
Ethics and Cultural Diversity — A Framework for Decision-Making

by Dula F. Pacquiao

Believing that healthcare outcomes will be more satisfactory if the patients' cultural knowledge and values are understood and integrated appropriately in care planning, the author proposes a culturally competent ethical decision making model based on human rights — the fundamental right of individuals, families, groups, and populations to healthcare that is meaningful, supportive, and beneficial—and a reconceptualization of ethical principles to include the values and assumptions of clients. The ideal result is culturally congruent healthcare in which practitioners learn about their clients' lifeways and work with them to find satisfying ways to resolve clinical and ethical issues.

Morals and philosophical beliefs are constituted within the social, historical, and cultural experiences of a society. Western societies share the philosophical belief that humans have the capacity to be rational and scientific and that reason is a universal attribute regardless of one's race, culture, personal endowment, and life experience. Thus, reason is a universally applicable standard for judging every situation (Lovejoy 1974).

Social and Cultural Contexts of Morality

The philosophical traditions of universalism and rationalism have shaped western concepts of personhood: human persons are imbued with a universal capacity for reason and action. Any deficit of this natural ability is attributed to cognitive, motivational, informational, or linguistic deficits, and once these have been compensated for, a person can be expected to make decisions that are logical and morally acceptable (Shweder and Bourne 1997). Each person is viewed as a distinct entity, separate from his or her social role and relationships. Geertz (1975) aptly describes this western view of the person as "a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment and action organized

into a distinctive whole and set contrastively both against such wholes and against a social and natural background" (p. 48).

However, not all human behaviors can be classified as rational or irrational. Culture is primarily concerned with nonrational ideas and their expressions; it speaks of meaning and reality as constructed by groups of people. Culture is the realm of the arbitrary in which human beings interact to create their own distinctive, symbolic universe (Shweder 1997).

Cultural diversity requires a relativistic stance achieved by the ability to switch frames of understanding. It requires an awareness that fundamentally different perspectives may coexist and incompatible frames can handle any and all new evidence (Shweder, 1997). Frame switching permits acceptance of variant patterns of meanings and recognizes that logic and science may be limited tools for understanding differences.

Human Rights, Lifeways, and Health

Discontented with the narrow, disciplinary perspectives competing with each other for influence over the direction of public health policies, Mann and Burris (1998) proposed a human rights framework as a new template for public health.

They posited that modern human rights, arising entirely outside the health domain (outside health disciplines), and seeking to articulate the preconditions for human well being, seem a more useful framework and vocabulary for public health. Human rights and health are mutually embedded goals; thus, protecting and promoting one has a consequent reciprocal effect on the other. That is, human rights are intrinsically important social moral assumptions, and they have instrumental value in contributing to public health goals.

Leininger (1991) has demonstrated that meaningful and beneficial care occurs when the

There's something more to thinking than reason and evidence. Many of our ideas and practices are beyond logic and experience. – R. A. Schweder

patient's cultural care values, expressions, or patterns are known and used appropriately by care providers. A reservoir of knowledge about culture-specific and universal aspects of care enables practitioners to make care decisions that fit the lifeways of different groups. This knowledge is grounded in *emic* (native) perspectives about caring and inductively generated from the people themselves.

Leininger (1991) makes a distinction between generic care and professional care. Any care situation involves *emic* (insider) and *etic* (outsider) perspectives. In fact, professional caregivers and healthcare organizations may have a different set of values and assumptions about caring from those of patients and their families. Cultural conflicts that can lead to ethical dilemmas arise from competing world views and moral assumptions. Leininger identifies action strategies that are grounded in knowledge of the care recipients' culture and in the participation of both

