in decisions satisfactory to all participants, but it might assist doctors and patients to live with complexity.

How can culture be engaged in medical practice?

It is easy to say that a person's or group's values, beliefs and moral framework should be understood and respected, but harder to see how this concept can be put into practice. Time constraints make it difficult for individual doctors to

University of Newcastle, Newcastle, NSW.
Rob Irvine, BA (Hons), PhD, Senior Lecturer, Department of Sociology and Anthropology, Faculty of Arts and Social Sciences;
John McPhee, BCom(Hons)(LegStud), Consultant in Health Law, Clinical Unit in Ethics and Health Law, Faculty of Medicine and Health Sciences;
Ian Kerridge, MPhil, FRACP, FRCPA, Conjoint Lecturer in Ethics, Clinical Unit in Ethics and Health Law, Faculty of Medicine and Health Sciences, and Staff Specialist in Haematology, Newcastle Mater Hospital.
Reprints will not be available from the authors. Correspondence: Dr R Irvine, Department of Sociology and Anthropology, Faculty of Arts and Social Sciences, University of Newcastle, Callaghan, NSW 2308.
irvine@socanth.newcastle.edu.au

deliberate over these issues. Therefore, the aim must be for doctors to work through important ethical issues in advance so that they can be dealt with quickly and effectively in the consultation room.

Health professionals must recognise the importance of understanding patients' cultural frames of reference when taking histories and making decisions about patient care. Doctors can enhance their abilities in this area by:

- learning the skills of listening;
- taking the time to listen attentively to patients' personal narratives;
- being open to learning about other cultures; and
- recognising the cultural basis of their own beliefs and assumptions.

In this way, doctors can develop a deeper understanding of people's reasons for seeking care and gain insight into their culture, beliefs, experiences and moral judgements. It may also provide insight into the commonality of shared human experience.

It is not appropriate to ignore cultural difference on the grounds that it raises difficult issues or appears inconsistent with standard Western medical practice. Nor is it appropriate to reduce the experiences and heterogeneity of individuals to cultural stereotypes. For example, while there are moves to take account of cultural differences in medical decision-making, the tendency in medical practice and contemporary bioethics is still to recognise the primacy of the individual in decision-making. But this approach may be inappropriate in some cultural contexts. Moreover, individuals may differ in their beliefs about decision-making, regardless of their cultural background. Failing to acknowledge another's culture may lead to failure of engagement or even discrimination. On the other hand, treating a person according to predetermined cultural norms, rather than as an individual with specific needs or goals, also carries the risk of discrimination. These tensions can not be resolved by resort to institutional policy or legislative reform but only through rigorous attention to a person's story.

Cultural issues can also be addressed by including all interested parties in negotiations. This may be achieved by:

- explicitly acknowledging the patient's cultural norms, beliefs and values;
- locating the patient's individual beliefs and values within that cultural context;
- being explicit about the process of decision-making that generally guides doctors' behaviour (eg, standard practice would be to give prognostic information about terminal illness directly to the patient);
- coming to an agreement between all parties (perhaps including the patient's family) regarding how the doctor–patient interaction will proceed (eg, what information will be given and to whom).

The process of bridging the cultural divide does not imply uncritical acceptance of all cultural norms as being intrinsically equal, as there may not always be room for compromise. It does imply, however, that discussion about values should be open and transparent and that questions of cultural conflict arising from the inevitable collision of different paradigms of health, illness, society, law and morality should be debated in a critical and reflective manner. By engaging with non-Western forms of moral and medical knowledge, new and unexpected relationships might be forged and new modes of thought might be revealed that would enrich and enhance our conception of the good and our realisation of well-being.

Finally, attention to interactions between individuals in the healthcare setting is unlikely to resolve the many complex issues raised by questions of culture. Indeed, we need to pay attention not only to individual beliefs and cultural traditions, but also to the institutions that shape and perpetuate those traditions. Structural solutions would need to critically examine the nature of medical education, the process of socialisation of medical practitioners and the characteristics of institutions such as hospitals and area health services.

The case

The Western view of autonomy stresses the primacy of the individual in decision-making. On the other hand, people belonging to cultures in which there is a tradition of community and family support may often wish to include others in decision-making. Seen in this light, Mr T, rather than abrogating his autonomy by allowing his son to be the primary decision-maker, may be exercising shared family or communal responsibility in decision-making. However, the doctor must be aware that, while patients may not differentiate their own best interests from those of their family, values are "individual" and patients' beliefs and choices may differ from those of their family, both in relation to specific issues (eg, the diagnosis of cancer) and to the process of decision-making.

In this instance, the doctor should suggest that an interpreter be used to provide translation, both to enhance cultural awareness and sensitivity in the clinical interaction and to reduce the possibility of coercion. The doctor should also sensitively explore Mr T's own values, beliefs and information needs, and consider whether these differ substantially from those of his family. In practical terms this could be done by "offering truth" rather than imposing it, by asking Mr T whether he would like to know all available information or whether he is happy for his family to make decisions for him.[9]

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