Healthcare as A Cross Cultural Experience
A treatise on the intersection of culture, ethics, and healthcare

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The anthropologist Haviland suggests “that people maintain cultures to deal with problems or matters that concern them”. The idea is that culture provides a framework or context for our human experiences. Culture influences what we believe, what the major milestones of life are, and what values we respect most. Culture is one of the most important influences in understanding our personal ethics. In healthcare issues arise when two moral agents are of conflicting cultures. We as healthcare professionals must understand the cultural context in which our patients experience life and participate in their care. It is imperative that caregivers be culturally competent. Steven Covey in his book the 7 Habits of Highly Effective People said it best in his 5 habit, “Seek first to understand then to be understood”. It is a simple principle but one that is invaluable when seeking to be culturally competent. The following is a treatise on culture, healthcare, and ethics. We are going to discuss a number of different topics that frequently involve the intersection of culture, healthcare, and ethics. We are seeking to understand where the balance is between the autonomy of the patient and the healthcare provider’s cultural ethics, what is the providers’ ethical responsibility to the patient in terms of culture, and how does this apply to specific situations where culture, ethics and healthcare intersect.

To be truly culturally competent the practitioner needs to be cognizant of their own cultural biases. The healthcare provider is usually quick to recognize their personal culture but must also be aware of the healthcare culture within which they practice. Western healthcare working within the “biomedical” model of healthcare is a culture onto itself. It has all the basic components of a culture. There is a societal hierarchy, there are cultural rituals and customs, there are sacred texts, there are culture values and beliefs, and there is a common cultural ethic. If the healthcare professional understands this then every patient interaction becomes a cross-cultural interaction; which completely changes the paradigm of cultural interaction from an ethnocentric “normalcy is white” perspective to one of “insurgent multiculturalism” where the provider is actively analyzing differences in power, historical perspective, socioeconomic disparities, and cultural context. This ethically translates in a duty to remove disparity and injustice from ones practice and to recognize the “moral worth” of and give “equal respect” to all patients by understanding cultural incongruence between the personal culture of the healthcare provider, healthcare culture and the personal culture of the patient. While the first step to changing this paradigm is incorporating this idea of insurgent multiculturalism or antiracist pedagogy into the training of professionals so that healthcare professionals are

2 Wear, D (2003). "Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education.". Academic medicine 78 (6), p. 549.
at all times aware of their ethical responsibility to be mindful of the cultural context in which the patient is participating in their care.

Samovar and Porter put forth a definition of culture by Marsella:

Culture is a shared learned behavior which is transmitted from one generation to another for promoting individual and social survival, adaptation, and growth and development. Cultures have both external (e.g. artifacts, roles, institutions) and internal representations (e.g. values, attitudes, beliefs, cognitive/affective/sensory styles, consciousness patterns, and epistemologies).

Using this definition one can clearly see how healthcare is itself a culture. Each generation of healthcare providers are educated and trained by the previous generation. Healthcare providers are constantly trying to modify their behavior to enhance their own survival. This characteristic is seen in attempts to expand scope of practice, encourage recruitment into the profession, as well as encouraging selective entry into “healthcare society”. Western healthcare has massive institutions that perpetuate and represent the culture. One could argue that institutions of healthcare academia, hospitals, and professional organizations are all cultural institutions that are built to promote the culture in order to ensure its survival. Within these institutions there are defined roles, for instance there is cultural hierarchy in teaching hospitals. This is based on a sort of paternalistic structure, generally there is a patriarch and then a number of subjects each of vary rank. The patriarch is typically the attending physician and the subjects typically residents ranked by year. Healthcare even has sacred texts and artifacts. Healthcare journals and textbooks are typically only acceptable guides for practice, rarely do we look outside the realm of medical literature for guidance in practice. Probably the most defining characteristics of healthcare culture come from the values, attitudes and beliefs by which healthcare professionals practice. Healthcare culture places value on evidence, reproducibility and sound theory. Healthcare culture places value on education, training and experience. In healthcare objective observations are more valuable than subjective evaluations. Quantification of evidence is valued over qualitative description of individual cases. Healthcare culture also has a pervasive belief in very little that is supernatural, while individual providers may have individual supernatural beliefs, healthcare culture is innately humanist. The problem is when patients with differing beliefs, values, and cultural context interact with those in the healthcare culture. How does the healthcare provider integrate the culture of healthcare and that of the patient successfully?

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5 Wear, D (2003). "Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education.". Academic medicine 78 (6), p. 549.
Historically healthcare professionals have been taught to be culturally sensitive. This would entail didactic education on “different” cultural behaviors and characteristics. This would include a grab bag of facts that generally outline why other cultures are different and maybe even ways to “accommodate” these cultures. We have since moved to model of “cultural competency”. This includes the same idea that we educate students on myriad of general facts about other cultures, but this time we take a step backwards and emphasis using generalizations about “non-white non-North American” cultures to define how interactions with individuals are going to go. There is a new way of thinking about cultural education, an anti-racist pedagogy that has healthcare professionals develop analytical skills that a practitioner can use to discover disparities of power, autonomy, socioeconomics, and cultural context. In this way a practitioner can look at each individual patient in a cultural context which helps individualize care while incorporating the patient’s cultural behaviors. For instance in the course of talking to a patient you find your patient is a women from Thailand, some who is “culturally competent” would say this is a Thai woman and as such would follow Thai cultural norms. Looking at culture from an insurgent multiculturalism prospective would peer deeper into the influences on healthcare that this patient might have and take into account the fact that her being Thai is really one part of the cultural prospective this patient has. Wear uses a quote from Hunt that illustrates this point:

>culture is neither a blueprint nor an identity; individuals choose between various cultural options . . . . It is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origins. Individuals’ group membership cannot be assumed to indicate their culture because those who share a group label may variously enact culture.

