

Medical Care and Multiculturalism

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Abstract: One issue that arises in the practice of medicine in a culturally diverse society is whether, and to what extent, should healthcare professionals respect their patients' treatment choices, particularly when these choices reflect their cultural and religious worldviews. Are there moral limits to accommodating the medical decisions of patients when they are motivated by cultural and religious beliefs which conflict with those of the medical community? In this paper, I argue that there ought to be moral boundaries on what kinds of medical decisions ought to be tolerated and therefore accommodated by medical professionals. They should be culturally accommodating to the extent that doing so does not lead to the harm of the patient. Also, accommodations should be made if the medical knowledge is not continuously reliable and replicable. First, I will review the moral principles that support this proposed position. Second, I will address the issue of how understandings of health and disease can vary among cultures. Third, I will defend the position that there ought to be moral limits to what kind of patient requests ought to be accommodated by medical professionals and how this position would be translated in practice.

In Anne Fadiman's book, *The Spirit Catches You and You Fall Down*, the case of an epileptic Hmong child named Lia Lee outlines the challenges of practicing medicine in a culturally diverse environment. The experience of the Lee family, like that of many others, was complicated by cultural barriers, such as issues with cultural sensitivity or different notions of disease. The most critical aspects of their case were those dealing with informed consent and decision-making delegation to family members. In this paper, the point I will argue is that while medical cultural accommodation should be preferable, medical treatment should only be culturally accommodating to the extent that doing so does not lead to the harm of the patient and is based on the best medical knowledge available. First, I will review the principles that support my reasoning. Then I will address how broadly the definitions of disease and disability can vary among cultures. Finally, I will bring attention to the moral implications and limits of informed consent and decision making by detailing a protocol that healthcare professionals should adopt to be more efficient in treating and helping these patients.

According to Beauchamp and Walters and the Belmont Report, treating a patient in an ethical way must follow three basic principles: autonomy, beneficence, and non-maleficence. The principle of autonomy compels medical professionals to recognize and respect the patient's right to make an informed decision regarding what they wish to have done to their body in regard to medical treatment. The principle of beneficence compels medical professionals to treat patients in a way that promotes the patient's best health interest. The principle of non-maleficence is reflected in the instruction of "first, do no harm." Physicians have many goals when treating a patient, such as caring for the patient in the respect of extending their life. This can be achieved through invasive procedures or by ensuring

the patient is compliant with the treatment. The physician must also stay in line with the wishes of their patient, which sometimes requires them to conduct palliative care.

Although the three principles of autonomy, beneficence, and non-maleficence are useful general guidelines to shape the medical treatment of patients, the principles are not specific enough to provide moral guidance in how physicians ought to tailor the treatment plan of patients coming from diverse cultural backgrounds. One of the profound issues of Lia Lee's case is that patients, due to their culture, might have dramatically different conceptions of health and disease from those of the medical community. This will lead to patients seriously opposing the recommendations of their doctors. In this kind of dilemma, how should physicians approach the treatment of their patients? The three principles seem to prescribe conflicting recommendations. A mere appeal to autonomy would seem to press doctors to respect the decisions of their patients even if they are most likely wrong. But a mere appeal to beneficence or non-maleficence would seem to press doctors to be paternalistic and override patient autonomy for the sake of promoting patient health. To make more precise specifications of how to treat culturally diverse patients, we must consider other normative commitments in addition to the three general principles.

In advocating for an approach that is accommodating to patients and their cultural backgrounds, one must first recognize that culture is not a means to stereotype a patient, which leads to treating the patient with less than optimal care. For instance, an African American pregnant woman might be misdiagnosed with hypertension instead of pre-eclampsia, simply because African Americans have a tendency for higher blood pressure.¹ This tendency of using generalization is noticed by African American patients, which creates distrust in their provider. This distrust, in turn, could lead African American patients to not disclose important information. If this happens, the doctor might create a situation that is detrimental to their patient's health.

Therefore, under no circumstances should healthcare providers assume anything about a patient. They should be as unbiased as possible and avoid the cultural imperialism of imposing their own cultural beliefs onto others. For instance, a common stereotype of Hispanic women is that they exaggerate the expression of their pain.² Thus, their pronouncement of the level of pain being experienced is expected to be inaccurate. But it seems plainly wrong for a physician to treat their patient according to this stereotype. If a woman with Hispanic features is crying in pain, medical professionals should recognize such expressions as genuine pain and ought to respond appropriately, irrespective of the negative stereotypes of Hispanic people. From an ethical point of view, it is morally impermissible to treat patients with different qualities of care based on groundless assumptions and biases a doctor might have.

