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Common Principles and Multiculturalism

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Abstract

Judgment on rightness and wrongness of beliefs and behaviors is a main issue in bioethics. Over centuries, big philosophers and ethicists have been discussing the suitable tools to determine which act is morally sound and which one is not. Emerging the contemporary bioethics in the West has resulted in a misconception that absolute westernized principles would be appropriate tools for ethical decision making in different cultures. We will discuss this issue by introducing a clinical case. Considering various cultural beliefs around the world, though it is not logical to consider all of them ethically acceptable, we can gather on some general fundamental principles instead of going to the extremes of relativism and absolutism. Islamic teachings, according to the presented evidence in this paper, fall in with this idea.

Keywords
Principlism, Ethical relativism, Informed consent, Truth disclosure

Introduction

Contemporary bioethics has its theories, principles and methods of practice which their application may be different in various cultures. Moral conflicts and bioethical dilemmas in different countries are so dissimilar. In the same way, the solutions and practical approaches would be different considering the social and cultural context. The diversity is not limited to the national borders of countries, owing to this fact that many societies are cosmopolitan and multi-ethnic now. Cultural barriers may be present within people of a country. So, general knowledge about other cultures and skills of an effective communication should be currently parts of medical and healthcare professionalism.

One verse of Qu'ran, the holy book of Muslims, counts multiculturalism as an advantage of the creation. It states: *"O, mankind! Verily, We created you all from a male and female [`Adam and Eve] and appointed for you tribes and Nations to be known to each other [by specified characteristics] Verily, in Allah's Sight the most honorable of you is the most pious of you; and Allah is the Informed Owner of Knowledge."*

(49:13). Though the different cultural contexts may produce difficulties for patients, physicians and other care providers, it would be a tool for empowerment of human being.

However, this is a reality that there are different cultures with different traditions around the world. No doubt, many people think that their own culture is superior to others', so they try to criticize other cultures for what they think is morally wrong and indefensible and in need of reform. This is a main challenge in anthropology and intercultural bioethics that whether we should have a neutral position against all cultural contexts or not. There are some customs which obviously violate the human dignity and human rights. So, how we judge them? In response to the mentioned issue, some intellectuals have suggested three different ideas of: "relativism", "absolutism" and "common general principles". Bringing the issue in one case can shed more lights on the matter and pave the way for a comprehensive discussion.

Case[1]:

Mr. A, born in a Eastern culture, recently moved to the West to join family members. When his neck became seriously swollen and spotted with inflamed lymph nodes, he was rushed to the emergency room of a nearby hospital. With symptoms of Hodgkin's disease, he was admitted for further treatment and required assessment for chemotherapy. Neither he nor his family was conversant in English.

The staff questioned him about his health history and that of his family. From the start, he and his family were deeply offended by the staff's efforts to inform him of his condition by inquiring into his personal health. He did not respond to many of the nurses' questions, which he regarded as rude and intrusive. He and his family also believed the staff lacked professional competence.

When the staff insisted on his signature for written consent, they were met with resistance and distrust. Ahmed and his family could not understand why anything in writing was necessary.

Ahmed then needed to have a tracheostomy tube inserted after he choked while sipping soup. Inserting the tube was difficult, and the long time it took to do so resulted in anoxic encephalopathy. Ahmed suffered a severe loss of oxygen to his brain, and from that time on remained in coma.

Not yet brain dead, his situation deteriorated. His family was extremely offended when the medical staff approached them to discuss treatment options including forgoing treatment. The family remained deeply suspicious of the staff's motives (1-3).

Main issues

Effective communication

Establishing a good relationship between physician and patients in a multicultural society seems to be a complex matter. The issue would be more complicated when the languages are not the same. Namely, there are many situations when the plurality of cultures in the clinical setting can lead to conflict, of which are the issues of "informed consent" and "truth-telling". The differences may influence on effective communication. So, sensitizing physicians and other staff to the differences is necessary.

