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HONESTY, INTEGRITY AND CULTURE:

WITHHOLDING INFORMATION FOR CULTURAL REASONS

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ABSTRACT:

Australia has an increasingly multicultural population. With such a diverse range of backgrounds and beliefs, clashes of cultural values are common and unavoidable. These situations must be addressed, as they have obvious implications for patient care. In this paper I consider the ethical issues raised in a specific scenario where a "Western"-trained doctor is requested by a patients' family to withhold information from the patient for cultural reasons. I look first at the nature of the disagreement, exploring the possible reasons for the conflicting views of the doctor and the patient's family. I then go on to discuss some issues which render the disagreement more complex than it first appears. Finally, I discuss three possible options for the doctor and some ways of deciding which of these to take. I look at a common theoretical approach to cultural 'clashes' of value, namely the universalism vs. relativism debate, and find that it is not as important as it seems at first. I conclude that in this scenario, notions of integrity and autonomy are far more important for the doctor's decision than any beliefs concerning the relativity or universality of moral values.

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CHAPTER 1: INTRODUCTION

1.1 - Scenario for Discussion: [1]

> Mr. Wong, a 73 year-old Chinese immigrant, has been diagnosed with locally invasive nasopharyngeal cancer. He is receiving radiation therapy and chemotherapy at an outpatients' clinic in Melbourne, and also sees a Chinese practitioner for traditional Chinese medical treatment. Mr. Wong speaks only Cantonese, and when he attends the clinic he is always accompanied by his son and sometimes by other members of the family, who act as translators. Despite treatment, his cancer progresses to a point where it is immediately life-threatening due to haemorrhage. During one particular visit to the outpatients' clinic, the physician asks Mr. Wong's son to explain that the treatment hasn't been successful, that there is no other treatment that they can offer, and that there is a possibility that he could die very soon from a haemorrhage. The son refuses to translate, saying, "For us Chinese, we are not used to telling the patient everything, and patients are not used to this either. If you tell them, they can't tolerate it and they will get sicker".

In this thesis I will use the above scenario to explore some of the ethical considerations for an Australian-trained doctor when requested by a patients' family to withhold information from the patient for cultural reasons. The scenario creates a difficult moral dilemma for the doctor. In what way should she approach a disagreement which seems to be based on different and irreconcilable value systems, when it has obvious implications for patient care? Should she take values into account

[1] Adapted from "Patient 2" in: B. Koenig and J. Gates-Williams. *Understanding cultural difference in caring for dying patients (Caring for patients at the end of life).* **The Western Journal of Medicine** 1995;163(3):p.204

which are not important to her, but which may be for the patient, or the patient's family? If so, how should she choose which particular considerations are of moral importance? And can she act on these choices without compromising her own beliefs about what is right? This chapter will begin by briefly putting the scenario in context, summarising the main approach and arguments of the paper, and addressing relevant methodological issues.

1.2 – Background and Summary

Australia is an increasingly multicultural society. Our population comprises people from many different backgrounds, encompassing numerous traditions and beliefs. One consequence of this growing diversity in the health-care context is the advent of frequent clashes of 'cultural values' between patients and their carers.

There has been increasing attention in medical literature directed towards health-related attitudes and values that differ between cultures.[2] Comparisons have been made both between countries and within various societies. For example, in Italy, telling a woman she has a benign tumour is viewed as telling 'partial truth', which is seen as morally acceptable.[3] In Australia however, the same action may be viewed as deception and therefore morally reprehensible. There are also many examples of scenarios involving a disagreement between a dominant Western medical system and patients from various other cultural groups. One which is commonly cited is the Navajo family in the United States who object to the telling of bad news because of strong traditional beliefs about the power of the spoken word.[4] Another is the Ethiopian refugee who has been 'circumcised' in her home country, and approaches her doctor after childbirth asking to be 're-sewn' to preserve her purity and family honour.[5] It should be noted that scenarios such as these do not always involve a

[2] For example, see: P. Seibert, P. Stridh-Igo and C. Zimmerman. *A checklist to facilitate cultural awareness and sensitivity*. **Journal of Medical Ethics** 2002;28; H. Engelhardt. *Japanese and Western bioethics: Studies in moral diversity*. In: Hoshino, (ed.). **Japanese and Western Bioethics**. Dordrecht: Kluwer Academic Publishers; 1997; L. Turner. *Bioethics in a multicultural world: Medicine and morality in pluralistic settings*. **Health Care Analysis** 2003;11(2)
[3] M. Good, B. Good, C. Schaffer, et al. *American oncology and the discourse on hope*. **Culture, Medicine and Psychiatry** 1990;14:p.63
[4] Traditionally, Navajo Indians believe not that language reflects reality, but that it *shapes* reality. This makes informed consent and related practices difficult, as any discussion of possible negative outcomes is seen to actually cause those outcomes. See J. Carrese and L. Rhodes. *Western bioethics on the Navajo reservation - benefit or harm?* **Journal of the American Medical Association** 1995;274(10)
[5] C. Baker. *Cultural relativism and cultural diversity: Implications for nursing practice*. **Advances in Nursing Science** September 1997;20(1):p.6