The idea is to look at people as multicultural beings and really start looking for what barriers to care, discrepancies in power, and differences in individual values might influence how this patient receives care. Healthcare providers most often hold a great deal of power and a greater understanding of the care the patient is receiving, as part of this power providers are ethically responsible for making sure all of our patients receive care with respect and that their personal values be taken into account when receiving care.

Healthcare providers are ethically responsible to be more than culturally competent. We have a duty to provide the best care possible to all our patients. In order to do this we need to understand our patients’ values and beliefs, as well as their perceived social status, socioeconomic class, and any other cultural factors that might subject them to unequal treatment. Healthcare providers are taught that the patient should be part of their own care; they should be empowered to take responsibility for their healthcare. Healthcare providers need to be aware of the patient’s desires and respect the patient as having significant moral worth. Stone in his lecture on ethics and culture in healthcare education puts for the following framework for an ethical approach to patient culture in healthcare. His framework is based upon the patient being a significant and equal moral agent this is dependent on the patient equal and significant respect. This respect is based
on the recognizing a patients rights and being just in the care of the patients. For this framework to be fully substantiated in healthcare education and healthcare practice, Tervalon suggests that institutions must make an effort to diversify the faculty and student base, train all faculty in culture and healthcare, and to indentify and redress areas of practice that are discriminatory.

In order to talk about major cultural conflicts in healthcare providers need to recognize every interaction between a healthcare professional and a patient is a cross-cultural interaction. Healthcare institutions must address cultural education so that healthcare professionals have the tools to adequately address cultural issues. It is the right of the patient to be treated with respect and their culture be valued. It is the provider’s ethical duty to provide the best care possible for all of our patients while still respecting their autonomy as an equal. This transitions into some the issues that involve the intersection of culture, ethics and healthcare and might better explain the need to be aware of the cultural influences on a patient’s perspective.

One the most controversial issues involving the intersection of culture, ethics and healthcare is death. End of life care is an umbrella term used to cover traditional home care, palliative and hospice care, as well as more controversial interventions such passive and active euthanasia and physician assisted suicide. End of life care is a complicated issue that involves decisions heavily influenced by cultural values, religious values and personal views. The personal, emotional and metaphysical implications of end of life care make universal recommendations almost impossible. Issues involve differing definitions of autonomy, life, death, and informed consent make the ethics of end of life care very complicated. Cultural perspectives are generally based on religious guidelines, as well as traditional ways of dying. End of life care is also complicated by the fact that the patient is not always a competent decision maker or has left their decision making to their family. As well end of life care is largely guided by the influence of the treating physician, surveys show that end of life care has wide variation based on physician’s personal culture and ethics and may not take into account the ethics of the patient and their family.

In order to discuss the cultural aspects and ethics of end of life care we need to understand what end of life care actually is. Traditional home care involves a variety of different interventions but typically involves patients spending their last days at home undergoing basic palliative care, and treatment of any pain and anxiety. An increasingly more common end of life practice is palliative or hospice care. This involves a patient being in a care facility that can provide more extensive care than at home. This again revolves around pain management, anxiety management and nutritional support. The controversy occurs in end of life care when a patient requests that life sustaining measures (ventilation or nutrition) either not be initiated or be withdrawn (passive voluntary euthanasia) or when a patient expresses the desire to end their life with the assistance of a physician (physician assisted suicide or active voluntary euthanasia). Physician assisted suicide involves a physician order for a lethal combination of medications and instructions for the patient on how to use these medications for the
patients desired outcome. Active voluntary euthanasia is when a physician actively ends the life of the patient with the patients directly expressed consent. There is also the issue of involuntary euthanasia and hastening death with the use of respiratory suppressing medications. Although generally unpopular there is some belief that it is ethical to actively hasten the death of terminally ill patients who are incompetent and in intractable pain.

The legal landscape for end of life care is unclear. Most countries have vague laws regarding most of end of life care with explicit bans on active euthanasia. The Netherlands where the first to sanction voluntary active euthanasia and physician assisted suicide, and data from reporting procedures are providing some insight into the practice. Although the Dutch did not pass legislation until 2002, after Oregon passed physician assisted suicide legislation in 1997, they have had de facto decriminalization of euthanasia since the early nineties. Belgium later in 2002 passed legislation similar to the Dutch law. In the United States Oregon and Washington have enacted “Death with Dignity” legislation; this allows physician assisted suicide under tightly controlled conditions. Japan has through case law decriminalized voluntary active euthanasia in instances where pain is intractable, death is imminent, and there is clear consent from the patient. China is currently in the process of developing laws regarding euthanasia. There is a deep divide between rural citizens and the academic class on the issue. The rural and lower income citizens are for the most part against any form of euthanasia based on long standing cultural and religious beliefs. The intelligentsia including the majority of healthcare providers is in favor of decriminalizing both voluntary and involuntary euthanasia. The topic is one that creates deep divisions even within what would be typically homogenous cultures.