An effective communication is a main factor for a good relationship between patient and care providers. For achieving this, understanding patient's feelings, expectations and values would be very helpful. For instance; for such a patient who has recently moved to a different country, admission to the hospital can put him under an undue stress. This may interfere in his relationship with the staff. Navigating stressful circumstances is one of the healthcare team responsibilities. The hospital environment, staff's behavior, and the family sympathy would relief his stress considerably. On the contrary, an unfriendly and inflexible conduct of the physician or staff would ruin the patient-caregivers relationship.

Medical staff should fulfill their duty to provide a good communication. The goals of communication, according to the 3rd Annual Disease Management Outcomes Summit in Johns Hopkins University are to (4):

- exchange information;
- reach mutually satisfying decisions;
- develop a common understanding; and
- build trust.

Linguistic and cultural barriers

In the current case, if we want to determine main barriers, we should point out linguistic barrier at first. Language discrepancy may result is a kind of miscommunication. The patient and his family were not conversant in English, and the staff was not also familiar with the patient's language. It seems that there was not any other person to translate the words and facilitate the communication. This matter might be impressive on misunderstanding between the patient and the staff. An interesting poem in the book II of "Masnavi" of Rumi is noteworthy, in which he tells a story as follows: "Four persons, a Persian, an Arab, a Turk, and a Greek, were traveling together, and received a present of a dirhem (money). The Persian said he would buy "angur" with it, the Arab said he would buy "inab," while the Turk and the

[1]. This case was stated in reference 1 for the first time, but we deleted the name of the patient and the countries to use it for a general discussion. This case has been discussed by some authors, including references 2 and 3.

Greek were for buying "uzum" and "astaphil" (staphyle), respectively. Now all these words mean one and the same thing, viz. "grapes;" but, owing to their ignorance of each other's languages, they fancied, each one wanted to buy something different, and accordingly a violent quarrel arose between them. At last a wise man who knew all their languages came up and explained to them that they were all wishing for one and the same thing" (5).

It is undeniable that in the case of "Ahmed", their ignorance of each other's languages has augmented the obstacles in the relationship between caregivers and patients. Not satisfied with the linguistic communication, both parties were in distress and ready to complain about not enough assistance. In this difficult situation, differences in values, perceptions, style of expression and cultural mores may produce a strong barrier if the staff is not familiar with these differences. Sometimes even phrasing a sentence or question in an appropriate way would result in patient's misunderstanding. Some sentences or inquiries may seem insulting. For instance, Arabs or Muslims are not comfortable with questions about drinking wine or sexual habits, particularly when their privacy is not protected. It is noteworthy that even though some family members have been living in this new country for some years their beliefs and behavior may not be similar to the Western people. Many immigrants change their style of living in a new country but it is not easy to change a belief or behavior formed after a long rearing.

Considering the secular nature of bioethics in the West, it is obvious that religion may make a conflict between patient and health caregivers. Sometimes the ideas about one subject (like abortion) are completely opposing, but in some cases there is a conceptual variation in which the concepts of ethics and their interpretation about one subject (like autonomy) may be divergent. As Macklin stated, cross-cultural misunderstanding can affect the way people in one country perceive a situation in another (6).

Informed consent

One important issue is taking an "informed consent". This notion is related to the concept of autonomy which is the main principle of the Western bioethics. Some people believe that autonomy is over respected in Western culture while in some cultural contexts there is no room for individualism. Western culture is low-context and non-Western culture is high context, according to Edward Hall (7). Low-context cultures emphasize independence, the individual, and a future time orientation. But High-context cultures emphasize interdependence, interconnections with others and a present time orientation. In a high-context communication, less information is conveyed by verbal expression and most of the message is embedded in the social context or internalized in the communication process itself (7). This theme, while interesting, may cause a big gap between patient and care providers. In this case, the patient (Mr. A) and his family do not feel any necessity for a signature, since they think the consent is a kind of approval for being honest. So, request to sign a written form may have a particular meaning of blurred mutual trust for patient, especially when there is not an effective linguistic communication.

Likewise, the notion of autonomy (vs. paternalism) is acceptable in many cultures but sometimes the people's perceptions and the limits are dissimilar. For instance, privacy of some individual or familiar information in some ethnics, particularly in women, is more sensitive than that in the West. In western culture, query about contraception even in a single young girl is not offensive but it is intolerable in some cultures or religions in which sexual contact before marriage is unlawful.