'Western' doctor and an 'ethnic' patient; it could be the other way around, or, more and more frequently, both could be from two different 'non-Western' backgrounds.[6]

There has been particular attention in bioethical literature to those moral differences found in some Asian countries, particularly China and Japan. The difference is often framed as one between the 'family-oriented East' and the 'individualist West'. Whilst the core bioethical principles of justice, non-maleficence and beneficence all translate to similar concepts in, for example, Hindu or Confucian tradition, the principle of autonomy appears to translate to something very different, or perhaps, by an individualist definition, not at all.[7] When a doctor in Australia today is presented with a patient from such a culture, and a family who perhaps do not share her ideas regarding self-determination, it is not surprising that conflict can arise concerning truth-telling and informed consent.

The approach taken in this paper will be firstly to focus on understanding the disagreement in the scenario concerning Mr. Wong from both sides. Chapter two will introduce what the doctor's view may be, and move on to provide a possible explanation for the family's request. Chapter three will look further at these issues and illustrate why the disagreement is not as simple as it first appears. In chapter four I will discuss the options that the doctor might have, and a way of thinking about these options in order to decide which one to take. In literature that looks at cultural differences, an approach often taken is to ask whether, in the face of such obvious moral disparity, there could be values which are universally applicable, or if there are simply many different and irreconcilable codes which cannot be compared. This debate is often framed as that between two opposing theories: *universalism* and *relativism.* In chapter four I will therefore discuss these two notions, and the implications for this particular scenario of the doctor adopting one or the other. I will

[6] Turner.p.104
[7] C. Tai and C. Lin. *Developing a culturally relevant bioethics for Asian people*. **Journal of Medical Ethics** 2001;27

conclude that although at first glance the option the doctor chooses seems linked to whether she supports relativism or universalism, other considerations, especially the version of autonomy she supports and her views on integrity, are far more important.

1.3 – Methodological Issues

This paper is a theoretical analysis of a specific scenario. It utilises the tools of philosophical bioethics to examine the disagreement and explore the options for the doctor. The main theoretical concepts explored include notions of autonomy and integrity, and the on-going debate involving moral relativism and universalism.[8]

Most of the cross-cultural discourse in health has been anthropologically or clinically based; fostering an awareness of different cultural beliefs, and recommending more 'culturally appropriate' communication methods and practices when dealing with patients from a particular background. These considerations are obviously important when talking about etiquette and various communication techniques, niceties of social interaction, and so forth. However, there is a difference between respecting difference where it still concurs with our values, (for example, being aware of any dietary considerations and making sure they are addressed[9]), and being blindly 'tolerant' of requests on cultural grounds that directly conflict with our own moral standards. I am thus interested in the moral aspect of these encounters and how to deal with them. Communication skills and an awareness of cultural difference are obviously required to carry out whatever course of action is ultimately decided on, however they may not be enough to reach the decision itself. Just as communication methods are important but will not be covered in this paper, legal concerns which may be relevant when discussing information-giving and informed consent will not be mentioned either.

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[8] Although the question of whether the family should have been involved in translating in the first place is interesting, I am concerned with the moral considerations *given* this situation. It is also beyond the scope of this paper to discuss the involvement of family in medical decision-making. For further reading on this, see: J. Hardwig. *What about the family?* **The Hastings Center Report** 1990;20(2); J. Blustein. *The family in medical decisionmaking*. **The Hastings Center Report** 1993;23(3)

[9] Seibert, Stridh-Igo and Zimmerman. Another example is respecting the wishes of Islamic patients and their relatives by turning a patient's body toward the east after death. Because this is an action which does not compromise patient care, requires only a small change to normal practice and is not costly, it does not challenge any values held by the physician and it is easy therefore to be respectful of difference. (See Koenig and Gates-Williams.p.248)

There is a need to clarify that this discussion is by no means a paper on 'how to treat the dying Chinese patient'. I acknowledge that no assumption can or should be drawn about anyone from simply studying the available literature on their 'culture'. As Koenig and Gates-Williams point out, generalisations made about culture overlook the continuously changing nature of all societies, as well as the variation that exists *within* these societies.[10] It is obvious that any data concerning trends in Chinese attitudes towards death and dying should not be used to *predict* the beliefs of Mr. Wong or his family.[11] It may, however, be reasonable to use this data to try to *explain* the family's response; given that the request for non-disclosure has been made by appealing to cultural values it seems at least reasonable to consider it on these terms. The discussion concerning "Chinese" culture is thus an exercise in trying to understand the underlying philosophy and beliefs which may have lead to the request of Mr. Wong's family.