Instead of these stereotypes, what should be implemented in our medical practices is cultural sensitivity. It is worth pointing out that cultural sensitivity and negative stereotypes are drastically different. Cultural sensitivity is about being aware of differences in values that influence one's idea of, understanding of, and approach to health. Negative ste-

¹ Martin, Nina, and Renee Montagne. 2017. "U.S. Black Mothers Die In Childbirth At Three Times The Rate Of White Mothers : NPR."

² Metz, Jonathan M, and Dorothy E Roberts. 2014. "Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge." *American Medical Association Journal of Ethics* 16 (9): 674–90.

reotyping, on the other hand, is labeling a person based on a bias, which can be instilled through education, poor experiences, or social currency. Therefore, racism, negative stereotyping against ethnicity, or heterosexism, negative stereotyping based on sexual orientation, are ethically impermissible and against the provider's professional integrity. These negative stereotypes, which are often invoked following mere observations of physical or social attributes (e.g., race or culture), push doctors to provide less than optimum care and therefore could be extremely harmful.

In practicing culturally sensitivity, medical professionals recognize that there may be very different cultural understandings of disease and disability. I argue that this is necessary to improve overall physician-patient communication, help physicians direct their patient's health care, and encourage patients to be more open to compliance. It is difficult, if not impossible, to find a universal definition of health across all medical cultures. "Health" is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."³ The definition of "disease" or "infirmity" is much more complicated to define. In the scientific field, *disease* has usually been defined as the loss of homeostasis of the body. Intuitively, we recognize that this also includes trauma and certain disabilities that disrupt the "normal" body prototype. However, it is foolish to think that other cultures might not hold other definitions of health, disability, and disease. For instance, epilepsy is conventionally understood by our medical community to be a harmful, undesirable neurological condition. Conversely, the Hmong believe, just as the Ancient Greeks did, that epilepsy is a sacred disease.⁴ Both cultures recognize that it is a disease, but in the Hmong culture, there is prestige attached to epilepsy, since it opens up the potential vocation of being a Shaman. In the example of Lia, her parents rushed her to the emergency room when she was seizing (they recognized it as a medical issue), but they also believed her to carry a kind of sacred gift. Knowing this cultural aspect, physicians would interact with better awareness of and attentiveness to the Lee family, leading to many improvements to Lia's care and potentially changes in her outcome. For instance, they could have had a Shaman present at some point in her treatment and could have discussed treatment options with the parents. In doing so, they would be recognizing Lia as a gifted child while also preserving her wellbeing.

Differences in definitions of health and disease are not the only issues that arise in physician-patient relationships involving patients from different cultural backgrounds. It is also important to recognize the significant degree of epistemic uncertainty in many medical diagnoses. Many experts on the healthcare system, medical schools, hospitals, and insurance companies, are coming to the realization that doctors are human and therefore make mistakes. Literature on this topic reveals the intricacies of making a correct diagnosis or treatment despite the occasional uncertainty of the very people who often believe that they are infallible.⁵ Dr. Jerome Groopman's *How Doctors Think* reveals the fallibility and epistemic finitude of doctors when deciding how to treat their patients. One notable case is when Groopman had pain in his back and his doctors could not make a diagnosis.⁶

³ "WHO | Constitution of WHO: Principles." 2016. WHO. World Health Organization.

⁴ Anne Fadiman. 2012. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*.

⁵ Shem, Samuel. 1978. *The House of God*. Delta Trade Paperbacks.

⁶ Groopman, Jerome E. 2008. *How Doctors Think*. Houghton Mifflin.

Each physician he visited had a different diagnosis. Eventually, his physicians resorted to inventing a diagnosis and even doing invasive surgery. This type of scenario was also viewed in *The House of God*, when each specialty -surgery, emergency medicine, or hospital internist- has a different way of approaching medicine, with sometimes opposite results. For instance, a surgeon may want to excise the appendix, while the emergency medicine physician might want to try antibiotics first, thus enrolling the patient in the CODA research project.⁷ We must recognize the pressure of physicians to find a diagnosis, often in as little as fifteen minutes, since that is considered the ideal time they should spend with a patient to satisfy insurances and administrative expectations. However, from the moral point of view, this seems wrong. When there is significant medical uncertainty, it is in the interest of the patient to be informed of such uncertainty.

