

Cultural Engagement in Clinical Ethics: A Model for Ethics Consultation

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In the rapidly evolving healthcare environment, perhaps no role is in greater flux and redefinition than that of the clinical bioethicist. The discussion of ethics consultation in the bioethics literature has moved from an ambiguous concern regarding its proper place in the clinical milieu to the more provocative question of which methods and theories should best characterize the intellectual and practical work it claims to do.¹⁻¹⁰ The American Society for Bioethics and Humanities addressed these concerns in its 1998 report, *Core Competencies for Health Care Ethics Consultation*.¹¹ The report tries to answer the question as to what disciplinary training, background experience, and levels of knowledge in ethics the clinical ethics consultant should have, and what specific skills and character traits the clinical ethics consultant should cultivate. In addition to acquiring knowledge of common bioethical issues, theoretical concepts in ethical theory and moral reasoning, and health-related law and policy, the report also recommends that ethics consultants demonstrate knowledge of the health beliefs and perspectives of patients and healthcare providers. In our opinion, this recommendation underscores a crucial aspect of the practice of ethics consultation in the increasingly multicultural settings of healthcare institutions. Clearly, the dynamic of American life and culture is permeated with diversity and variety as new groups suffuse their own beliefs and faith perspectives into the health sector. New immigrant groups force society to question traditional healthcare practices and to accommodate changing medical needs. The influence of these "minority" groups accelerates the need for change and adaptation in order to provide effective, meaningful care. This effect will only increase because demographic projections suggest that those cultural and ethnic groups presently designated as minority groups will compose a majority by 2060.¹² In some states, such as California, New Mexico, and Hawaii, this trend has already materialized.

Moreover, provider and patient populations increasingly hail from diverse ethnic and cultural backgrounds,¹³⁻¹⁵ bringing with them a host of different values and beliefs. The clinical ethicist can no longer assume that the practitioner and patient or even the ethicist share a common moral perspective or a homogeneous set of values regarding health and well-being. New criticism contends that bioethical inquiry has limited itself to problems within a Western, principle-driven, biomedical model. Interestingly, although the field of bioethics claims to be an interdisciplinary domain of inquiry, there is a remarkable paucity of research examining its interface with social science fields such as anthropology and political science. Indeed, anthropologists such as Marshall, Kunstadter, Sankar, and Muller call for a more collaborative intellectual exchange between bioethics and anthropology.¹⁶⁻²⁰ These authors argue for an expanded

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use of the interpretive methods employed in the social sciences as a key to understanding the interactions between culture, health, and bioethics.

In many ways, the practice of clinical ethics consultation has become, for some, more an exercise in solving problems of communication and misunderstanding than in reconciling genuine moral conflict or ethical disagreement. However, we contend that ethics consultants should take seriously the challenge of providing culturally relevant advice rather than assuming that culturally driven value disputes are merely “communication problems.” In our view, it is vital that ethics consultants continue to develop skills in intercultural diplomacy, not only as a way to prevent ethical conflict from occurring but also as a means of making the practice of ethics consultation in a pluralistic setting morally sound. To our knowledge, the clinical ethics literature does not address *how* clinical ethicists might develop these skills and is silent on the role of the clinical ethicist as a cultural mediator.

The aim of this paper, therefore, is to propose a new approach to respond to the unique challenges of cultural difference and diversity as they manifest in the context of clinical ethics consultation. Unlike models of cross-cultural health encounters that focus on narrow notions such as “cultural competence” or require compromise between one dominant culture and a minor one, we offer an approach that preserves the cultural identities of both patients and practitioners. The principal aim of this approach is to increase the possibility of better patient-provider relationships. This approach or framework is called “Cultural Engagement” and is intended as a practical device by which the ethics consultant can build culturally relevant knowledge and understanding into his or her professional role. This framework is based on the idea of “engagement,” a reciprocal process of communication and dialogue whereby one individual’s values, expectations, and moral and health beliefs are made explicit to the other individual, thus promoting common understanding and trust. In this framework, the role of the ethics consultant expands from that of a facilitator and negotiator of moral conflict to that of a mediator of intercultural understanding and mutual cooperation. To illustrate the way in which the concept of Cultural Engagement achieves these aims in practice, we report an actual case involving a patient and physician with culturally divergent views on the treatment of end-stage renal disease. The article concludes with several recommendations for future applications of this approach.

