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Clinical Case
Ethics Expertise and Cultural Competence
Commentary by Henry S. Perkins, MD

Seena Ramsarathan was brought to the hospital by her son-in-law. She had arrived in America 2 days earlier from her remote village in India in anticipation of the birth of her first grandchild. Soon after arriving, Mrs Ramsarathan's family noticed that she was unable to keep down much, if any, food. Though they had avoided the American medical system in the time they had been in this country, the family was frightened at her continued vomiting and took her to the hospital.

With the help of a translator, the primary team at the hospital was able to gather Mrs Ramsarathan's story. She had rarely seen a doctor during her lifetime. She spoke no English and had never learned to read. She said she had begun developing difficulty eating certain foods 6 months earlier, and the problem seemed to get progressively worse.

A gastroenterologist, Dr Ellamjeet, was consulted. Before emigrating to the US to complete his training, Dr Ellamjeet had gone to medical school in India and was fluent in the same dialect as Mrs Ramsarathan, which was a great comfort to her. She was still visibly unsettled by her surroundings. While a translator was intermittently available for the primary team, it soon became clear that Mrs Ramsarathan and especially her family wished for Dr Ellamjeet to be her primary doctor.

Mrs Ramsarathan's son-in-law, who emerged as the spokesperson for the family, was concerned that the tests would reveal a serious diagnosis and asked Dr Ellamjeet not to tell his mother-in-law directly, but to allow him and the other decision makers in the family to decide when, and how, and to what extent to communicate the diagnosis to Mrs Ramsarathan. A limited work-up revealed, as suspected, a mass highly suspicious for advanced carcinoma. Mrs Ramsarathan's son-in-law believed, and Dr Ellamjeet concurred, that frankly revealing a dire diagnosis in these surroundings would not be in her best interest.

Dr Ellamjeet explained this to the primary team. "This kind of information is not something that is forced upon the patient in this culture. It would be doubly cruel to her. Not only would she find out that she is dying, but she would find out in a way that is completely foreign to her, deprived of traditional, subtle ways and cues of expressing and accepting death. It would be to foist the entire burden of this knowledge on her and not let her family carry the burden for her in the way they are accustomed. The humane

thing is to do what the family wants—let them care for her as they would if she were back home."

Members of Mrs Ramsarathan's care team wanted a better sense of her prognosis and what treatment options she would be forgoing if they accepted Dr Ellamjeet's suggestion. They consulted Dr Cameron Michaels of the surgical oncology team. Dr Michaels expressed his conviction that Mrs Ramsarathan ought to be told her likely diagnosis and said that he would not treat her unless she knew what her diagnosis and treatment options were. Furthermore, he would not treat her if she wholly deferred medical decision making to her son-in-law. "While the overall benefits of the treatments I can offer her in terms of longevity and pain relief might outweigh the harms, to inflict those known harms on her (eg, the probable side effects of chemotherapy, surgery, and radiation) without her knowing why it was being done would be inhumane. There is a world of difference, at least as I see it, between enduring the costs of a treatment as a necessary evil in view of some greater good and suffering through that evil for no known reason. I refuse to walk into her room after putting her through one of these therapies and have her look up at me with eyes that say, 'Why are you doing this to me?'"

Facing an impasse, the primary team discussed calling for an ethics consult. They approached Dr Ellamjeet who responded, "If you need to get an ethics consult for legal reasons to protect the hospital and physicians or to ensure that there is no misunderstanding, I understand. But simply from the perspective of the best interest of this patient, Mrs Ramsarathan, no ethics consult is going to be informative. I don't consider myself an ethicist, but, having been down this road with patients from this part of India many times, I can confidently say that I have a better grasp of Mrs Ramsarathan's interests than would a Western-educated ethicist, no matter how well-intentioned, with only a cursory understanding of her culture, family dynamics, and traditions of living and dying. But do as you wish."

Now, unsure whether an ethics consult will be helpful, the primary team tries to regroup. The intern on the team thinks aloud, "Is there such a thing as cultural expertise and, if so, how would it fit into clinical bioethics?"

Commentary

An ethics issue is a conflict of values about what to do [1]. Recognizing an ethics issue depends on *sensing* discordant values, but resolving it skillfully depends on *specifying* those values and the actions each suggests. Mrs Ramsarathan's case presents several genuine ethics issues. Her primary team physicians recognize 2: Should they tell Mrs Ramsarathan about her likely cancer diagnosis? Should they request an ethics consultation over Dr Ellamjeet's objection? The team may not recognize 3 others: Should the physicians relinquish to Dr Ellamjeet all care negotiations with the family? Should they honor the son-in-law's decisions about Mrs Ramsarathan's care? Should the physicians find another surgeon who will treat Mrs Ramsarathan without disclosing the diagnosis to her?

The primary team physicians may already have ideas for addressing each issue, but choosing a sound resolution requires specifying and weighing the underlying values carefully.