The topic of death and end of life care is a defining topic in most cultures. There is some evidence that seems to correlate religiosity with opinions on end of life care. The greater the religiosity of the culture generally correlates with a negative opinion of any hastening of death, both euthanasia and physician assisted suicide. A survey of US physicians found a strong correlation between strong religious belief and negative opinion of euthanasia. However this correlation was not nearly as strong in the case of physician assisted suicide. Although unproven, it seems that although personally against hastening of death US physicians see the autonomy of the patient and the patient’s moral value as more important to respect than personal values and beliefs. Generally bioethicists seem to agree that patient autonomy is first and foremost ethically. Culturally the US is deeply divided. Christian conservatives feel that hastening death is wrong as it is circumventing ‘God’s will’ and is violating a commandment by god to not kill and have respect for human life as defined in the books of Exodus and Deuteronomy, this belief however is not held by all in the US. These are not the only objectors to the physician assisted suicide and euthanasia, there are some that feel that current physician assisted suicide laws do not adequately protect against abuses and protect the patients. There are also those that hold highly the value of personal autonomy and freedom and have developed a “Death with Dignity” movement. The argument is that each person has both the right to live and to die, and that it is immoral to force terminally ill patients to live in pain and
suffering, while being a burden to their caregivers. There also seems to be a middle ground taken by Jewish Americans. Jewish law is explicit about not allowing the killing of another human being for much of the same reasons Christians believe this. However there are allowances for passive euthanasia primarily from the Talmud. One particular parable seems to guide this belief; the story is of a Rabbi being put to death in slow torturous way. The Rabbi refuses to commit suicide but promises that if his death is hastened by removing the things that are impeding his imminent death the person who hastened his death would rewarded with entry into the World-to-come. Once this request is carried out a heavenly voice calls down and approves this action and after sacrificing himself to God the person who hastened the Rabbi’s death is taken to the World-to-come. These differing cultural views create turmoil but also add to a necessary dialog on the ethics of the euthanasia in the US. This division within the culture is not uncommon; this is an issue that is being struggled with all over the world.

In Japan traditionally a “good death” is at home, either suddenly or of gradual old age, pain free and without worry. However changes in public health, disease rates and healthcare now make it rare to have either of these. As in most countries that have adopted a western approach to medicine, most death occurs in hospice care. Unlike some Buddhist influenced cultures there is very little stoicism amongst the Japanese in terms of pain control, it is ideal to die without pain. Although legal the idea of voluntary active euthanasia is not one that is congruent with Japanese culture. Although patients may ask for relief, this is generally not a request to die but a request for pain and anxiety control. The major issue the Japanese have with voluntary active euthanasia is the “voluntary” part. Many times, at the request of the family, a terminal patient’s condition is not disclosed to the patient. This is may be to ease the anxiety of the patient and allow them to die without worry. However this makes it difficult to obtain informed consent for voluntary active euthanasia when the patient has no idea they are dying. Traditionally there has been ritualistic suicide in Japanese culture, but even this was assisted by a trusted helper who once the samurai had dealt themselves a fatal wound would hasten their death by beheading the samurai. It seems that culturally the Japanese have no problem with euthanasia, but an issue with informed consent. This is to the point that it seems that involuntary active euthanasia is actually more palatable as the patient can die suddenly without pain and have no chance to worry about their terminal condition. Whether this is practiced is uncertain and it is certainly not sanctioned by law although culturally there is little distinction between mercy killing and voluntary active euthanasia.

China is currently developing a legal standpoint on euthanasia. There is a conflict between the intelligentsia and the peasantry in China over the issue. The peasantry because of Confucius, Buddhist, Taoist and Christian beliefs is for the most part against all forms of hastening of death. The intelligentsia primarily non-religious is in favor of allowing all forms of euthanasia. However the argument for euthanasia is one that is distinctly different from that in Western democracies. The argument being put forth is that euthanasia is a resource saving measure in a struggling overburdened healthcare

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system. Current practice allows no form of euthanasia or hastening of death. This has become an issue as terminal patients are accumulating in hospitals being kept alive by heroic measures using up scarce resources to prolong an inevitable death. The unfortunate consequence of this is that many families are opting to take their family members home when expenses become too great, this has lead to the widespread practice of passive euthanasia which essentially is the hastening of death by withholding nutrition and life sustaining treatment. Although opponents fear widespread involuntary euthanasia if euthanasia is legalized, physicians are just expressing a need to be able to suggest that treatment be withdrawn in patients that have no hope of recovery and be able to provide these patients a comfortable death. Westerners and capitalists find this situation egregious, putting the cost of care above the lives of patients. However the ethics are different in Maoist China, communism dictates that individuals should protect the collective and unnecessarily using up scant resources is detrimental to society. Autonomy is not nearly a valuable ethical standard in a communist society. The ethics of this value system are also debatable and cannot in be adequately addressed in this paper.