Cultural Diversity in Healthcare

Culture is generally regarded as a shared framework of beliefs, values, and attitudes that are passed along to other members of a group through symbols, customs, traditions, and practices.²¹ Culture is the matrix of a particular group’s fundamental beliefs about art, language, literature, custom, and law; it is the vessel through which personal identities and ideologies are created. However, it is important to note that culture is not contiguous with either race or ethnicity and easily crosses such lines. One cannot assess an individual’s culture on the basis of skin color, language, or physical appearance.²² Additionally, it should not be assumed that individuals belong to or identify with a single cultural group; a person can maintain membership in a variety of cultural groups simultaneously and may ground his or her identity in the confluence of several cultural perspectives at once. Although moral values and

beliefs are born in particular cultures and influence the behaviors of the members of that group, they are subject to revision and refinement. Ethics is the reflective process by which a particular cultural group's moral proclivities and choices are systematically interpreted, examined, and defended. Culture and ethics are thus inextricably linked: the first providing basic, intuitive moral conventions and presuppositions of a given group, and the latter providing a more formal, normative framework in which moral choices are rationally defended and justified.

According to the definition given above, even medicine is a culture.²³ To facilitate and improve cultural relations between individuals involved in health-care, medicine has adopted the idea of cultural competence as a key construct in the diagnosis, clinical management, and outcomes of care.²⁴ Other professional organizations have begun to realize the enormous role that culture plays in healthcare practice and research. The Council on Nursing and Anthropology was initiated in 1969 to ensure the input of cultural content into nursing curricula, to enhance cultural research, and to help improve care to underserved or underrepresented patient populations. In 1974, the eminent nurse-anthropologist Madeline Leininger formed the Transcultural Nursing Society to help nurses optimize their competence in providing nursing care to culturally diverse groups. In 1986, the American Nurses Association promulgated a position statement entitled "Cultural Diversity in Nursing Practice," and other international nursing organizations have similar guidelines regarding diversity issues in a multicultural society.²⁵ Finally, in 1998 the American Medical Association initiated the Cultural Competence Initiative Work Group that has produced the source-book, *Cultural Competence Compendium*.²⁶ Even the government is concerned about the relationship of cultural diversity and medicine. At a recent U.S. Congressional hearing, for instance, anthropologists discussed the cultural and social factors surrounding pharmaceutical nonadherence.²⁷

Current Models

In the discussion that follows we examine several models of cultural awareness that appear in the relevant literature. We note that almost all of these models suggest that the path to cultural sensitivity in healthcare practice is marked by either (1) becoming *competent* in a particular culture different from one's own or (2) attempting a *compromise* between cultural perspectives believed to be incommensurable. We argue that neither of these approaches is adequate for the kind of work that clinical ethicists are called on to do, and we suggest that cultural understanding is a more appropriate aim to pursue.

Purnell and Paulanka in *Transcultural Diversity and Health Care*, describe their notion of cultural competence. They observe that when individuals of dissimilar cultural orientations encounter each other in a therapeutic relationship, the likelihood that such a relationship will be satisfying is improved if each party attempts to learn about the other's culture. This process leads to cultural competence, which they define as:

- 1) developing an awareness of one's own existence, thoughts, and environment without letting it have an undue influence on those from other backgrounds;
- 2) demonstrating knowledge and understanding of the client's culture;

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- 3) accepting and respecting cultural differences;
- 4) adapting care to be congruent with the client's culture.²⁸

We note that Purnell and Paulanka's approach is an ideal standard, but one that would be difficult to sustain in actual practice settings. Most healthcare professionals would find it difficult to achieve a level of complete competence about the beliefs, meanings, and lifeways of all the patients under their care. And yet, Purnell and Paulanka assert that learning about the patient's culture, verifying generalizations, and providing culturally specific interventions is a realizable goal in the practice setting. To this end they endorse reading books and consulting academic scholars who have studied a particular culture. They also suggest that the practitioner develop expertise in the largest minority group in a practitioner's area. Common barriers to this goal, though, include the problem of ethnocentrism—the pervasive, often unconscious belief that one's own culture is superior to all others. Additionally, the ever-increasing burden of time constraints encountered by physicians, nurses, and support staff presents another obstacle to this ideal. Finally, by studying disembodied materials such as books and scholarly articles, the ethics consultant may find himself or herself categorizing individuals by culture, which can lead to the problem of cultural stereotyping.²⁹

A dominant portion of the literature on transcultural conflict focuses on medical practice.³⁰ An analysis of these writings reinforces the proposition that many of the ethical issues regarding healthcare practice and medical technology inevitably involve social and cultural features.³¹⁻³⁷ These articles view culture as a barrier, problem, or an obstacle that we must overcome by enhancing knowledge and comprehension.³⁸⁻⁴² Those studies that investigate patients' perspectives of cross-cultural ethical issues are generally limited to case studies, ethnographic interviews, and surveys.⁴³