Truth telling

Disclosure of diagnosis and telling the truth about the patient's outcome in a serious illness is a sensitive responsibility of health caregivers, on which cultural and religious background of the patient would influence. In Western bioethics, every patient has "the right to know", so the physician or other health caregivers are obliged to tell him the realities of his diseases. But in some cultures, truth telling, and above all telling bad news, should be consulted with family members. Some elements would be important in dealing with this issue:

- The person who disclose the realities
- The manner of telling news
- Available supports (such as family, spiritual and social support)
- The methods of coping with difficulties and stress in different cultures

All of above-mentioned elements would influence on the care provider's decision about truth telling. As Ornek Büken declares, the subject of truth telling may vary from country to country and culture to culture (8). In a high-context culture, family members may play a more prominent role in decision-making in comparison to the patient. Emotional support is a real need in many non-Western cultures, and close family members are the first people who ask to know about realities of disease but patient sometimes do not know the nature of his disease until death.

No universal ethical mandate exists to tell patients the truth about their terminal illness, as Macklin confirms (6). The patient's close family may keep information about disease from the patient because they think that disclosure of a

cancer diagnosis would have adverse psychological effects. However, it is the duty of physician to know whether the patient is willing to put the responsibility of decision making on shoulder of her family or not, and whether she is in agree with withholding information. This duty should be done in an appropriate way in which the family is also respected. The healthcare professionals should talk to the patient about her ideas about the extent of information which she would like to receive personally from her physician or nurses.

The healthcare professionals should evaluate if patient is psychologically ready to hear a bad news about her health and her future. In a dying patient, his values and expectations should be taken into account by health caregivers in order to make the last days of life more pleasant. Patient's attitude about "death" is very impressive on his psychological state; being hopeless or depressed. Discussion about termination of treatments needs a special attention to the cultural background in order to the trust between patient and health staff remains intact.

Ethical approaches

The main key words in this case study are: mutual respect, effective communication, kind and truthful relationship. According to the 3rd Annual Disease Management Outcomes Summit in Johns Hopkins University (4), the intimacy of emotions and the private, often uncomfortable sharing of information between patient and physician require a foundation of mutual responsibilities that include: respect, open and honest communication, trust, and compassion.

In the current case, the caregivers should try to overcome the language misunderstanding by using a translator. It is pleasing that the use of experienced translators or interpreters has begun in the current decade in some countries (9, 10). For instance; in the United States, several state Medicaid programs now reimburse for translation services (10). The need assessment in different countries, as a primary step, is necessary. It's a common fallacy that in countries with cultural homogeneity, there is no need for interpreters. More profound study may not confirm this. For instance, in Iran, most people may have similar culture (let alone immigrants from Iraq and Afghanistan, etc), but there are many groups of people with different religions, different languages and various accents. Turkish, Kurdish, Lorish, and Arabic are some known languages in Iran besides Farsi. Despite this fact, there is any plan for training of cultural competency because there have not carried out studies that show the importance of this issue. In fact, health policy makers should feel the need to provide special, applicable and effective plans for training translators and interpreters.

However, this conclusion is obviously true for the descriptive thesis of ethical relativism: truth-telling, informed consent, and decision-making about medical treatment vary in different cultures (6). It is not expected that physicians or other caregivers be anthropologists but they should be able to understand patient, his values, feelings, expectations, and the way he views the ethical problem. They should also be respectful to patients' values and beliefs, and not to be seeking a kind of "ethical imperialism" by following their ideas even if they think it would be better for the patient.

But whether respect to patient's belief is always ethically sound. Consider these two cases: first, scarifying newborn infants as a traditional ritual to prevent drought in an indigenous group in Chile; and second, the freedom of sexual relationship in different ages and eradication of fetuses on request in the West. This is a challenging concern that to what extend we should respect cultural beliefs. In this regard, relativists claim that ethical rightness and wrongness are completely related to the cultural context and there is not any universal moral principle by which we can judge. According to the extreme relativists' position, there are no available transcultural standards by which different cultures might be judged on a scale of merit or worth (6). In other words, cultural relativity around the world necessitates a kind of relativism in ethics and ethical conducts. On the contrary, absolutists support fixed universal principles by which we can decide about morality of cultural rite and beliefs. The absolutists believe in a single universal moral standard which all people are obliged to obey. There are some people who believe in the supremacy of the western culture and they judge about other cultures by their westernized principles. Unfortunately, this kind of "ethical imperialism" is an ordinary approach in some international organizations.