Values are either cultural or idiosyncratic. For values to be considered "cultural," members of a group must share them, teach them, and use them to interpret life experiences. (Race, nationality, and ethnicity are often mistaken for culture but do not actually define it and reflect it only roughly.) While both kinds of values affect any situation, cultural values dominate in Mrs Ramsarathan's case.

Only by defining who shares which values can the primary team physicians reason through the cross-cultural ethics issues in this case. To complicate matters, every person belongs to many cultural groups at once. For example, the primary team physicians belong to the cultural groups of American nationals and physicians; Dr Ellamjeet, to Indo-American immigrants and physicians; and Mrs Ramsarathan, to Indian nationals and patients. While most assessments of cultural differences focus on ethnic groups, other kinds of cultures may also pose value conflicts. For example, 2 distinct but often unrecognized cultures? those of physicians and patients? create many conflicts in clinical settings. In Mrs Ramsarathan's case ethnic cultural differences pose the most important conflicts. Still, her physicians must be alert for other kinds of cultural conflicts.

The primary physicians have already made a good start at characterizing the ethical issues here. In particular, the physicians recognize the fundamental value conflict underlying the question of whether to tell Mrs Ramsarathan her diagnosis. Disclosing it would promote truthfulness and personal self-determination, core values of American culture. Not disclosing it and negotiating care through the family would honor filial duty and collective familial decision making, core values of many Far Eastern cultures [2-3]. Having identified this difference, the physicians need a sound decision-making approach to resolving it. They might ask, as the intern did, "Does expertise in ethics and culture exist?" and, "If so, can that expertise help us?"

Ethical and Cultural Expertise

An ethics consultant sensitive to cultural differences can offer valuable assistance. Like other clinical consultants, the ethics consultant commands special expertise—traditions of ethical reasoning; insights from complementary fields such as psychology, sociology, anthropology, and law; and lessons from practical experience. Furthermore, every ethics consultant has faced cross-cultural ethics problems. Even if he or she has only limited knowledge of the particular cultures involved in a case, the consultant brings a disciplined and tested general approach to decision making.

One common approach [4] frames ethics issues as "action questions," that is, questions that require choices among possible actions. Such framing helps channel deliberation toward a definite, practical conclusion. Aspects of this approach include identifying an ethical concern, stating it as an action question, imagining all reasonable action responses, identifying the values behind those responses, weighing the values against each other, and choosing an action. Interviewing all parties directly addresses several

aspects of this approach at once and is always a good way to start. Resulting insights often clarify the known value conflicts, expose unseen ones, and suggest fresh solutions. Experience and imagination may then guide the consultant to more harmonious resolutions than previously thought possible. In the process the consultant will likely avoid a common pitfall—overruling one culture's values too quickly.

An Ethics Paradigm

An ethics consultant would surely recognize the paradigm for the main problem in Mrs Ramsarathan's case: Can withholding diagnoses from patients be justified on cultural grounds? Ethics scholars have debated this paradigm extensively. One solution has survived their scrutiny—asking the patient herself [5]. Hence, the primary physicians and the ethics consultant should ask Mrs Ramsarathan early on (through a qualified third-party translator, not Dr Ellamjeet or a family member) whether she wants the physicians to tell her the diagnosis directly. Furthermore, the physicians should ask Mrs Ramsarathan whether she wants to participate in decisions about her care. If she wants to leave such decisions to her family, the physicians should then ask her particular preference for a proxy. This solution not only clarifies decision-making authority but also honors both sets of core cultural values.

Of course, not all cross-cultural ethics issues are resolved so neatly. Sometimes harmonizing values is impossible, and physicians must choose the values of one culture over those of another. In general, ethics consultants favor giving patients' or families' values great leeway. But there are limits, especially when a patient's values violate a physician's deepest personal or professional convictions [6]. Such situations should prompt consultation with colleagues, preferably including a culturally knowledgeable ethics consultant. Conscience may prevent a particular physician from providing the care requested but still allow referral to another physician. Thus, Dr Michaels may refuse to operate on Mrs Ramsarathan without disclosing her diagnosis to her but may, in good conscience, refer her to another surgeon who *will* operate without disclosing the diagnosis. Nonetheless, in rare situations (particularly involving life-threatening risk to innocents) conscience may dictate that the physician protect a vulnerable patient while requesting outside oversight from the proper civil authority [6].

Summary

Mrs Ramsarathan's case shows that cultural expertise exists, that it complements ethics expertise, and that it can aid in clinical management. Every physician should develop sensitivity to the widest possible range of cultural values. The physician should also expect to encounter cross-cultural ethics issues in patient care. When they arise, the physician should use the basic concepts outlined here to try to resolve them, probing to specify the underlying conflict of values and trying to harmonize them. That disciplined process will resolve many issues. Yet the most intractable may require special expertise. For that reason every practicing physician should have ready access to an ethics consultant experienced in cultural conflicts.

The diversity of patients and physicians makes cross-cultural clinical ethics issues inevitable [6]. A skillful approach to resolving them is as necessary for good medical practice as any technical knowledge or procedure.

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