Still other articles document that patients of diverse ethnic backgrounds vary in their response to pain, interpretation of symptoms, access to follow-up care, and compliance.⁴⁴ Cultural differences are implicated in a number of ethical conflicts involving issues such as truth telling, the process of informed consent, the autonomy of patients and roles of family, and end-of-life issues.⁴⁵⁻⁵⁰ A recent study of healthcare professionals' perspectives about a cross-cultural ethical conflict evaluated the influence of cultural information on the practitioner's tendency to respect the patient's wishes.⁵¹

Much of the literature emphasizes the use of decisionmaking frameworks as a method of managing cultural difference.⁵²⁻⁵⁴ One approach to resolving disputes in a cross-cultural context is a model of cultural awareness and sensitivity developed by Galanti. In this model, a set of cases and vignettes help illustrate how descriptions of cultural behaviors and actions can be utilized to help practitioners become more culturally aware.⁵⁵ This interpretive approach is an excellent educational tool aimed at increasing knowledge of general health beliefs and behaviors. It is well suited for classroom and seminar discussions but its utility in actual clinical practice may be limited. In another model, Jecker and colleagues outline a three-step process in determining how to reach decisions regarding cultural difference. These elements include identifying common goals, identifying mutually agreeable strategies to meet those goals, and making sure that the strategies fit with the values of the healthcare providers and patients.⁵⁶ The underlying assumption of this

model holds that a description of the patient's cultural variance is a sufficient path for understanding how the practitioner should respect patients' wishes and preferences. However, although this approach appreciates the underlying value commitments of both patient and provider and shows respect for individual difference, its focus on decisionmaking strategies may obscure more important needs and desires on the part of the patient. For many individuals, even initiating a conversation is influenced to some extent by cultural values and rules that may be misunderstood by those attempting to promote shared decisionmaking. Additionally, it must be noted that increased sensitivity to cultural influences on health behaviors, beliefs, and practices is not by itself sufficient to achieve a genuine understanding of a *particular* patient's health-related goals. Although language, nonverbal communication, physical appearance, and social habits may provide general information about common cultural norms, they are not sufficient for providing care that is patient centered and culturally relevant.

Most importantly, the literature contains little discussion of the impact of cultural diversity on clinical ethics consultations, except for an article published by Orr, Marshall, and Osborne in 1995. In a discussion of how cross-cultural differences can lead to ethical dilemmas, Orr et al. describe a method of resolving moral quandaries in cross-cultural patient care. This process relies on compromise and negotiation as essential features of the decisionmaking process. Cases containing ethical dilemmas are analyzed along four dimensions:

- 1) an ability to communicate effectively with patients and their families;
- 2) a sufficient understanding of the patient's cultural background;
- 3) identification of culturally relevant value conflicts; and
- 4) a willingness to pursue discussion of the ethical dilemma until a compromise is reached or an otherwise satisfactory resolution of the problem is achieved.⁵⁷

These ideas may help physicians and other health professionals when caring for patients from other cultures. This model has much to offer in cases where parties are able to compromise their values and beliefs. However, many of the most common ethical dilemmas in healthcare arise simply because individuals are unable to compromise—unable to give up what they consider to be cherished moral values and traditions. Moreover, although compromise between divergent opinions may be inevitable in many cases, the term can carry a negative connotation, implying situations where an individual may be asked to forfeit a cherished belief or practice. In contrast, the Cultural Engagement approach does not require patients or providers to compromise beliefs or culturally embedded practices. Rather, in this approach, cultural difference and diversity is an important ideal to be preserved and respected. Its principal advantage over other models is that it encourages a rapprochement or engagement of diverse perspectives and values. In other words, our model helps patients, families, practitioners, and ethicists to engage each other's differences and similarities in a conversational process aimed at genuine cultural understanding and mutual cooperation. Cultural values are thus integrated into the patient-provider relationship and treatment plan in order to foster the goal of competent, compassionate, and culturally relevant care.

Toward a Philosophy of Cultural Engagement

In the discussion that follows, we trace some of the intellectual ideas that are foundational to the development of our model of Cultural Engagement. The primary philosophical impetus for this model is the conviction expressed by John Stuart Mill in his celebrated essay "On Liberty." He asserts, "Only through diversity of opinion is there, in the existing state of human intellect, a chance of fair play to all sides of the truth."⁵⁸ Mill believes that freedom of thought is a valuable and necessary ingredient of social progress because it helps in the search for truth and moral character. For Mill, the sphere of human liberty includes three essential domains: a liberty of conscience; a liberty of tastes, pursuits, and plans of life; and a liberty of uniting or assembling with others. Taken together, these three spheres of human liberty constitute the principle of self-determination, understood in both its individual and social sense.

