Cultural Assessment in Bioethical Advocacy — Toward Cultural Competency in Bioethical Practice

by Ramón Valle

The continued diversification of the U.S. population poses increasing challenges for bioethical advocates (e.g., ethicists, physicians, nurses, social workers, psychologists, surrogates, researchers, and lawyers), especially those serving rapidly expanding and culturally varied populations. The issue from the bioethics perspective is that the members of ethnically diverse groups often bring different normative expectations and their own preferred decision-making formats to the bioethics table. For example, some advocates will encounter a "collectivity," or the family-as-a-whole rather than the individual, as a decision maker. In other instances, they may encounter cultural groups whose members (or some of whose members) will value the principle of beneficence more than personal autonomy. Moreover, such value-based challenges are likely to continue since forecasters predict that diversification will actually quicken in the United States throughout the next five decades. In the face of these changes in the bioethical climate, advocates must be prepared to strengthen their cultural assessment skills. Taking a multidimensional approach to the problem yields a four-point cultural assessment model to help advocates handle the great diversity of outlook and orientation among their culturally diverse clientele.

The United States has always been a nation of diverse peoples; however, its essential cultural core has come from its European, and specifically its English-Anglo heritage, as reflected in its language, laws, customs (McLemore and Romo 1998), and in the development of its ethical precepts (Cristakis 1992). However, a decided shift has taken place in the demographic shape of the U.S. population in the second half of the twentieth century; the growth rates of ethnically diverse populations of African, Asian, and Latin American heritage have begun to outstrip the proportionate growth of European heritage populations (McLemore and Romo 1998).

The U.S. Census projections echo these changes. As of 1995, the proportion of such ethnically diverse peoples, to which also the Native American/American Indian peoples can be added, accounted for 27 percent of the nation's population with Euro heritage persons accounting for 73 percent of the total U.S. population (U.S. Bureau of the Census, 1995; figures from the 2000 census are not yet available to this level of specificity). These data reflect a steady growth of ethnically diverse populations: from 12.3 percent in 1970, to 16.6 percent in 1980, to 19.7 percent in 2000 (http://www.census.gov). By 2050, the population ratio is expected to tip even further toward the continued growth of ethnically diverse populations. By mid-century, ethnically diverse groups, again including Native American members, are expected to represent 47 percent of the U.S. population in contrast to mainstream Euro ethnic groups representing 53 percent of the population. In these five decades, ethnically diverse groups, again including Native Americans, will have increased by 74.1 percent, while mainstream European heritage peoples will have decreased proportionately by 27.4 percent.

Nevertheless, these numbers are not the crucial factor. The major implication for bioethical advocates is that they face a growing need to understand multiple ethical decision-making outlooks, customs, and normative expectations.
through which to communicate the complexity of bioethical issues. The U.S. bioethics field "stands at a crossroad [facing] a multicultural world vastly different from that of its origins" (Davis and Koenig 1996, p. 8).

The Presence of Ethical World View and Explanatory Model Differences

Many differences in ethical perspectives are already apparent. Recently, Blackhall et al. (1995) examined several key bioethical decision-making variables with reference to cancer diagnoses in four ethnically diverse groups: Koreans, Mexican Americans, African Americans and Euro Anglos. The researchers examined provider attitudes about telling patients their diagnoses and prognoses, and asking whether patients should make the decision about life support interventions.

Less than half the Korean respondents, 47 percent, and just under two thirds, 65 percent, of Mexican Americans stated that they would tell a patient about a metastatic cancer diagnosis. In contrast, 88 percent of African Americans, and 87 percent of Euro Anglo respondents indicated that they would do so. When it came to giving the patients their prognoses, only 35 percent of the Koreans and 48 percent of the Mexican Americans favored doing so. In contrast, 63 percent of the African Americans and 69 percent of the Euro Anglos favored telling the patient. With reference to involving patients in decisions about using life-supporting technology, slightly over a quarter of the Korean respondents, 28 percent, and 41 percent of the Mexican Americans indicated that they would do so. The percentages of African American and Anglo respondents in favor of involving the patient in these decisions were 60 percent and 65 percent, respectively. Table 1 illustrates these findings.