This problem of epistemic uncertainty in the correctness of a diagnosis or treatment plan is found in any patient-physician relationship. But it does seem to have unique implications for how to tailor the treatment of patients who hold different views about the meaning of health and disease. I argue that, in these cases, physicians should be even more open to patients' culture or point of view. One reason is that it will probably be more productive in helping the patient through their ailment, as it will demonstrate to the patient that the physician has their best interests in mind, as well as leading the physician to gain the patient's trust more rapidly. When there is no clear curative recommendation for a medical condition based on current medical knowledge, such as mental illnesses, Alzheimer's, Parkinson's, or Huntington's, the patients should be the primary decision-maker about what type of medicine and which treatments they prefer. Western medicine is generally put on a pedestal of perfection; it cures all, diagnoses all, and treats all. This is understandable due to medical advancements like Germ Theory or the development and perfection of surgeries. However, it is important to recognize that western medicine is not faultless, especially in the realm of mental and degenerative diseases. Due to the fallibility of western medicine, I advocate for a deliberative model of physician-patient relationship. In this model, the physician is the "partner," discusses procedures and treatments, listens to patient preferences, and then helps the patient make reflective, informed decisions, overall acting as a counsel to the patient about their health.

A poignant example of the need to reform our medical approaches in a way that resembles the deliberative model is the case of patients with mental illnesses. Western medicine's "approach" to mental illness is based on Emmanuel's paternalistic model, consisting of the physician deciding what is best for the patient. In this model, the physician believes they know more about the ailment, and so medicates them with little evidence that it benefits the patient. Meanwhile, in Geel (Belgium), doctors observe and listen to their patients – the deliberative model of care- and incorporate the patients into society, leading to a higher success rate of patients thriving while dealing with their mental illness.⁸ Therefore, trusting the patient to decide what they wish to do with their life achieves a higher level of autonomy and healthcare of the patient. Therefore, Western medicine is

⁷ Davidson, Giana H, David R Flum, David A Talan, Larry G Kessler, Danielle C Lavallee, Bonnie J Bizzell, Farhood Farjah, et al. 2017. "Comparison of Outcomes of Antibiotic Drugs and Appendectomy (CODA) Trial: A Protocol for the Pragmatic Randomised Study of Appendicitis Treatment." *BMJ Open* 7 (11)

⁸ Miller, Lulu; Spiegel, Alix. n.d. "The Problem with the Solution : Invisibilia : NPR."

not in a position to make judgments regarding the quality and direction of treatment in these “epistemic” conditions. The principle of autonomy should typically be respected in cases of medical uncertainty about care (mental illnesses and terminal diseases), where healthcare providers should listen to the patient’s directives.

It is worth noting, however, that patients should not be licensed to do anything to their body with the assistance of their physician. An example of this would be when certain cultural health-promoting practices do not, in fact, promote health, but instead lead to harm. Lead, for instance, is a key ingredient in the remedy “Daw Tway,” which is used to help children with digestive issues.⁹ Giving lead would be considered harm, thus according to the do-no-harm principle, these cases should be addressed and halted by the physician. This would require, and morally justify, the physician-patient relationship to reverting to a paternalistic model. Permitting this toxic treatment would go against the non-maleficence principle and would therefore be morally impermissible for the physician to administer. Physicians have the moral obligation to inform the patient and communicate this decision to them using terms they understand. In other words, a physician should explain in terms relatively accessible to the patient, being respectful towards the culture (no condescending or paternalistic tone or references) and using the terminology the patient did. Another situation where the deliberative model is ill-advised is in an emergency, such as an unconscious patient, where time and level of consciousness are obstacles. Here, the paternalistic relationship is the only ethically responsible model.