In our view, it is respect for diversity in the opinions and habits of others that provides the ethical underpinnings of the multicultural approach in our model. The reader should note that accepting a diversity of opinions does not necessarily imply that one agrees with them. Rather, a commitment to multiculturalism means that a person understands, appreciates, and values his or her own culture, but in addition has an informed respect and curiosity about the cultures of others.⁵⁹ A multicultural attitude requires that when the cultural backgrounds and value systems of two or more groups differ in important ways, an effort to establish common grounds of understanding, meaning, and respect must take place. We regard this commitment as central to the expanding role of the clinical ethicist working in a multicultural context.

Cultural Engagement rests on three separate but interrelated assumptions. The first assumption states that all cultures merit a certain degree of respect, even if certain practices specific to a culture may appear to be threatening or incommensurable with one's own established norms. By engaging in discussions of our differences and commonalities, we combat the tendency to be ethnocentric or imperialistic in our attitudes toward others and we begin to approach the value of mutual understanding and respect. In normative ethical theory, the *principle of mutual respect* requires that all persons see themselves as moral equals in terms of their common humanity and dignity. The principle of mutual respect as used in Cultural Engagement implies respect for individuality as well as respect for difference. As a normative principle, mutual respect denotes an attitude of accommodation toward individual autonomy as well as cultural autonomy. It rejects the notion that one's own point of view is superior to that of another, or that an individual's set of values can be presumed to be congruent with those of a particular culture. In other words, our approach rests on the assumption that the patient and the provider are unique self-defining individuals rather than fixed cultural stereotypes.

A second assumption is the belief that illness and the threat of pain, suffering, loss, and/or death are unavoidable conditions of human life. Although illness expresses itself in diverse ways, most ill people demonstrate the following characteristics: feelings of dependence; the need for comfort, protection, and help; and a desire to have these needs met in a culturally respectful manner. Furthermore, the experience of illness often provokes feelings of vulnerability, not only in patients but also for those who witness their losses and

fears and attempt to care for them. When ill, patients depend on the technical knowledge and professional skills of the provider, often a previously unfamiliar individual, in order to regain health, function, hope, and/or a sense of value. In many cases this dependency may be culturally foreign or unwelcome, and it may threaten the patient's sense of autonomy and independence. This idea, which we refer to as the *principle of vulnerability*, is an integral part of our model of Cultural Engagement. It assumes that patients are vulnerable not only to the threats of illness and loss, but also in the ways they are treated by others, especially those who have power over them. This vulnerability creates special ethical responsibilities on the part of providers to use their power in ways that do not exploit or stigmatize those under their care.

Finally, the third assumption of our model is the belief that cultural differences regarding healthcare should be integrated into clinical training and practice. In Cultural Engagement the focus of ethical consultation is not aimed at the application of rules, principles, and theories of a dominant medical culture, but rather at the unique moralities of the cultural worlds of both patients and providers. Each party brings to the clinical encounter its own cultural heritage and belief system about health, illness, wellness, and disease. When these values or moral traditions conflict, a common moral perspective from which to understand and deal constructively with these conflicts is needed. We refer to this idea as the *principle of cultural relevance* and are indebted to the work of Arthur Kleinman and others who have inspired this approach. Our model of Cultural Engagement is an adaptation of these ideas for use by ethicists working in clinical situations that involve cultural discord between patients and caregivers. Following Kleinman, we hold that cultural influences on the health beliefs of *both* the patient and the provider can be best understood through the use of an explanatory model paradigm. According to Kleinman, "explanatory models are the notions about an episode of sickness and its treatments that are employed by all those engaged in the clinical process."⁶⁰ In clinical settings, it is crucial that caregivers and ethicists understand the patient's interpretation of the illness experience and the culturally derived meanings it may have for him or her. It is also essential that caregivers and ethicists understand their own value framework and refrain from inadvertently imposing it on others. In Cultural Engagement, the relationship between the patient and practitioner is regarded as a cultural encounter as well as a moral activity. That is, the patient-provider relationship is the moral space in which moral values, needs, and ideals are embedded. It is grounded in and nourished by trust. For the patient, trusting a primary caregiver means having confidence that what is entrusted will be respected, protected, and dignified.⁶¹ This includes the expectation that ones' personal beliefs and values will be treated with as much care as a broken limb or a dysfunctional pancreas. As Sissela Bok puts it, "Trust is a social good to be protected just as much as the air we breathe or the water we drink. When it is damaged, the community as a whole suffers; and when it is destroyed, societies falter and collapse."⁶² In our opinion, trust is regarded as more fundamental than duties of beneficence, veracity, and nonmaleficence because without trust, no one would have a reason to take on these duties in the first place.⁶³

In sum, Cultural Engagement is a conceptual and normative framework. It is an approach to cultural pluralism that aims at increasing intercultural understanding of cultural difference, instead of viewing it as a problem that needs to be solved. Grounded in an ethic of trust, it encompasses three principal concepts: mutual respect, human vulnerability, and cultural relevance. This frame-