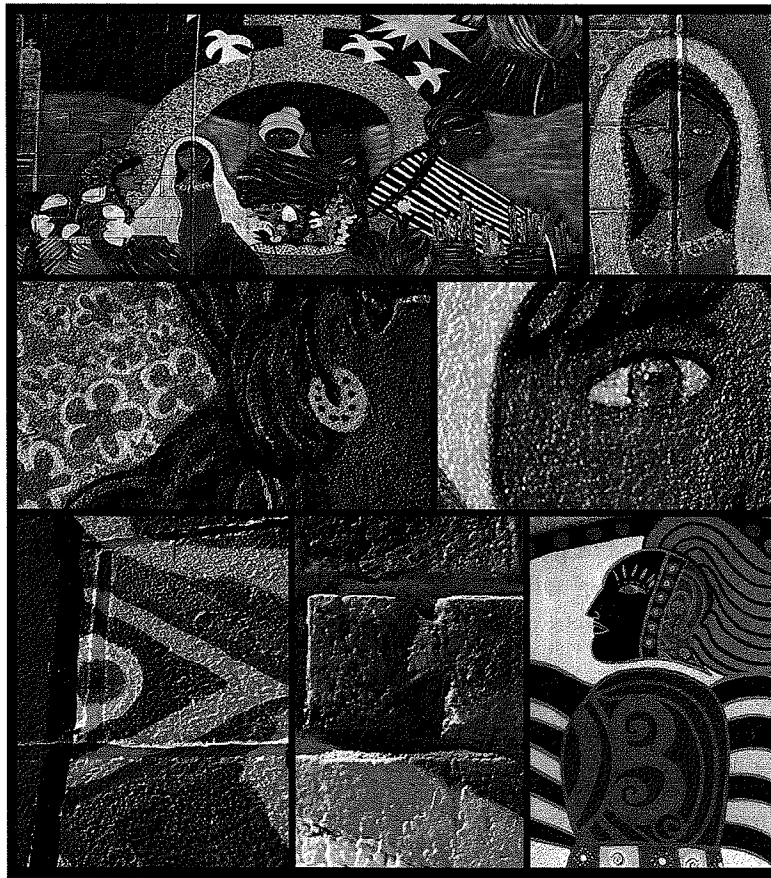
practitioners and consumers in decision making. She describes three strategies:

1. Cultural care preservation or maintenance — professional actions and decisions that help people of a particular culture retain and preserve relevant care values so that they can maintain their well-being, recover from illness, or face disabilities or death.
2. Cultural care accommodation or negotiation — professional actions and decisions that help people of a designated culture adapt to, or negotiate with, others for beneficial or satisfying health outcomes.
3. Cultural care repatterning or restructuring — professional actions and decisions that help clients reorder, change, or greatly modify their lifeways for new, different, and beneficial healthcare patterns while respecting the clients' cultural values and beliefs. These changes provide a beneficial or healthier lifeway than clients had before they helped establish the new patterns (Leininger 1991, pp. 48-49).

Culturally Competent Ethical Decision Making

Based on Mann and Burris's and Leininger's insights, I have developed a culturally competent ethical decision-making model. This model adopts the human rights framework for ethical decision making. It affirms the fundamental right of individuals, families, groups, and populations to healthcare that is meaningful, supportive and beneficial. Within the context of human rights and culturally congruent care, ethical principles are reconceptualized to include the values and assumptions of clients. As a culturally congruent model, it mandates practitioners to learn about their client's cultural lifeways and to work with them to find satisfying and meaningful ways to resolve issues.

Using the model, practitioners can switch frames of understanding so that they can respect a westerner's value of autonomy and equally, a nonwesterner's value of group solidarity. The model provides a continuum for accommodating



different values, assumptions, and morals across cultures groups. It presupposes the human right of individuals, families, groups, and populations to culturally congruent decisions about life events (Pacquiao, in press).

Leininger's (1991) action strategies are adopted in the model. These actions are based on the following prerequisites:

- cultural knowledge about the clients,
- assigning prime importance to the clients, and
- valuing care providers' roles as learners of the consumers' culture and as coparticipants in decision making.

Decision making that is culturally congruent with the client's system of meanings is ethical since it respects and protects the inherent values and assumptions of people who provide a context of meaning to their lives. Ethical principles achieve meaning only when the intended recipients find

them congruent with their valued ways of being. Culturally congruent actions are the processes by which ethical principles are applied and human rights are preserved.

All three components (human rights, ethical principles, and culturally congruent actions) are the ingredients of culturally competent ethical decision making. These three components must be present to achieve culturally competent decision making. Figure 1 depicts the relationship among components of the model. Cultural competence is achieved when ethical decisions preserve human rights to meaningful and satisfying care that is grounded in patients' culturally constituted values and lifeways (Pacquiao, in press).