Blackhall et al. conclude that ethnicity was the primary factor in the ethical decision-making attitudes of their subjects, although respondent age, gender, and education were also implicated. They further note that the Korean and Mexican American respondents were more likely to hold to a family centered approach, which the literature identifies as a collectivist or communitarian posture in bioethical decision making (Post et al. 1996, p. 353). Additionally, Blackhall et al. (1995) indicate that African American and Euro Anglo respondents appear to lean toward a patient autonomy decision model. In their summary, however, they state that pressing the "autonomy"

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model across ethnic groups may be counterindicated. Moreover, they recommend that it is vital to uncover the beliefs and assumptions that are commonly held among members of different ethnocultural groups, but that are usually left unspoken.

In their study, Hopp and Duffy (2000) also indicate that the application of mainstream bioethical decision models to other ethnic populations, such as African Americans, is counterindicated. They conclude that African Americans were less likely than Euro Anglos to complete advance directives, or appoint a durable power of attorney for healthcare, but more likely to opt for unconditional life-prolonging procedures. In a similar vein, Caralis et al. (1993) also found African Americans deciding for more aggressive end-of-life treatments.

Bedolla (1995), speaking from a clinical standpoint, indicates that the members of some cultures, such as Mexican Americans, differ from mainstream U.S. bioethical thought in the way that they arrange bioethical decision values. Bedolla notes that Mexican Americans, especially those coming from more "traditional" cultural backgrounds tend to favor physician beneficence over the principle of patient autonomy. He remarks that Mexican American patients and families who come from a traditional cultural
background have a normative expectation that the physician is in charge and will act to obtain the greatest good for the patient, rather than expect patients to act independently on their own behalf.

Bedolla also notes that among these same more traditional Mexican Americans, the individual's roles are developed in a communal context and that autonomy and self-determination may not be clearly understood among the members of this sector of the ethnic group. Finally, Bedolla states that the ethical position that the patient has a moral right to an autonomous decision may be held by those who are more closely tied to U.S. mainstream cultural orientations, or by those who are more acculturated, to use the Blackhall et al. (1995) terminology.

Other clinicians and ethicists working with other ethnic groups in different biomedical settings have also added to a better understanding of the diversity of bioethical outlooks, including the fact that ethnic groups are internally heterogeneous and cannot be stereotyped as having uniform bioethical perspectives. Ip et al. (1998) indicate that there are many different ethical decision-making patterns internal to ethnic Chinese group members that advocates need to understand and take into account. The advocate working on life prolonging decisions with members of this ethnic group needs to be aware that the group-as-a-whole may include Taoist, Buddhist, and traditional Chinese religious philosophical perspectives. Ip et al. (1998) also note that Chinese persons coming from the first two viewpoints might be comfortable with nonaggressive end-of-life treatment, although for different reasons. The Taoist, may focus on the possible "irrelevance" of trying to prolong life, while the Buddhist, holding to the "transitory nature" of life itself, may likewise forgo extraordinary treatment. However, the person coming from the more traditional Chinese orientation may hold the view that "honor and respect" for one's elders and ancestors requires prolonging life by all means, including extraordinary methods.

As a further note, Ip et al. (1998) indicate that none of the ethnic Chinese persons, regardless of their specific religious perspective, would give first priority to patient autonomy. Muller and Desmond (1992), also working with ethnic,

<table>
<thead>
<tr>
<th>Ethnic Groups in Study N=200 each</th>
<th>Truth Telling Re: diagnosis</th>
<th>Truth Telling Re: Prognosis</th>
<th>Having patient make life support decisions</th>
</tr>
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<tr>
<td>Korean</td>
<td>.45</td>
<td>.35</td>
<td>.28</td>
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<tr>
<td>Latino</td>
<td>.65</td>
<td>.48</td>
<td>.41</td>
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<tr>
<td>African American</td>
<td>.88</td>
<td>.63</td>
<td>.60</td>
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<tr>
<td>Euro Anglo</td>
<td>.87</td>
<td>.69</td>
<td>.65</td>
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Source: Blackhall et al., 1995

Table 1. — Empirical indicators of bioethical decision making diversity in disclosing metastatic cancer to patient.
Table 2. — Culturally influenced hierarchies of bioethical principles.