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work presumes that during every clinical encounter patients and providers exchange ideas about moral and cultural values. These exchanges include culturally nuanced evaluations of concepts of life, death, suffering, and human flourishing, as well as expectations about the proper way to relate, communicate, and function in the sick role. Although providing care congruent with established principles of medical ethics is an appropriate goal, the provider and the ethicist should *interpret* these principles in a way that is culturally meaningful to the patient. As a facilitator of cultural exchange, the role of the ethics consultant thus expands from a myopic view of value conflict to one that embraces the fact of diversity and difference. The aim of the clinical ethicist, then, is to bridge the moral and experiential gap between the patient and the provider by acting as a conduit through which cultural meaning, significance, and understanding can be explored and made explicit.

The Praxis of Cultural Engagement

Cultural Engagement is the method for accomplishing this immense task. We contend that ethics consultants working in multicultural settings have an unprecedented opportunity to promote intercultural understanding of human illness and the moral questions it imposes on the lives of patients and healthcare providers. Cultural Engagement is a process whereby the clinical ethicist assists the patient and provider in exchanging information regarding their explanatory models of illness in an effort to increase cultural understanding that will lead to more satisfactory healthcare outcomes. It is not a model of ethical decision making per se, but rather a teaching tool that can be used not only by ethics consultants but by practitioners as well. As a process-oriented method, Cultural Engagement consists of a set of questions that elicit the practitioner's and patient's explanatory models of disease and a Cultural Engagement (CE) chart that captures their ideas about the illness experience.

In a typical case involving cultural conflict, the ethics consultant is called to the clinical setting because of a perceived ethical problem or conflict identified by the healthcare provider. The consultant begins by separately asking the patient and provider a series of questions aimed at eliciting information on how each interprets the illness and treatment course. This information is used to interpret how the patient and provider approach the disease or healing process. Their responses are documented in a CE chart, using their exact words. The CE chart is a simple tool consisting of questions and note-taking space (see Figure 1).⁶⁴ It is essential that the respondent's own words are documented verbatim because they are often clues to determining the source of misunderstanding and value conflict. We suggest that the clinical ethicist begin the history of the perceived ethical conflict by questioning the practitioner. This step is summarized in the practitioner interview column. The clinical ethicist elicits the provider's explanatory model of disease, which serves as a point of reference for the perceived conflicts. According to Kleinman, when a patient and a practitioner come together, they begin sharing their different ideas regarding the illness, its signs and symptoms, and its causes and meanings. After sharing their explanations and expectations, each person revises his or her explanatory model to incorporate new understanding. As further conversations ensue, these explanatory models continue to undergo revision. The process proceeds until the patient and practitioner arrive at a common understanding.

Categories	Practitioner interview	Patient interview
Illness or health problem(s)	<p>What are the patient's health problems?</p> <p>What has the patient told you about the health problems?</p>	<p>What are your health problems?</p> <p>How have the problems affected your body and your life?</p>
Causes(s) or etiologies	<p>What are the causes for each health problem?</p>	<p>What do you think caused these problems?</p>
Treatment goals and concerns	<p>What has been done for these health problems?</p> <p>How can you help this patient?</p> <p>What is your concern or problem about the patient?</p>	<p>What have you done for these health problems?</p> <p>What do you need in order to be helped? What can the doctor do for you?</p> <p>Who helps you make health decisions? Who should be told your medical condition?</p>

Figure 1. Interview questions for the Cultural Engagement chart.

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The primary objective of the ethics consultant at this point is to understand the medical features of the case, including the practitioner's perspective regarding medical treatment and his or her understanding of the patient's best interests or biomedical good. In completing the CE chart, the ethicist is able to discern the nature of the conflict from the provider's culturally embedded point of view. The actual activity of completing the chart also helps the ethics consultant avoid inadvertently biasing the process with his or her own cultural prejudices.

Next, the clinical ethicist conducts a similar conversation with the patient and documents the responses in the patient's CE chart.

In ascertaining the patient's beliefs and preferences regarding the health problems and treatment options, the clinical ethicist is able to gather important, culturally sensitive information that may explain the perceived conflict in care. The primary objective of the ethics consultant is to ascertain what needs the patient feels must be met in order to consider his or her care to be acceptable, acknowledging that the patient may not regard the medical practitioner as the sole healer. Additionally, it is important that the ethics consultant refrain from assuming that the patient is the primary decisionmaker or the person to whom medical information should be disclosed. Instead, the patient is asked to specify the individual authorized to make health decisions or receive medical information. In this way, the ethicist shows respect for the autonomy of the individual as well as the for cultural norms of the patient and family.