In the Netherland’s end of life care is of very high cultural importance. Since the mid 1990’s euthanasia and physician assisted suicide have legally sanctioned under specific terms. A review of the statistics collected on end of life practices has shown some interesting trends. Hastening of death by euthanasia or physician assisted suicide was most common in patients less than 65 and with cancer. Euthanasia and assisted suicide has steadily declined in practice since 1990’s and has been replaced by what is considered quality end of life care. Especially in the elderly Dutch physicians are more likely to use continuous deep sedation without hastening death or to aggressively alleviate symptoms using opiates and benzodiazepines. The physician patient relationship in the Netherlands seems to be one of significant cultural importance, when discussing end of life care the personal relationships that physicians have with their patients seems to play heavily into their decision making.

End of life care is a complicated issue and one that has deep cultural implications. A number of different ethical and cultural factors play into what is the right way to handle end of the life care. The primary objective to observe the rights and the needs of the patient, allow their full autonomy and be just in giving care. The many cultural perspectives on the issue allow exploring deeper into the issue of end of life care to possible find an answer to what is the ethical way to handling the final days of a patients life. It is very apparent that there is no one answer to end of life care and that each country must establish its own standard of care based on the needs and values of their people.

Much like death, another issue at the crossroads of ethics, culture, and health care is birth and family planning. This entails not only contraception but also abortion. This topic absolutely has no right or wrong answer. American culture is divided in half over whether the prevention of birth is ethical. This topic heavily involves the intersection of culture, healthcare, and ethics. The main idea of this paper is to give background information on this topic and to try and to discuss the ethical facts on both sides. This
will allow one to decide for themselves which side of this heated debate they chose to be on.

Emergency contraception, such as Plan B, will be the focus of contraception in this paper, merely because the recent uproar with its status as OTC/behind the counter. So what is Plan B? Plan B is a form of emergency contraception that is taken after sexual intercourse to reduce the likelihood of pregnancy. It does not fully eliminate the risk of pregnancy. There is one main mechanism of action and two main theories of how Plan B works. The only proven mechanism is that Plan B can prevent or delay ovulation. The first unproven theory is that Plan B might be able to inhibit tubal transport of the egg or sperm, and therefore prevent the released egg from being fertilized. The second theory of Plan B’s mechanism of action is the most controversial and is a main reason for the uproar from certain cultures. This mechanism states that Plan B “might work after fertilization by altering the endometrial lining (the lining of the uterus) or shortening the luteal phase, thereby inhibiting implantation of a fertilized egg”\(^7\). This last mechanism brings up the debate “characterized by marked cultural ambiguity about the meaning of pregnancy, conception, and contraception”\(^8\). Some believe that aborting a pregnancy only occurs once the fertilized egg is implanted into the endometrial lining. Others believe that life begins at conception and implantation has no bearing. They believe that once conception or fertilization occurs, anything after this is considered abortion even if the egg does not implant itself. Therefore, in the eyes of some, this third mechanism of action is theorized as potentiating an abortion. However, it must be reiterated that this theory has not been proven. Also for those who believe that life begins after implantation Plan B does not cause an abortion. Plan B does not affect a zygote once it is implanted.

There are many other reasons for the debate over Plan B. Many organizations who oppose it include, “Concerned Women for America (CWA), the Catholic Medical Association, the American Life League, and Human Life International.” These groups believe that a “public health disaster that would ensue if teens used Plan B, including the rampant spread of sexually transmitted infections (STIs) and pregnancy among teens who would no longer have an incentive to use condoms”. The American Life League (AFL) is one group who believes sexual risk taking behavior will increase. They believe women will not be able to control themselves if they have the peace of mind that they will not get pregnant. In this case women will become slaves to their bodies and have no self control. Therefore, they believe supporting Plan B would like supporting premarital sex and promiscuity. The AFL stated “Pills Such as Plan B are designed with one purpose in mind: to destroy the evidence that a sexual encounter has occurred that could result in the conception of a child. The emergency in this case is a baby. If these pills are made available over the counter, adolescents who might have given such a result a


second thought will not be inclined to take pregnancy into consideration before engaging in risky sex.”  

These groups claimed that sexual risk taking behavior, unprotected intercourse, pregnancy, and Chlamydia and herpes infections would increase drastically with the use of Plan B. Studies have actually shown that none of these factors have increased since the increased use of Plan B. One problem that does occur with Plan B being OTC is that if women went into see their physician, the physician would screen them for STIs. As a result, women are decreasingly getting screened for STIs. Other reason’s why these groups fight for Plan B to be abolished is that they believe it will “invoke the specter of incestuous, adult sexual predators using emergency contraception to rape children and adolescents without fear of being caught by pregnancy. It would be a welcome tool for adult sexual predators who molest family members, children of friends or students. They could keep a stash in their bedroom drawer or their pocket to give their victims after committing each rape.”  

Even in cases with two consensual adults, opponents argue that the male may push the drug on their female sex partners. The males will also pressure the female having sex without a condom, which inevitably will expose the female to STI risk and pregnancy risk. Therefore, the main arguments for opponents to Plan B are the potential to induce an abortion, increase in sexual risk taking, and the male figure to push the drug onto the female. These are the reasons why opponents of Plan B believe what they believe with regards to the use and availability to Plan B.