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<thead>
<tr>
<th>Context</th>
<th>U.S. Mainstream Environment</th>
<th>Ethnically Diverse Environments</th>
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<tbody>
<tr>
<td>Principles</td>
<td></td>
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<tr>
<td>1. Autonomy (a key driving principal)</td>
<td></td>
<td>1. Beneficence</td>
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<tr>
<td>2. Truth telling (an equally strong driving principle)</td>
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<td>2. Nonmaleficence</td>
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<td>3. Beneficence</td>
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<td>3. Distributive justice</td>
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<td>4. Nonmaleficence</td>
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<td>4. Autonomy (a more distant priority)</td>
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<td>5. Distributive justice</td>
<td></td>
<td>5. Truth telling (an equally more distant priority)</td>
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<tr>
<td>Sources</td>
<td>Nuremberg Declaration 1946</td>
<td>Bedolla 1995</td>
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<td></td>
<td>Helsinki Conference 1971</td>
<td>Blackhall et al. 1995</td>
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<td>Hern et al. 1998</td>
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<td>Hornung et al 1998</td>
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<td>Ip, et al. 1998</td>
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<td></td>
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<td>Muller &amp; Desmond 1992</td>
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Chinese, express a similar view. Hornung et al. (1998) highlight truth telling, limiting treatment, and the role of family in medical encounters as three areas in which cultural differences emerge.

The Hornung research group, which focused on advance directives and included durable power of attorney by designated as well as de facto surrogates, found that ethnically diverse respondents were less likely than Euro Anglo ethnics to express their healthcare choices, even when correcting for educational differences, age, and marital status. High (1991); Hornung et al. (1998); and Orona, Koenig, and Davis (1994) conclude that in many instances family and shared group decision-making approaches may take precedence over individual autonomy.

Eleazer et al. (1996) report that ethnicity has a significant impact on patients’ ethical choices for life prolongation, more so than other status variables such as education and gender. Muller and Desmond (1992) present ethics as a discipline whose origins trace back through the roots of Western philosophy, which gave primacy to individual rights and culminates with personal decision-making autonomy taking center stage. These authors indicate that less attention has been paid to ethical dilemmas in culturally diverse contexts and that it is presumptuous to assume that Western bioethical precepts are universally accepted. Others, such as Post et al. (1996), argue that the overarching focus on autonomy in current bioethical thinking and practice has correspondingly weakened beneficence and patient-oriented
caring practice. These authors note that more communitarian (collectivist-oriented) cultures will lean toward less assertive decision-making approaches and defer more to physician judgment. They also note that respect for persons and the right to autonomous choices and beneficence may not be mutually exclusive. In their view, however, beneficence speaks more closely to the interests of the patient’s care and management of the illness’s various effects.

Finally, Muller and Desmond (1992) indicate that people bring culturally bound values and behaviors to all consequential experiences, especially wherever interpersonal encounters are at work, and that includes the bioethical decision-making situation. A number of other observers examining bioethical issues ranging from palliative care and surrogate decision making to disclosure and end-of-life concerns also point to cultural influence as a significant indicator of bioethical decision preferences (Davis 1996; Hern, Jr., et al. 1998; McNamara, Waddel, and Yeun 1997; Michel 1994; Mitchell, 1998; Oppenheim and Sprung 1998; Picket 1993; and Radford et al., 1991). Table 2 presents a comparative hierarchy of bioethical principles drawn from a review of the preceding reports of ethical advocates in different cross-cultural settings.

A Multidimensional Approach to Cultural Assessment in Ethical Advocacy

Decidedly in the circumstances just described, bioethical advocates and their ethnically diverse clients can find themselves at ethical decision-making loggerheads, as all parties come to the situation with different world views and explanatory models. Moreover, it is not likely that these issues of cultural diversity in bioethical advocacy will simply go away. Rather, the demand for culturally compatible strategies within bioethics can be expected to increase commensurate with demographic changes. Figure 1 (p. 20) illustrates the circumstances in which many advocates may find themselves when they engage in ethical decision-making activity with persons of different cultural orientations. Hence, there is an urgent need for the field of bioethics in general, and for advocates in particular, to develop culturally attuned capabilities to meet the growing demand for cultural competence in bioethical practice.

An initial building block toward cultural competency in bioethical advocacy is to recognize that culture is a multidimensional notion and that cultural assessment and intervention in bioethics requires an equally multifaceted approach. In this regard, La Puma (1995, p. 3), looking at the intersection of culture and bioethics, notes that

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...culture is not a “thing” but a “context” within which one constructs ethical meaning. Cristakis (1992, p. 1079), likewise focusing on culture and ethical concerns, adds that “culture not only imparts meaning but also provides the means whereby its members can conduct purposeful interactions.” Gregory (1995), continuing in a biomedical context, adds that culture is the vehicle through which values and beliefs affect human conduct. From more expansionist perspectives, Erchack (1992) sees culture as including all aspects of human experience, or as Gudykunst (1994, p. 35) states, “culture includes everything that is human made.”