At this stage of the process the clinical ethicist will have a strong idea of how each individual interprets the illness experience. By comparing and contrasting the patient and practitioner responses, the ethicist is able to demonstrate the differences in values, beliefs, and illness constructs, thus isolating the value dispute and paving the way for intercultural understanding. By approaching the case within a framework of Cultural Engagement, the ethicist engages the patient and the provider in a reflexive dialogue about their explanatory models of disease and cultural beliefs regarding treatment. To illustrate the way in which this model works in ethics consultation, we report the following case in which we were asked to provide an ethics consultation.

The Case of Mrs. Hernandez

Mrs. Hernandez (pseudonym) is a 60-year-old woman from Mexico admitted to the University of Texas John Sealy Hospital in Galveston. She is not an American citizen and speaks only Spanish. Her son Miguel, a permanent U.S. resident, speaks both Spanish and English. Mrs. Hernandez has been diagnosed with the following conditions: end-stage renal disease, type II diabetes, anemia, malnutrition, and skin lesions. Her physician, Dr. Abdul, is completing a third year of residency in Internal Medicine. Dr. Abdul is a native of the Ivory Coast and is fluent in French, English, and Spanish.

Several days into Mrs. Hernandez's hospital stay, Dr. Abdul requested an emergency ethics consult to help sort out issues related to end-of-life decision-making. In his opinion, continued treatment was futile because all of the patient's illnesses were irreversible. He stated that the patient could go into cardiac arrest at any time, and thus he was prepared to write a do-not-resuscitate (DNR) order. However, the family had instructed the medical team to "do everything possible" to keep Mrs. Hernandez alive. Dr. Abdul stated that given

Responses	Dr. Abdul's CE Chart	Hernandez Family's CE Chart
Identified illness or health problem(s)	<p>(i) End-stage renal disease She has no energy and cannot urinate.</p> <p>(ii) Diabetes, type II She does not eat much.</p> <p>(iii) Anemia Not receiving proper care or nutrition.</p> <p>(iv) Skin lesions; inadequate skin turgor Her skin is coming off.</p>	<p>(i) Kidney problems She has no energy now. Can't spend time with the family.</p> <p>(ii) Skin sores Discomfort and pain</p> <p>(iii) Swallowing problems She is weak; she can only swallow warm liquids.</p>
Perceived cause(s) or etiologies	<p>(i) End-stage renal disease Uncontrolled diabetes, organ failure.</p> <p>(ii) Diabetes, type II Family history; uncontrolled insulin levels.</p> <p>(iii) Anemia Malnutrition, low iron stores, neglect.</p> <p>(iv) Skin lesions Malnutrition, neglect.</p>	<p>(i) Kidney problems Ancestors, age, too much sugar in her blood clogged the filters.</p> <p>(ii) Skin sores Unknown.</p> <p>(iii) Swallowing problems Doctor's medications.</p>

<p>Anticipated treatment goals and concerns</p>	<p>(i) End-stage renal disease Peritoneal dialysis; diet management. DNR order; allow her to die. If family refuses a DNR, move patient to hemodialysis and place in long-term care center. Family lacks understanding of the seriousness of her illness.</p> <p>(ii) Diabetes, type II Insulin, diet management. Work with family and patient to educate them about the importance of insulin, glucose testing, and diet. Family is pushy and belligerent.</p> <p>(iii) Anemia Proper nutrition, food supplements. Normalize iron levels; increase energy.</p> <p>(iv) Skin lesions; inadequate skin turgor Proper nutrition, food supplements, wound care. Minimize physical contact with patient's skin. Improve nutrition, heal sores, ensure better care.</p>	<p>(i) Kidney problems Amulets and charms. Dialysis so she can go home and spend time with her family. Eldest son, Miguel, helps with decisions.</p> <p>(ii) Skin sores Amulets and charms. Don't touch her.</p> <p>(iii) Swallowing problems Feed her through a straw. Help her to eat. Stop the medications. Bring her home.</p>
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Figure 2. Cultural Engagement chart comparison.

the patient's medical condition, it was highly unlikely that a nursing home would admit her and that, in his opinion, little more could be done for Mrs. Hernandez at the hospital. He requested that an ethics consultant speak to the family.

Upon arriving at the patient care unit, we introduced ourselves to Dr. Abdul and began to ascertain the ethically relevant issues. We believed that the real conflict in this case was not disagreement over potentially futile medical care. Rather, we approached the unit with the assumption that the source of the conflict was likely due to cultural misunderstanding. We engaged the practitioner in a conversation about Mrs. Hernandez's condition and treatment plan. When asked what health problems the patient was having, the physician articulated the various diagnoses and etiologies that pertained to Mrs. Hernandez. We entered his responses into a CE chart as a way to record his information and to gain access to his explanatory model (see Figure 2).