On the other side of the debate, proponents of Plan B have their own arguments. This paper will give a detailed rationale for why these groups believe Plan B should be easily accessible. It is up to the reader to see which way they see this ethical situation and by being educated on the facts of both sides, which side they chose to support. Proponents believe that woman should have easy access to Plan B because it has been proven to be safe and effective in preventing unintended pregnancy. It is safe enough, to the point that woman can use it without physician supervision and with a consultation by a pharmacist. Experts argue that taking Plan B is much safer than becoming pregnant, arguing that “the high morbidity rates associated with pregnancy are argued that expanding access to emergency contraceptive pills could eliminate such morbidity as well as reduce abortion rates. Reducing the need for abortion was presented as a good in itself, justified on neither moral nor health grounds.”  

Consequently, Plan B is safe enough for women to have easy access to and it produces a safer outcome since fewer abortions are likely to result. The main argument with access for this side is that the sooner a female get access to emergency contraception the more efficacious it will be. Anytime after 72h Plan B is no longer effective. “Difficulties in finding doctors to prescribe; delays in getting

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appointment after hours and on weekends; the high costs of doctor appointments; and 
doctors’ intrusive queries about their sexual relationships," 12 are some reasons why there 
may be a delay in access to Plan B. Since the drug becomes less and less effective as 
time goes on and the longer the delay, this group wants Plan B to be easily accessible. 
Beyond medical safety, women have also argued for autonomy. They want the right to 
control their own body and their own life. Women want the autonomy of making their 
own reproductive health decisions. Women do not want the economic burden of having 
to go see a physician for a prescription. Usually the actual visit to the clinic would take 
much longer and cost more money than the emergency contraception itself. Women also 
believe that they have the autonomy in making sexual decisions as well. They do not feel 
p Pressured in having sex. This side argues that men and women have the potential of 
getting caught in the heat of the moment and therefore engage in sex without 
contraceptive protection. In this case, females want the autonomy and the ability to be 
back in control of the situation. If a female does get caught in the heat of the moment, 
they want to be able to have a way out. This is the purpose of emergency contraception. 
People make mistakes. In every other situation, people try and fix their mistakes. Why 
can’t a woman have the right to fix her mistake with Plan B? Especially in the case of 
rape, women feel hopeless and out of control of the situation. Plan B gives these women 
control over an unwanted pregnancy.

The facts of both sides have been stated and it is up to the reader’s discretion as to which 
side they belong to. In a topic such as oral contraception, it is very difficult as 
practitioners to find a common ground. Depending on one’s culture and one’s beliefs the 
patient and the practitioner may end up on opposite sides of the debate. This then 
becomes an ethical dilemma. If a patient does not want emergency contraception, but the 
practitioner believes in emergency contraception, the solution is easy, let the patient 
decide what they want. However, in a situation where the patient wants emergency 
contraception but the practitioner does not morally and ethically believe it is right, this 
situation poses a problem in the healthcare setting. Does the pharmacist/physician have a 
legal and healthcare obligation to this patient, or does the pharmacist/physician have the 
right to refuse to allow a patient to use emergency contraception. Alongside the topic of 
emergency contraception, many “pharmacists also have strong feelings about dispensing 
drugs used for assisted suicide, euthanasia, and capital punishment, and ethical questions 
regarding the dispensing of erectile dysfunction drugs for convicted sex offenders and 
HIV-positive patient have emerged.” 13 Many healthcare providers believe that they have 
the right to refuse to dispense medications that go against their cultural morals, religion, 
and ethics. With this argument, healthcare providers argue with two general principles, 
non-maleficence and autonomy of the healthcare provider. “The principle of non- 

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dispensing the drug in question can cause harm to another human being, be it a fetus”. Autonomy is the second principle, which is actually used even more in this situation than non-maleficence. Practitioners believe that they have the right to decline prescriptions due to their own cultural beliefs. Opponents will argue “that if a pharmacist is not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with his or her values, then he or she has chosen the wrong profession.” However, in recent years many pharmacy organizations including the American Society of Health System Pharmacists (ASHP) have argued in favor of the pharmacist’s autonomy. They believe pharmacists have the right to refuse a prescription if they deem it unethical. There are always two sides to the story, so which one do we choose? In order to attempt to find a balance between the autonomy of the patient and the autonomy of the practitioner is to completely educate both sides before making a decision. The pharmacist must totally understand their views, they must know what their employer expects of them, and what the laws and boards of pharmacy rules state. There may never be a middle ground when it comes to the topic of contraceptive, but education is the first step in understanding different cultures.

Another issue where culture, ethics and healthcare seem to collide is culture related surgeries such as female circumcision. Depending on one’s philosophy and one’s culture, the procedures may be ethical. Others see this as horrifying and offensive attacks on autonomy and as aberrant and unethical for a provider to participate in.