The important point to be made about core definitions of culture is that ethical systems, in general, and modern bioethics, in particular, fit into its construct. Codes of ethics and ethical principles are actually formalized expressions of cultural values and beliefs. However, if one is to attain cultural competency in bioethical practice, one cannot stop there. If the nexus of culture and bioethics is left at the definitional stage, or
if the notion of culture is too broadly stated, difficulties arise. After all, despite their more abstract philosophical bases, bioethical principles are an applied human endeavor. They come alive in the interactions between advocates and their clients in diverse settings. Therefore, the broad construct of culture must be made more concrete and manageable.

A four point cultural assessment model can be used to handle the great diversity of the outlooks and orientations of an emerging ethnically diverse clientele. To use this approach, the advocate must first divide the cultural assessment task into “manageable” tasks around some specific cultural dimensions. From there the advocate proceeds to make more comprehensive assessments of the situation and the participants involved in it. The components of an applied cultural assessment model and the tasks to be undertaken by the advocate can be delineated as follows:

- Identifying the Locus of Culture. The first component and task for the advocate is to identify and understand where the cultural attributes of the situation are located, noting specifically those areas of interaction and experience in which cultural phenomena play out.

- Delineating the Status Confounds. The second task for the advocate is to sort out the social status factors that would otherwise confuse the cultural analysis.

- Tuning into the Interactional Domains of Cultural Expression. The third task for the advocate is to “tune in” to the specific aspects of human engagement where culture is lived and expressed.

- Tapping into the Sources of Cultural Evidence. The fourth task for the advocate is to tap into the ordinary sources of cultural information.

Figure 2 (p. 21) cultural assessment model for bioethical practice.

**Identifying the Locus of Culture**

Though the idea of culture may appear abstract, it manifests itself in the context of everyday
Fig 2.-A comprehensive cultural assessment model for bioethical practice.

interactional life. The *locus of culture*, the first component of the cultural assessment model, encompasses three key features of group and individual life: a group’s symbolic as well as practical means of communication, such as its language, art, and artifacts; a group’s customs and rituals along with the member’s preferred interactional patterns, including how ingroups and outgroups are determined; and a group’s commonly shared values, beliefs, and normative expectations (Valle 1990, 1994, and 1998). These are the three facets of culture in which the advocate actually engages diverse populations in bioethical activity. They also provide the means to access the ethical decision-making process across what may be seen as a *cultural divide* between ethically diverse normative outlooks and bioethical orientations within the mainstream culture, which may include the advocate’s own ethical stance.

Researchers and bioethical advocates (e.g., Bedolla 1995, Blackhall et al. 1995, Hern, Jr., et al. 1998, Ip et al. 1998, and Pickett 1993), collectively found cultural expressions rooted in the context of what their clients and their significant others “said,” how they actually “acted” (or indicated they would act), and who they “involved” in the ethical decision process (and on what terms) as well as in how they presented their “underlying beliefs” and “normative expectations.” Therefore, no matter how abstract the underlying principles may be, when the circumstances are described, the bioethical differences and issues become concrete acts and expressions that have to be placed in their appropriate cultural contexts.
Sorting the Cultural Assessment Confounds

Several additional elements can enter the bioethical exchange and distort the advocate’s understanding of the cultural factors at work. These elements include a series of status-related variables that are frequently inappropriately mixed into cultural analyses. Among these variables are “perceived” as well as “actual” power differentials between the advocate and the clients; the client’s socioeconomic status (SES); and the differences in literacy levels between the advocates and their clients, especially the health literacy capabilities of ethnoculturally diverse group members.

These elements are not cultural and need to be clearly separated from the examination of cultural features. Briefly stated, power differentials, varied socioeconomic statuses, and literacy concerns can be found both within and between different cultures — including among members of the mainstream society. However, these variables do not help the advocate explain the cultural dynamics underlying the bioethical decision situation. This is why Caralis et al. (1993) and Blackhall et al. (1995) make special efforts to separate outcomes produced by ethnic beliefs and normative expectations from outcomes influenced by a person’s social status relative to his or her age, income, gender, or education.