Another important responsibility of the physician is to obtain informed consent. This can be very trying when doctors from foreign cultures are involved in the process of informing the patient about their diagnosis, offering treatment options, and explaining them. If there is a language barrier, an interpreter should be present, or accessible through a phone call. This protects the patient by helping the provider to not miss pertinent information or by preventing a complicated situation from arising. By bridging the communication gap, doctors can have a fruitful discussion about the patient’s beliefs and values, focusing on the medically relevant ones.¹⁰ As Kleiman states in 1980, “Patients should solicit the patient’s or the family’s perspectives of the disease (the bodily discomforts), the illness (their experience of the bodily discomforts), and their explanatory models (ideas about cause, timing, and mode of onset of symptoms, patho-physiological processes, severity of illness, and appropriate treatments).”¹¹ Then the physician can discuss medical topics and norms, such as how to handle a hypothetical terminal diagnosis, to understand the patient’s wishes and values. These could be in line with a specific culture, or not. As in Lia Lee’s case, her parents misinterpreted the concept of her prognosis, which was her death in a matter of days, as doctors declaring they were going to kill Lia.¹² Therefore, these questions protect the patient from potential misdiagnosis, mistreatment, or miscommunication. They also make sure that the patient understands what their disease is, thus avoiding treatment conflicts between their culture and the doctor’s advice. Furthermore, it also protects the physician from misdiagnosing because of faulty medical history and

⁹ “Arsenic and Lead Poisoning.” 2017. Accessed December 30.

¹⁰ Culhane-Pera, Kathleen A., Vawter, Dorothy E., Xiong, Phua. 2003. *Healing by Heart*. Vol. 86.

¹¹ Ibid.

¹² Anne Fadiman. 2012. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*.

other frustrations they may encounter.

To illustrate this, we will review a clinical case about a woman from India called Mrs. Ramsarathan.¹³ She complained of abdominal pain and was treated by Dr. Ellamjeet. After testing and discovering that the patient had cancer, Dr. Ellamjeet, who had been treating her, and assumed he knew her culture, discussed her diagnosis with her family first, to determine whether to disclose this information to Mrs. Ramsarathan. Dr. Ellamjeet, per another physician's advice, consulted the ethics committee of the hospital, and still decided not to disclose the information. Had he known Mrs Ramsarathan's wishes from the beginning instead of discussing her care with her family first, as well as her diagnosis and other information regarding her health and care, it would have made for a smoother case. Furthermore, had Dr. Ellamjeet taken the time to discuss with Mrs. Ramsarathan the possibility of a terminal or life-threatening disease and communicated with her to determine what she wished to know or delegate to her family, he might have avoided the complicated ethical issues that came later. This 'putting the patient first' approach is in line with the deliberative model of physician-patient relationship, as elaborated by Ezekiel and Linda Emmanuel.¹⁴ Additionally, it exemplifies a model that respects patient autonomy and their individual values without the threat of stereotyping. This helps avoid the dangers of poor communication with foreign cultures.

In conclusion, following the principles of autonomy, beneficence, and non-maleficence, healthcare professionals should respect their patient's culture. This would foster trust between the patient and the provider in a shorter time frame, likely leading the doctor to come to the correct diagnosis faster, thus honoring better informed consent and patient autonomy.¹⁵ By following the protocol of first discussing with the patient their values, following the deliberative model, the physician would make sure that patients exercise their autonomy. Afterwards, the doctor might face fewer ethical issues with patient care. There are cases where patients' safety is crucial, so in certain cases medical professionals should adopt a paternalistic relationship. If the physician believes that the alternative treatment provided by the culture would be more harmful than not following it, then they should discuss this with the patient, to minimize emotional distress, and possibly with a board of physicians. Doctors must be careful not to be culturally imperialistic and not stereotype the patient, which is why it is crucial for the doctor to deliberate with patients on their values relative to their healthcare, as direct autonomy is not always praised in other cultures. The focus of this paper is centered on the culture clash that emerges from definition differences, informed consent, and delegating healthcare choices to family-members. The content of this paper focuses on the American culture bias; it would be interesting to see if other medical cultures have the same issues that are present in American hospitals.

¹³ Perkins, and Henry S. 2006. "Ethics Expertise and Cultural Competence." *Virtual Mentor* 8 (2).

¹⁴ Emanuel, Ezekiel J., and Linda L. Emanuel. 1992. "Four Models of the Physician-Patient Relationship." *JAMA: The Journal of the American Medical Association* 267 (16). American Medical Association: 2221.

¹⁵ Kuczewski, Mark, and Patrick J McCrudden. 2018. "Informed Consent: Does It Take a Village? The Problem of Culture and Truth Telling."

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