Female circumcision or female genital mutilation is a cultural tradition practiced primarily in Africa and the Middle East dating back thousands of years. The purpose of female genital mutilation is to ensure that a woman does not engage in premarital sex and after marriage does not commit adultery. Female circumcision accomplishes this by reducing the female sexual response and desire. Female genital mutilation usually occurs in early childhood (4-14 years of age). The child does not give consent; it is solely in the due wishes of the parent. The child is brought to a traditional attendant whom does not use anesthesia or pain medications, and has no sterile instruments. The child endures severe pain and often leads to other morbidities and potentially mortality. A prayer is said to bless the child and guide the child to remain chaste. In this culture virginity possesses a high social value. If a woman engages in premarital sex she is rejected by society and may potentially be killed. When a woman is offered by a family to a male for marriage, the family will be shamed if the daughter is proven to not be a virgin. The marriage will usually end immediately in a divorce and often the family member murders the daughter. These murders are not considered evil by this culture, but looked at as honor killings. Even if it cannot be proven that a woman is not a virgin, the suspicion itself may lead to dishonor to the family. These cultures believe that a woman’s innocence, morality and life may be preserved if a woman undergoes female circumcision. They believe that if a young female undergoes female circumcision she will be much less likely to lose her virginity. To this culture, preserving these aspects in a woman’s life is far more important than the serious complications that may arise when undergoing circumcision. In their eyes, this is ethically right because it is preserving the values that are most important to their culture. Since this culture values virginity so
highly it outweighs the risks of the procedure. One can use the ethical principals of autonomy, beneficence, non-maleficence, and justice to analyze this situation. First regarding non-maleficence, there is no way to defend this culture practice with regards to non-maleficence because harm is being done. Females undergo strenuous pain and often have infections and other complications following female circumcision. Therefore, harm is being done, and non-maleficence is being violated. Beneficence means to do good things. In this situation it depends again on whether you look at doing the greater good (and in the process causing harm) or only always doing good without a wrong. This culture may see that they are abiding by the principle of beneficence since they are doing the greater good by preserving the female’s virginity. In this situation, the female’s autonomy is absolutely being infringed upon. However, in these cultures women typically are not thought of as having rights or autonomy no matter what the situation is. They do not possess self-determination, the family determines what sort of life she will live. Justice is the last principle one should look at. This culture believes the greater good for society would be to use female circumcision. From a western culture point of view female circumcision violates justice, non-maleficence, beneficence, and the patient’s autonomy. Female circumcision is unethical given modern western values, but other cultures may use religion and cultural values as justification for these procedures.

In modern western culture there are an increasing number of elective female genital surgeries. One of these procedures is hymeneal reconstructive surgery. It is an elective cosmetic surgery on the female genitalia similar to breast augmentation on the breasts. The idea is to give the female genitalia a more ideal image. This will increase a women’s self esteem. Another reason for this is to make a woman look and feel like a virgin again. Looking and feeling like a virgin again increase a woman’s bodily self esteem. It is also used for woman who are of the cultures stated above who will be killed if they do not look like a virgin. The surgery restructures the woman so she looks like a virgin again and this prevents the honor killings. It is also used as a form of reconstructive surgery on the female genitalia if congenital defects are present. When comparing hymenoplasty/female genital cosmetic surgery with female circumcision/female genital mutilation, one can see that hymenoplasty is far more ethical than female genital mutilation, even in the eyes of western culture. Hymenoplasty needs informed consent from an adult female (18 years old) and is an elective procedure for a female’s own personal desire as opposed to an enforced chastity. This consent and electiveness maintains the female’s autonomy. Non-maleficence and beneficence are also maintained due to the fact that no harm is done and good is done. There is a trained professional, such as a gynecologist or plastic surgeon, whom uses local or general anesthesia and sterile instruments. This allows the procedure to be done with little to no complications and very rare complications. Therefore, even in western culture this procedure is ethical, whereas female circumcision/female genital mutilation is not.

A third form of cosmetic genital surgery is piercing the labia and clitoris for cosmetic reasons. Medical practitioners may become involved with attaching jewelry to female genitals. This form of surgery has no therapeutic benefit. Hymenoplasty is also cosmetic, however, in that case, there is a therapeutic benefit; whether it is restructuring
due to a congenital defect or for increasing self esteem and therefore mental health reasons. Consequently, piercing, unlike hymenoplasties have no therapeutic benefit. Technically, piercings are considered a Type IV female genital mutilation according to the World Health Organization. A type IV is defined as “pricking, piercing or incising of the clitoris and/or labia”\textsuperscript{14}. It falls into the same category and severity as “stretching of the clitoris and/or labia; cauterization by burring of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above”. The question then arises, if piercing has no purpose or therapeutic benefit and is defined very harshly, is it ethical? We will review piercing with the same ethical principles as female genital mutilation and female genital reconstructive surgery. Piercings are performed on females greater than the age of 18 and are not mandatory. The female gives informed consent to the practitioner. Thus, the female’s autonomy and rights are preserved. She is not forced into doing anything she does not want to do. With regards to non-maleficence, technically, if done properly we are not causing any bodily harm, although no procedure is without risk. Deformities do not occur, the procedure is conducted under sterile conditions, local or general anesthesia is given, the female experiences little to no pain since proper analgesia is given, and a trained professional dose the procedure to ensure minimal complications. With regards to beneficence, depending on each individual’s culture, one may either see piercing as doing good, or one may see it is a useless procedure that does not do good nor harm. Individuals, whom see this as beneficent, see this as a way to express themselves. In this sense, female genital mutilation and piercing do not share the same ethical dilemma. Piercing does not infringe on the patients medical or human rights.