Besides these two opposite concepts, some speak about a third notion of "fundamental ethical principles" (6). These anthropologists agree that "despite the superficial diversity of cultures, similar underlying structures and frameworks can be found" (6). For instance; liberty may be considered as a fundamental principle, but privacy is a culturally relative value. So, the attitude and practice of privacy and confidentiality could be different in societies without violating fundamental principles (6). Each of these principles can be used for decision making about morality of an action.

The Islamic faith may confirm this idea, considering the common origin and destination which all humans have. These general principles have been inspired on human by God, since Holy Qu'ran says: "*I swear by the soul and him who*

made it perfect, then he inspired it to understand what is right and wrong for it (its sin and its piety), (91:8)". No doubt, simply because a custom or ritual is a "tradition" in a culture cannot serve to justify its perpetuation when it quite clearly violates general ethical principles (6). Allameh Mohammad Taqi Jafari indicates some worthy points in the definition of culture (11). He says that every culture element must first originate from sound logic and supreme human emotions, and secondly provide man with the means for his development and perfection. He emphasizes "the more the culture of a society relies on basic, intelligible principles and supreme human perceptions, the more lasting the culture will be". According to him, culture has two aspects: relative and absolute. By absolute aspect we mean the comprehensive, general aspect of culture, such as the culture of appreciating beauty, respect for others, and gaining knowledge, which is applicable to all human societies. The relative aspect of culture arises from the particular ways of thinking, emotions and behaviors of a certain society, like mutual respect (11).

Giving emphasis to the ideas about fundamental ethical principles, three sources for moral disagreements can be numbered: divergence in facts and probabilities (such as consequences of euthanasia), moral status of the central entity (such as embryo in abortion), and difference in priority setting of values (such as child and parent rights when parents refuse to consent to a treatment) (6). In the cases of disagreements, there would be ethical resolutions by using fundamental ethical principles. Macklin's view is that "without ethical principles as part of a framework, there can be no systematic way to justify ethical judgments" (6). There are some things which are relative and some things which are not. Many bioethicists go on with four principles of respect for persons, beneficence, non-maleficence and justice, which are abstract but can take different forms in different cultural contexts. These principles are different from absolutistic principle, and could be very useful to judge morality of many cultural customs.

The four principles are also acceptable, according to the Islamic teachings, but if we want to arrange these principles concerning their importance, we may order them as follows: non-maleficence, beneficence, justice, and respect to autonomy. In some cases, we may change the order of principles or may use only one principle. We may have different interpretation and various reading of these principles in different societies. **On the other hand, we cannot limit the principles to these broad principles.** Some Islamic principles may also be suggested as main principles **including "the Public Interest" (Maslaha), the principle of "Do no Harm" (La Darar wa la Derar), the principle of "Necessity" (Darura) and the principle of "No Hardship" (La Haradj)** (12). **Owing to this fact that in many Eastern cultures the community rights has a special importance in ethical decision making, we may also propose "Public Interest" to add as the 5th general principle.**

Conclusion

Putting the mentioned points in a nutshell, physicians and other healthcare professionals are obliged to fulfill their duties by respecting their patients' attitudes and behaviors but they should also observe common ethical standards with its special interpretation in different backgrounds and various cultures.

Effective culturally sensitive communication is a necessary part of providing high quality care (13). Though we cannot determine absolute principles for all societies, there are general fundamental principles which should be respected and by which we can judge rightness and wrongness of beliefs and behaviors. Ethical imperialism and belief in the supremacy of the Western culture could not be defensible in the contemporary bioethics.

Taken into account the variety of cultures and languages in Iran and presence of a lot of immigrants from other countries such as Afghanistan and Iraq, and considering the growing attention to bioethics in Iran (14,15), as an Islamic Asian country with a profound culture, Iranian physicians should get familiar with intercultural bioethics and the approaches for a better communication in clinical practice.

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