As Olweny (1994) indicates, advocates must be careful to note whether they are observing cultural beliefs or behaviors driven by scarcity of resources and lack of access to appropriate information. Social status differentials with regard to healthcare access and delivery are potential explanations for Hopp and Duffy’s report (2000) that African Americans usually opt for unconditional life-prolonging treatment in end-of-life bioethical decision-making situations. A number of other observers also point directly to social inequality as a motivation of decision-making orientations apart from cultural considerations (e.g., Byrd and Clayton 1992, Charatz-Litt 1992, and Dula 1991 and 1994).

Linking to domains of expression

Advocates must next turn their attention to where people express their culture, namely, to the context of their thinking, feelings, and behaviors. These domains of expression may have taken place in a past time and exist in the form of a written record or maintained as “stories” or “traditions” held by the members of specific groups and their individual members (Sample, 1995). These domains of expression can also have a “present context” in the encounter between advocates and their ethnically diverse clients.

Collectively, the domains of cultural expression likewise encompass the philosophy, religious traditions, and the guiding moral precepts of a people or group. Ethical systems and bioethical formats emerge as offshoots of such philosophies as do a group’s artifacts, heroes, holidays, and so forth. Informed consent documents for research purposes and advance directives for healthcare purposes are types of “cultural artifacts” that may or may not be familiar to ethnically diverse clients.

For the most part, however, the notion behind the domains of expression component of this model is that, aside from the advocate’s study of a specific ethnocultural client-group’s history, culture will most often be encountered in the day-to-day contacts between the advocate and the clients. In such exchanges, the advocate must learn to decipher the intent of the clients’ thoughts and feelings and the impact of their behaviors. Culture is largely a mundane enterprise.
Not that the principles involved cannot rise to great heights, or that the issues can fail to capture the attention of a whole society. Witness the need to ensure the rights of informed consent belonging to members of vulnerable populations in research, or to protect the confidentiality of medical information, such as information about a person’s genetic predisposition or health risk status. Much of the cross-cultural variance in ethical perspective is encountered, however, in the everyday work of the clinical and research encounter with ethnically diverse clients. The advocate must remain aware that culture does not exist in the abstract. People express their culture in relatively ordinary ways, namely, in their thoughts (cognitions), their feelings (affects), and in what they do and produce (behaviors). These areas of human interaction provide grist for the mill that produces cultural competency in bioethical practice.

**Obtaining Cultural Information**

Similarly, the actual sources of the advocate’s information about cultural differences in bioethical outlooks are quite ordinary. That is, culturally based ideational formations, the underlying feelings about ethical issues and decisions, and the behaviors that attend ethical concerns are encountered in the clinical exchange or the research interview. They come from clients themselves, from information provided by the patients’ significant others and collateral sources, and from the advocate’s own concentrated study and observation, including long hours spent in studying cases, participating in education and training, and pursuing the actual bioethical exchange itself.

**Understanding Pitfalls and Problems in Cultural Analysis**

Admittedly, this task-oriented model (see Fig. 2) requires some consistent developmental effort. Culture comes in many guises and is not always immediately recognizable in the bioethical context. For example, while people may enter decision-making situations with value orientations and expectations, they do not, so to speak, “visibly wear” these values or normative outlooks on their person. On the contrary, value orientations and expectations are generally not made explicit, even by the advocates themselves, but remain below the surface of the ethical decision to be made. In fact, the greater portion of one’s value substratum is rarely made explicit. As Hern, Jr., et al. (1998, p. 31) note, “culture is not evident as a set of rigid ‘beliefs’ that can be biopsied or extracted from individuals.”

Another problem is the fact that culture and status considerations come bundled together in varied mixes depending on the client system and bioethical decision circumstance. The cultural assessment model recommended here is not intended to present culture as a kind of “static” and “orderly” phenomenon in which things happen sequentially or come with clear-cut labels.

Rather, the advocate’s usual experience is that everything comes meshed together; hence, the urgency of sorting out the cultural confounds of literacy or other social status factors from ethnocultural value orientations. Moreover, the thoughts, feelings, or behaviors of the different actors within the bioethical decision situation come in different forms and are sometimes only

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available through the indirect reports of other persons, rather than through the advocate’s direct experience. This bundling of everything within culture reinforces the advocate’s need to approach cultural assessment at the same preparatory level as the actual bioethical decision itself, which has to be studied for its multiple ramifications.