The main question in these three types of procedures is what the healthcare provider should do. Should the healthcare provider respect every single culture or at some point should they no longer be open minded because of the risks? The healthcare provider should always be open minded. They should look at different cultures and respect them. They should not try to interfere with traditions of other cultures or try to impose their own cultures and traditions onto the patient. However, there comes point, where both the patient and the clinician needs to weigh the risk vs. benefit. Female genital mutilation or female circumcision in the eyes of western culture serves no purpose. In the eyes of many African and Islamic nations, it does serve a purpose. However, too much harm is done to the patient/female to deem this practice ethical. Healthcare providers should educate everyone on this practice and should advocate change in laws to protect women and their autonomy. Western countries have since abolished and outlawed female circumcision irrespective of one’s culture. Many African nations and Islamic nations have outlawed this practice as well. However, there still exists many nations who see this practice as ethical and the greater good, and have therefore not outlawed this practice.

With regards to reconstructive surgery and cosmetic genital surgery, many people may see these practices as non-therapeutic and therefore non-ethical. However, clinicians should stay open minded to the wishes of the women who chose to undergo these procedures. Clinicians should always look to see if the situation abides by the principles of ethics. In these two situations, autonomy, non-maleficence, beneficence, and justice are all abided by.

Western culture is often taken as a whole, however there are sub-cultures within western culture based on religious practices. Many religious groups have values and beliefs that are different than most of western culture. Blood transfusion is a potentially life saving strategy which takes blood products from a donor’s circulatory system into a recipient’s circulatory system. They are used often when patients have had massive blood loss due to trauma or hemodynamic instabilities due to complex surgery. Blood products are also given if a patient is severely anemia or thrombocytopenic. In the early years of blood transfusions many patients died merely due to the lack of knowledge of blood components. Modern blood transfusions do not occur until a patient has been matched with a proper donor to ensure that an immunological consequence does not occur. Besides the immunological complications, donors also have to be screened for many diseases. Some examples of disease screening are HIV, Hepatitis A,B,C, west Nile virus, CMV and many more. The intensive screening has proven to decrease the morbidity and mortality rates significantly. This has allowed patient’s to have blood transfusions with little to no complications. Some complications that could potentially occur are “febrile non-haemolytic transfusion reaction, which consists of a fever which resolves and causes no lasting problems or side effects. Haemolytic reactions including chills, headache, backache, dyspnea, cyanosis, chest pain, tachycardia, and hypotension. Blood products containing bacteria could cause a severe sepsis. Hepatitis B, HIV, Hepatitis C, respiratory distress, graft versus host disease, volume overload, iron overload, and hemolytic reactions” are also possible complications. However, these are very rare and do not occur if proper medical support is given.

Although blood transfusion’s benefits have proven to outweigh its risks by a long shot, controversy still remains in some cultural doctrines and religions. The main group against blood transfusions is the Jehovah’s witnesses. The medical community has strongly criticized this belief. Even reformers and former members of the Jehovah’s Witness community have criticized this belief. It is extremely hard to denounce a patient’s cultural belief. However, it is extremely difficult ethically to not denounce a patient’s cultural belief when a patient’s life is at risk. This puts a strain on the healthcare provider. They may not agree with the patient’s culture and beliefs, and in life threatening situations may pose a huge ethical dilemma for the healthcare provider. It is the job of the healthcare provider to seek to understand where the balance is between the autonomy of the patient and the healthcare provider’s personal ethics. We will look at when a healthcare provider should refuse to comply with the Jehovah’s cultural wishes in refusing a blood transfusion.

One must first understand the rationale and cultural background of why Jehovah’s witnesses do not believe in blood transfusions. The problem is that many physicians and society have not been educated on why Jehovah’s do not believe in blood transfusions. Many Jehovah’s Witnesses themselves do not know why exactly they cannot have blood transfusions. It is therefore very pertinent to educate the patients and physicians on the matter to understand the context of the situation. “The lack of this knowledge in the medical community contributes to the generally supportive attitude, even though many physicians do not agree with the practice” 16. The Jehovah’s Witness doctrine is based on three biblical passages. The problem with this is the bible was written far before blood transfusions existed so there are no direct listings of blood transfusions. The passages talk about eating blood and how it is unethical. Jehovah’s Witnesses try and equate eating blood with transfusions. The first biblical passage that talks about blood is Genesis 9:4, where Jehovah (God) states “But you must not eat meat that has its lifeblood still in it”. Another passage is from Leviticus 17:10-16 where God gave a law to Moses, saying: “None of you may eat blood, nor may an alien living among you eat blood.” (Leviticus 17:12). A third passage is from Acts 15 which states “you are to abstain from food sacrificed to idols, from blood, from the meat of strangled animals .... “. (Acts 15:28,29). These three passages are the reasons why Jehovah’s Witnesses do not believe in blood transfusions. As one can see, none of these three passages specifically denounces blood transfusions directly. No where in these passages did God state that transfusions are a taboo and unethical. It is clearly stated that one should not orally ingest blood. There are no benefits to orally ingesting blood. Ingesting blood just gets broken down by stomach acid and little to no nutrients are utilized as food. However, transfusions are not oral. They are directly from a donor’s circulation to a recipient’s circulation. The patient is not eating the blood. With this method, the recipient can utilize the blood and use it to distribute nutrients and oxygen throughout the body. The recipient does not break down all the blood components such as white blood cells, albumin, platelets, red blood cells, etc as if they would if they ingested it. Therefore, there is actually a therapeutic benefit in doing so. There also is no violation of the bible. The bible clearly states “eat”, or abstain from “food” that contains blood. Nowhere in these passages does it state anything about blood transfusions. Therefore, it is up to the Jehovah’s Witnesses to update these passages and interpret them to modern times. Jehovah’s Witnesses interpret these passages and apply and ultimately do not find blood transfusions ethical. One must know that Jehovah’s Witnesses once did not find vaccinations or organ transplant ethical as well. However, they have quietly now accepted vaccinations and organ transplants. One must ask, what is the different between organ transplantation and blood transfusion. Technically, blood transfusions are just like transplanting an organ. It is definitely closer to transplanting an organ than it is to eating blood as food. Most Jehovah’s Witnesses do not know or understand why they shun transfusions, so as a medical professional it is very prudent to inform them of the rationale.