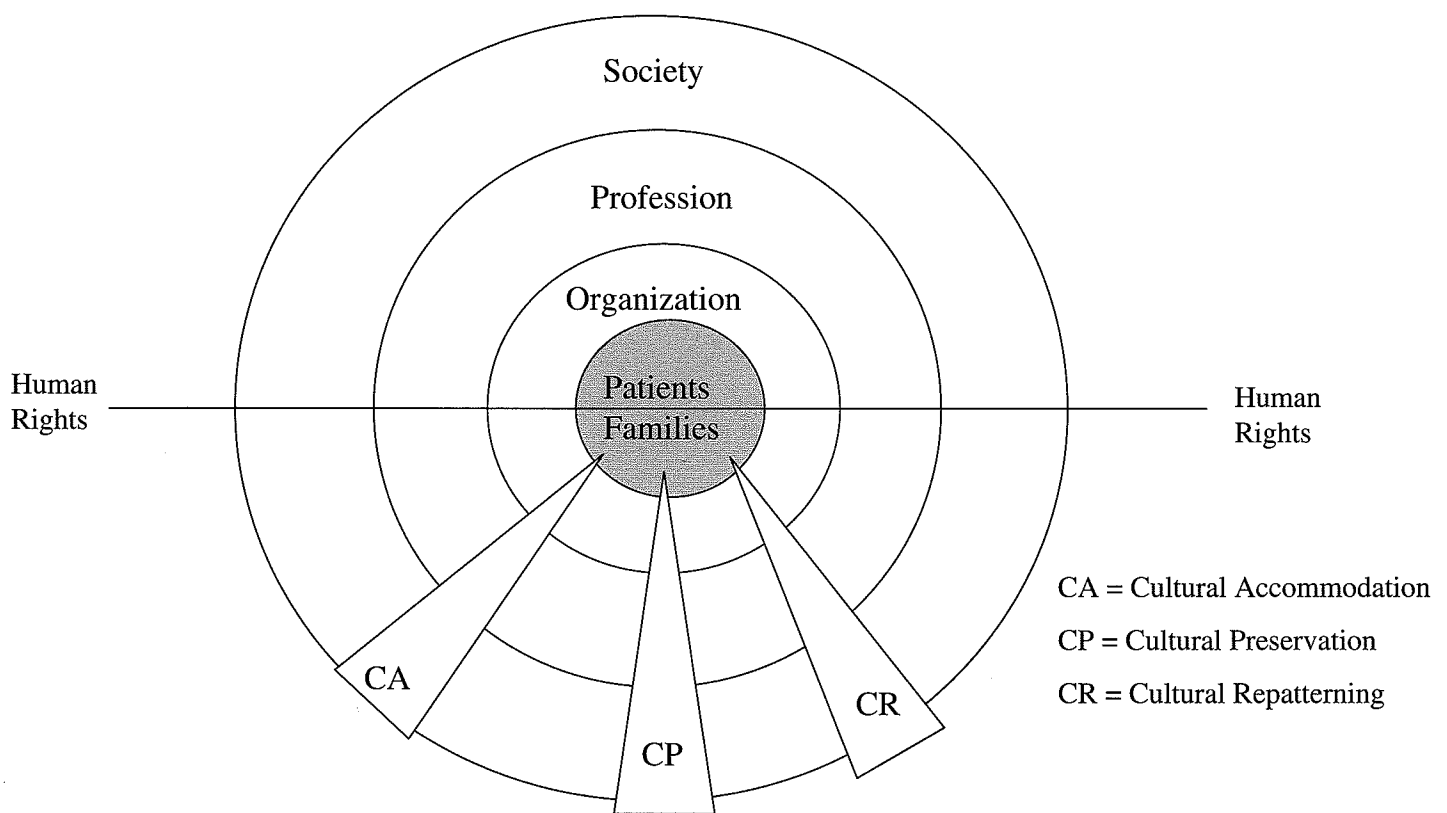
Applying the Model

To use the model, four levels of cultural knowledge must be established:

- cultural values, meanings and practices of clients and families,

Figure 1. Culturally-Competent Model of Ethical Decision-Making

Adapted from J. Mann's Human Rights Model and M. Leininger's Cultural Care Theory



This figure belongs on page 14; it was inadvertently omitted.

- organizational assumptions, that affect the situation,
- dominant professional norms such as ethical codes that influence practitioners, and
- dominant societal norms such as laws that impose structure on decision making.

Case Study

A sixty-year old Muslim female was admitted to the hospital accompanied by her son and

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daughter-in-law. She had joined her son's family in the United States five years ago after her husband died in their homeland, Egypt. She did not speak or understand English. Her son stated that she had been moaning at night, unable to sleep and had been eating poorly for the past few weeks. After a battery of tests, she was diagnosed with terminal liver cancer. When the attending physician (an Egyptian) presented the information to her son, he insisted that his mother not be informed of her diagnosis and forbade anyone to use the word *cancer* in front of his mother. He asked that the doctor and the staff use the diagnosis, tumor in her liver.