For the most part, Dr. Abdul employs a biomedical model of disease causation to describe a patient's "multiple organ failures." In his assessment of this case, he stated that the disorders were brought on as a result of the patient "being neglected and not receiving proper care or nutrition." The treatment plan to remedy these maladies included oral and parenteral feedings, oral insulin, and wound care. The physician added that although these measures were medically indicated, they would not reverse any of her underlying conditions or restore her to health. In fact, he asserted that further care, especially resuscitative care in the event of cardiopulmonary arrest, would be futile. He added that he felt that the patient's son was "being pushy" and that the son and other family members were "very vocal" and "belligerent." We noted that although the physician was able to communicate in the Spanish language, he did not seem able to communicate directly with the patient who, though frail and vulnerable, was more or less able to participate in decisions about her care. When asked how he thought he could be of most help to the patient he stated that a DNR order was the best course, adding that he did not think that the family understood their mother's condition or its severity. He said that it would be best to let her die peacefully, given that she had such a poor prognosis.

After reviewing the patient's medical record, we approached the family. Mrs. Hernandez was lying in bed, and two adult children, a daughter and the eldest son, Miguel flanking her. After introducing ourselves, we received permission from Mrs. Hernandez to talk together at her bedside in order to understand some of her concerns regarding her health. We began by asking the patient or family to tell us in their own words what sort of health problems the patient was having. Miguel responded in English that she was having kidney problems, skin sores, and swallowing problems. He believed that these conditions came from her age and her ancestors. During this bedside discussion, we learned that in their family the eldest son has the role of decisionmaker and that Miguel would be the appropriate person to provide consent or refusal of treatment, if necessary. Miguel's responses were entered into the patient's CE chart using his terminology (see the last column in Figure 2).

A subsequent meeting was held with Miguel and the social worker assigned to the case. The purpose of this meeting was to provide an opportunity for the family to demonstrate their understanding of their mother's condition and to relay any knowledge of treatment preferences she might have stated in the past. We learned that the patient and family believed in the care offered at the

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hospital but that they also endorsed the use of amulets and charms as tools to promote healing. Miguel's major concern was that his mother was away from her family and that the doctors were causing her more pain than good. Although the son was reluctant to talk about the possibility of his mother dying from her illness, he made clear that he knew how poor her prognosis was. We learned from this encounter that dying is not something that one openly talks about in this patient's culture. When asked what the family regarded as important care for their mother, Miguel said that his mother had told him she wanted to return "back home," apparently referring to her son's home in Texas. The most important value for this family was to spend as much time as possible with their mother. Miguel felt that this goal could best be achieved if the doctors helped them to stabilize their mother's condition to the point where she could leave the hospital.

We provided the patient's son with information written in Spanish on advance directives and encouraged the family to begin a frank discussion of the kinds of end-of-life decisions they might be required to face in the near future. One of our goals was to have her sign a Durable Power of Attorney for Healthcare so that the medical record could establish the patient's desire to designate her son as the primary decisionmaker. Second, we wanted the family to understand their options regarding treatment and we wanted to clarify for them that an order not to resuscitate in no way meant that the patient's overall care would be compromised. Respecting their reluctance to talk about death, we simply left the document with Miguel and did not push the matter at this point. We made ourselves available to answer his questions at a later time.

Dr. Abdul was informed of our effort to explain to the patient's family the concept of an advance directive and that the patient could legally direct her son to make healthcare decisions on her behalf. Although the document was never formally completed, we felt confident that this process was respectful of this family's cultural preferences and that some degree of trust was created between the patient, family, physician, and healthcare team. The next day, Mrs. Hernandez was transferred to a specialized renal unit in order to be switched to a hemodialysis procedure. This simple change made Mrs. Hernandez's goal of being discharged from the hospital and returning home a real possibility. Despite the poor prognosis, and an earlier assessment that medical care was futile, the patient began to make daily improvements in wound healing and weight gain. The family also got what they wanted most, treasured time with their mother in the setting that mattered most to them: home.

Synopsis

By maintaining a commitment to the principles of mutual respect, vulnerability, and cultural relevance, the ethics consultants initiated a process of sharing meanings that led to an outcome that satisfied both the patient and the provider. In the dynamic conversational exchange of perspectives, the values and health beliefs of both parties were respected. In no way was the patient, the family, or the physician asked to compromise or change his or her own cultural belief system. By simply listening to the needs and desires of each other elicited through the explanatory model history, the ethics consultant reconciled the cultural misunderstandings that gave rise to a perceived ethical dilemma. The result was an improved patient-family-practitioner relationship and the provi-

sion of care that was medically competent, ethically sound, and culturally sensitive. Cultural Engagement provided a framework within which to foster an environment of intercultural understanding and to build trust in the patient-provider relationship.