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Another problem with this doctrine is that Jehovah’s Witnesses now allow some parts of blood to be transfused. Jehovah’s Witnesses have to refuse whole blood, packed red blood cells, white blood cells, platelets, and plasma. However there are components of blood which they can accept. These are albumin, immunoglobulin, and hemophiliac preparations. “Perhaps the most peculiar and inconsistent aspect of the Jehovah’s policy is that they may accept all of the individual components of blood plasma, as long as they are not taken at the same time. In addition, JW do not even accept antilogous transfusion of their own predesposited blood, though intraoperative salvage (or cell saver) is accepted as long as extracorporeal circulation is uninterruptd via a tube”. There is no biblical explanation for differentiating what procedures they can and can’t have. There is no biblical explanation as to why or how they chose certain blood components over the other. This puts healthcare provider’s in a difficult situation. The educated healthcare provider sees three main flaws in this doctrine. First there is the fact that Jehovah’s Witnesses have changed their beliefs on transplantation and vaccination. Second, the fact that some blood components can be transfused but others cannot. Lastly, the fact that nowhere in the bible does it talk about transfusing blood, it only talks about eating blood as a meal. Once educated on the matter, one sees that the reason for refusal is very far-fetched and illogical. So the question is, if a patient refuses any blood products or a transfusion is it ethical to accept the patient’s decision and autonomy or is it ethical to go against the patient’s wishes and treat them in the best way possible? Are there certain situations where we can abide by the patient’s wishes or certain situations where we should not? Do we have alternative methods in which to treat the patient? The clinician should always keep these questions in mind and keep an open mind for the patient. If there are alternatives the clinician should respect the patient’s wishes and treat them accordingly. One should always consider the patient’s autonomy and keep an open mind for the patient.

There is also a problem with a patient’s autonomy when it comes to Jehovah’s Witnesses beliefs and blood transfusions. As discussed above, there are very illogical explanations as to why Jehovah’s Witnesses cannot undergo a blood transfusion. Most Jehovah’s Witnesses are not fully educated and do not fully understand their belief. This poses a problem with the patient’s autonomy. If the patient is not fully educated on their belief can they be fully competent with their decision making. They may be misinformed, misguided, or convinced in a belief that actually is not true. If this is the case, a patient refusing a blood transfusion because of a belief they do not fully understand or a belief which they were misguided into believing, then the patient is not making an autonomous decision. The facts have been skewed and the patient is actually making a decision that they never wanted to make.

For argument sake, lets sake a patient is fully educated on the matter and fully understand their rationale for not wanting a blood transfusion. The patient is therefore acting fully autonomous. Given a common by hypothetical situation such as an emergency situation in which a Jehovah’s Witness has just lost a large amount of blood from some sort of trauma. The patient’s only way to survive is by replenishing their blood. The patient is in hypovolemic shock and if they do not get a blood transfusion in the next couple of
minutes they die. While looking up the patient’s profile a physicians sees that the patient is a Jehovah’s Witness and has a “blood card” which states they will not accept blood transfusions. In this ethical dilemma what is the physician to do? Do they go against the patient’s wishes and treat the patient? Or do they accept the patient’s decision and let the patient die? Historical evidence has shown that if a physician goes against the Jehovah’s decisions and saves their life with a blood transfusion, the physician can be charged with battery. On the other hand, history has also shown that if a physician does not treat the patient and lets them die, they also can be charged. From an ethical stand point, one would probably believe that saving a life and getting charged would be better than allowing someone to die and getting charged. This ethical situation has been a hot debate in the last couple of decades and no true decision has been made. One can argue on both sides and show that both sides are ethical. The decision should be a mutual decision between the patient and the healthcare provider. A common meeting ground should be met and the patient should be treated accordingly. The patient and the healthcare provider must both be fully educated on the matter which will allow for a true autonomous decision. This should allow a balance between the autonomy of the patient and the healthcare provider’s personal ethics.

Culture, ethics, and healthcare are inextricably intertwined. There is a need for the development of more comprehensive cultural education in healthcare. Providers that are culturally aware can provide better more comprehensive care. Culturally competent care is needed in patients most vulnerable moments. From birth to death and the hereafter culture is part of all of us and as such must be acknowledged and respected when providing healthcare. Healthcare providers need to be cognizant of cultural influences in a patient’s decision making so they can inform themselves and the patient of all the facts so a patient can make an informed decision. Also healthcare providers need to understanding of cultural behaviors and values from all patients. Providers also need to be watchful for cultural behaviors that they participate in and determine for themselves if they are ethical. Open mindedness, understanding, and compassion are the keys to cross-cultural interact and good healthcare.
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