Another area of cultural assessment that requires attention is the avoidance of stereotypes.
Social histories, or summaries of specific ethnic groups, cannot explain every possible ethical case within that particular ethnocultural collectivity of persons. Likewise, individual cases cannot speak for the ethnocultural group as a whole. In the act of cultural assessment, the bioethical advocate must be on guard against stereotyping either individuals as representatives of the group as a whole, or whole ethnic groups based on what is known about specific individuals. Similarly, bioethical generalizations and assumptions about the relative uniformity of values, with regard to specific ethnically diverse client populations — or, for that matter, with reference to the bioethical orientations of individuals from the Euro Anglo, English-speaking, mainstream culture — need close examination.

A review of the Blackhall et al. (1995) data shows that not all the Korean, Latino, or other ethnic study participants responded alike. Moreover, while Table 2 presented the notion that bioethical principles will be ranked differently between U.S. mainstream populations and ethnically diverse populations, one needs to note that the principles of autonomy and beneficence will still apply to both sectors. This caveat appears to be the gist of what Jecker, Carrese, and Pearlman (1995) and Davis (2000) are suggesting relative to identifying “bridging” points between cultures. The issue at hand in the bridging activity is not uniformity between cultural orientations, but a focus on finding some common ground.

Putting the Bioethical Cultural Model to Work

Ethical advocacy can be a difficult undertaking in itself without adding the cultural dimension. Many bioethical advocacy matters arise in crises related to health concerns for the immediate client, or their decision-involved significant others, or both. From an actual bioethical practice perspective, the advocate and the clients are often meeting for the first time or, if an ongoing clinical relationship exists, the current decision topic may not have been discussed in detail prior to the crisis itself.

If the ethical decision-making event is in research, similar dynamics obtain. The ethical advocate asking for informed consent will most likely be meeting the subjects for the first time, and while the element of “crisis” may be missing, the potential “strangeness” and “complexity” of the research can generate a “sense of crisis” on the part of the subjects and their family or friends relative to their understanding of such things as risk-benefit ratios or the meaning of voluntary participation over the duration of the study. Add the clients’ or research participants’ ethnically and linguistically diverse outlooks to this mix, and the advocacy waters appear difficult to navigate.

Given the circumstances and potential pitfalls and problems encountered in cultural assessments in bioethical practice, the model presented here nonetheless provides the advocate with a readily applicable approach to engaging ethnically diverse populations in bioethical activity. The framework provides the means to distinguish differences that can be ascribed to “informational misunderstandings” — for example, to the clients’ lack of a technical background in the bioethical decision-making process — from factors that are substantively related to fundamentally different world views and explanatory models about how to think and act within the situation. The cultural assessment framework proposed here allows the advocate to use the ordinary interactional settings in which bioethical exchanges take place to document ethnically diverse clients’ views, feelings, and behavioral processes; and to do so by gathering information through self-reports, through the information provided by collaterals, or through the advocates’ own preparatory
study and continuing systematic observation. In this manner, as indicated by Orr et al. (1995) some common decision-making ground can be identified and worked on, even at the traumatic moment of the bioethical decision crisis itself.

Moving in this manner, the advocate can then take the step suggested by Jecser, Carrese, and Pearlman (1995, p. 6). They indicate that better ethical decision-making accommodations can be attained by focusing on the goals of the patients or clients (or, by extension, research participants) than by concentrating on the value conflicts inherent in the situation. Davis (2000, p. 62), reflecting on her study of fifty-six terminally ill cancer patients, suggests still another potentially viable “common ground” approach. After examining the case documentation on Anglo American, African American, Chinese American (Cantonese-speaking), and Latino/Hispanic American patients, she suggests finding an ideally bioethically constructed patient. In this construct, which she claims cuts across cultures, the patient is seen as a self-governing, future-directed, frank, and purposefully oriented person.

It may be that focusing on patient “goals” rather than value conflicts, and identifying “ideal” patient characteristics across cultures can provide bioethical connections between the advocate and ethnically diverse populations. However, there is additional basic cultural analysis to be done. As Cristakis (1992) indicates, differences in ethical outlooks and knowledge between cultures will not “conveniently disappear” but “must be engaged and negotiated.” To that end, the cultural assessment framework discussed here may be helpful in assembling the key information necessary to find common ground and ensure culturally compatible and culturally fair bioethical practice.

As population projections play themselves out over the next several decades, it will not be unusual for advocates to find multiple active cultures among their clients. Each of these ethnocultural groups may be vying for attention and understanding, while at the same time approaching the bioethical situation within their own traditional, ethnocultural group orienta-

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References


http://www.census.gov/population/www/documentation/twps0029/tab08.html