The nursing and medical staff reacted with anger. Many felt that they were being forced to lie and abandon their role as advocates of the patient's right to be informed. The staff concurred that by ignoring the patient's right to know, they were in violation of their professional ethics

and possibly the law. They saw the patient as having rights distinct from those of her son. When the doctor insisted that they honor the son's request, many felt offended and began to avoid conversations with both the patient and her son, lest they be placed in a compromised situation.

The staff recommended that the patient be discharged as soon as possible to avoid further ethical and possibly legal problems. They also recommended that the patient be placed on hospice care at home. When the patient's son was approached to get the patient's consent for hospice care, he consented on the condition that his mother not be told that she was dying from terminal cancer. None of the staff was willing to accommodate his request. The doctor decided to discharge the patient without the benefit of hospice care since it was documented that the son had refused placement.

Analysis

Establishing cultural knowledge about this family would have clarified the strong belief in predestination among Islamic Egyptians. Life events are viewed as God's will, and since God designs what happens, one does not prognosticate or use words such as *terminal cancer* that connote imminent death. Egyptians value group cohesiveness and solidarity. They take for granted that an established hierarchy will act on the individual member's best interest and make his or her decisions.

In the absence of her husband, this patient's son was expected to assume the role of decision maker and caregiver for the patient. Beneficence and nonmaleficence were thought of as protecting the patient from further worry and sorrow, and valued more than autonomy. In fact, informing the patient that she was dying can be perceived as a transgression of religious taboos that forbid humans to go against the divine will

It is obvious from the staff's reaction that their professional, organizational, and dominant societal cultures work congruently to uphold the philosophy that prizes individual autonomy

over group decisions. They used an autonomy paradigm as their model for judging whether actions are valid or morally good. In contrast, the patient's son employed a paradigm grounded in social relations and hierarchy.

The religious beliefs and group solidarity that are central to this family's system of meanings must be preserved and integrated or promoted. In times of illness and potential crisis, the significance of established bonds between family members governed by a male dominant hierarchy increase to provide support for the patient and her family.

Cultural accommodation is only possible when professionals and organizations support sensitivity and flexibility.

Preservation of these core cultural assumptions is an important aspect of providing meaningful care. Separating the patient from her primary support system by using autonomy as a paradigm for decision making will increase the patient's stress and isolation. The ethical principles of veracity and autonomy are clearly secondary to a culturally-based conceptualization of beneficence and nonmaleficence.

Cultural accommodation is possible when practitioners understand the core values that give meaning to people's lives. Accommodation can begin by working with the patient's son within the established family hierarchy and through mediators such as the male Egyptian physician. He who has cultural knowledge and a position of status and prestige within the family's concept of social organization.

Accommodating the son's request can be assured by mutual trust between the family and the attending physician. The staff must take a secondary role and allow the main participants to have greater control of their decisions. The patient's son is a coparticipant and should be permitted to take a major role in decisions affect-

ing his mother's illness.

Cultural accommodation is only possible when professionals and organizations support sensitivity and flexibility. Cultural repatterning permits caregivers to switch professional and administrative frames of understanding. Organizational policies regarding admission to hospice may need to be reexamined in light of new awareness about the situation. Cultural repatterning further requires an awareness of the inherent bias of professional and organizational cultures against cultural diversity.

Conclusion

Defining the problem and situation in the client's context is the goal of care planning. Understanding the *emic* world view of clients facilitates problem solving that preserves their human rights and cultural meanings. Relationship building with the clients, families, and groups is a prerequisite to a respectful and trusting copartnership that will enhance our understanding of multiple perspectives.

Culturally congruent actions of preservation, negotiation, and repatterning may be implemented simultaneously. Applications of ethical principles may be prioritized in various ways and achieved through these three strategies. Understanding the cultural variables and *emic* world views of clients is salient to selecting and implementing actions. Culturally congruent actions are predicated on trusting relationships between consumers and practitioners, and on interactions that integrate the cultural norms and language patterns of clients.

A significant component of outcomes evaluation is the realization that outcomes are not limited to biomedical goal achievement. Outcomes may take all or some dimensions of holistic indices inclusive of physical, psychological, social, cultural, and spiritual being. Outcomes are also differentially prioritized — in some cases, physical outcomes may be secondary to spiritual indices. Many meaningful outcomes may be expressed that are not even visible outside the client's

culture. Validation from clients and understanding their context will provide valuable information in identifying appropriate outcomes and indices of achievement.

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