Cultural Engagement does not treat every instance of value conflict as an ethical problem needing analysis and adjudication. Rather, our model sees value discord as an opportunity for intercultural exchange, cooperation, and understanding. Indeed, if clinical ethics consultations are to meet the needs of patients whose values differ from those in the dominant, white, middle-class provider group, more must be known about the influence of culture and ethnicity on life-and-death decisions, treatment preferences, and issues such as truth telling, informed consent, and patient autonomy.⁶⁵ In our view, the practice of ethics consultation demands a process that interprets culture-based differences regarding healthcare within a common moral framework that respects diversity, difference, self-determination, and cultural autonomy. On the conceptual level, this approach fosters an ethic of trust and attempts to synthesize individual, professional, and cultural values through a process of engagement. On the practical level, Cultural Engagement is a clinical tool for establishing a rapprochement between cultural groups that hold divergent beliefs and values. In sum, the model of Cultural Engagement is essential to the practice of ethics consultation, where knowledge of the health beliefs and illness constructs of both patients and providers can be employed to reconcile, and perhaps prevent, many of the ethical dilemmas they are called on to solve.

Other Issues

Although cultural diversity is often regarded as mandating tolerance for the beliefs and practices of others, Ruth Macklin argues that in some situations excessive tolerance can produce patient harm.⁶⁶ That is, an attitude of excessive tolerance may lead to abuses of fundamental human rights or needs. This raises some interesting questions for clinical ethics consultants. Is promoting the value of diversity always a moral good or are there some cultures or cultural practices that can be regarded as morally invalid or suspect? Similarly, how should the ethical obligation to provide beneficial care to the patient be understood when the patient's value system rests on drastically different metaphysical views about health, illness, disease, suffering, or care? The core of these efforts exposes a paradox: How is it possible to achieve a consensus on moral values and ethical guidelines in a healthcare encounter without sacrificing the cultural integrity of a particular group? Such questions, although beyond the focus of this paper, are indeed central to any discussion of the demands of morality in a culturally complex society.

Clearly, clinicians as well as clinical ethicists need to better understand the unique moral worlds that mark the diverse cultural landscapes of contemporary healthcare practice. At present, the proliferation of cultural variability in clinical settings suggests that the challenge of providing patient-centered care will become even more difficult. Although many institutions are beginning to offer training strategies in teaching and learning about cultural diversity and difference, no univocal agreement exists on just what forms of diversity and difference ought to prevail in a healthcare system.

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It is certain that more research is needed to examine the ways in which cultural values and meanings influence the practice of ethics consultation as well as the recommendations they offer. Specifically, our claim that a Cultural Engagement approach to cultural and ethical pluralism improves trust and prevents value discord in the patient-provider relationship must be empirically validated. Our experience with this model suggests so far that it is a helpful clinical tool to assess important value differences between patients and practitioners. Additionally, we believe that the Cultural Engagement model can enlarge the function of the clinical ethicist from a narrow focus on problem solving and dispute resolution to a role as mediator of cross-cultural diplomacy.

Notes

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20. Marshall PA. Anthropology and bioethics. *Medical Anthropology Quarterly* 1992;6(1):62.
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- about and attitudes toward life." Geertz C. *The Interpretation of Cultures*. New York: BasicBooks, 1973:89.
22. Bonnie O'Connor notes that "the relative importance or influence of race, ethnicity, or a specific culture in any individual . . . is unpredictable, and can only be confirmed by self-report." O'Connor BB. Promoting cultural competence in HIV/AIDS care. *Journal of the Association of Nurses in AIDS Care* 1996;7(S1):43.
 23. Arthur Kleinman notes that we must view healthcare itself as a system that is social and cultural in origin, structure, and significance. Healthcare can only be understood in relation to cultural practice. In *Patients and Healers in the Context of Culture*, he elaborates:

In the same sense in which we speak of a religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions.
- Kleinman A. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, 1980:24.
24. In proposing a curriculum for a course in human diversity and medicine, David Hufford develops several basic principles of "culturally competent" care. In his view, patients, doctors, and nurses are all cultural beings with emotional needs and social interests. The clinical milieu in which they engage is culturally grounded, involving both facts and values. These culturally shaped values and perspectives are as crucial to accurate diagnosis, clinical management, and good patient outcomes as the so-called objective facts of scientific medicine, laboratory values, and clinical therapeutics. Furthermore, Hufford stresses that the concept of a patient's "best interest" is culturally determined and thus can vary from one group to another or even from one patient to another. A competent patient's best interest cannot be accurately inferred from simple knowledge of his or her cultural heritage alone. Therefore a patient must articulate, consult, and approve the construal of his or her best interest. Hufford DJ. Introduction. *Southern Folklore* 1997;54(2):61-6.
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