Just as the family's point of view will be explored through a discussion of Chinese 'culture' and 'values', the doctor's view will be discussed with reference to 'Western bioethics' and 'Western culture'. This again is a generalisation, and problematic because it treats the 'West' as having a monolithic set of values. However, in this case it is nevertheless useful to illustrate the possible differences between the underlying philosophies of the doctor and those of the patient's family.

It should be noted that bioethics itself originated in the United States and is inescapably a 'Western' set of concepts.[12] In addition, most cited data comparing values of different ethnic groups with those of a dominant 'Western' culture are also from the United States, as little research of this nature has been done in Australia.[13]

[10] Koenig and Gates-Williams.p.247
[11] L.J. Blackhall, G. Frank, S. Murphy, et al. *Bioethics in a different tongue: The case of truth-telling*. **Journal of Urban Health** 2001;78(1):p.70
[12] G. Weisz, (ed.) Social Science Perspectives on Medical Ethics. Dordrecht: Kluwer Academic Publishers; 1990.p.3
[13] X. Huang, B. Meiser, P. Butow, et al. *Attitudes and information needs of Chinese migrant cancer patients and their relatives*. **Australian and New Zealand Journal of Medicine** 1999;29(2):p.208

This is a potential limitation, as Australia is undeniably different in many respects to the United States.

Lastly, there is also a body of literature which deals with what comprises 'culture' and how it should be defined. I will adopt a definition from Surbone and define culture as "the sum of the integrated patterns of knowledge, beliefs and behaviours of a given community".[14] This is sufficient for the purposes of my discussion; additional deliberation about what exactly constitutes culture is beyond the scope of this paper, and will not be explored further.

[14] A. Surbone. *The quandry of cultural diversity*. **Journal of Palliative Care** 2003;19(1):p.8

CHAPTER 2: THE DISAGREEMENT

In this chapter, I will outline a simplistic method of looking at the scenario from both sides, using approaches from the existing literature. I will then move on in chapter three to examine why the argument extends deeper than this superficial analysis, outlining some of the underlying complications.

The disagreement seems to stem partly from the apparently fundamental differences between Chinese and Western society. These differences, put simply, involve the emphasis in countries such as Australia on individualism – "'I' consciousness, emotional independence, and individual initiative",[15] contrasted with the more interdependent Chinese society, which places importance on

> 'we' consciousness, collective identity, emotional interdependence, group decision making, ascribed duties and obligations, reciprocity, and the maintenance of social harmony.[16]

This distinction between 'collectivist' and 'individualist' societies is one outlined by anthropologist Geert Hofstede in his book, *Cultures and Organisations*[17], and will be looked at further in the following two sections.

In an individualist society such as Australia, disclosure of medical information is seen to be ethically required, because it "upholds the principle of self-determination, and it enables patients to make autonomous treatment decisions consistent with their own goals".[18] However, this ideal of self-determination may not be shared by all people who live here, some of whom may place much higher value on family protectiveness and group cohesion. In this scenario these values have come

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[15] R. Ow and D. Katz. *Family secrets and the disclosure of distressful information in Chinese families*. **Families in Society** 1999;80(6):p.620
[16] Ow and Katz.p.620
[17] G. Hofstede. **Cultures and Organisations: Software of the Mind**. New York: McGraw-Hill; 1997 It should be noted that Hofstede stresses that it is not *individual preferences* but *central tendencies* of each culture that he is describing, therefore warning against applying his theories directly to individual people. His theories are nevertheless useful to examine the differences between both sides of the disagreement in question as fully as possible.
[18] E.J. Gordon and C.K. Daugherty. *'Hitting you over the head': Oncologists' disclosure of prognosis to advanced cancer patients*. **Bioethics** 2003;17(2):p.143

head-to-head, and the doctor must decide how to weigh them up, and what factors are worthy of moral consideration. This is not to imply that the family have no capacity for moral decision-making; they will also have moral decisions to make in response to the doctor. The focus in this project is on the doctor's decision because it is the doctor who now has to reach a conclusion about what is right to say or do.

2.1 - The Doctor

The doctor has been trained within a Western medical system, which over the last 50 years has had a growing emphasis on the principle of respect for autonomy, along with patients' rights to information and to make decisions about their own bodies. Furthermore, the healthcare staff are a part of wider 'Western culture'. They thus carry many deeply embedded notions across into their professional lives, for example, notions concerning the importance of individuality and independence, and of what constitutes a 'good' death.

Hofstede, as previously mentioned, outlines the general characteristics of an individualist society such as Australia. He argues that a person growing up in such a society is likely to be born into a nuclear family, and have little contact with their (relatively smaller) extended family. "They learn to think of themselves as 'I',"[19] and they are classified according to individual, not group, characteristics. Telling the truth is an attribute of a sincere and honest individual, even if it involves conflict, which is seen as a normal part of family life.[20] Children are expected to have their own opinions, and those who 'copy' the opinions of others are considered to be of 'weak character'.[21] According to Kevin Woo, such a society also encourages open exchange of information and the expression of emotion, and self-actualisation by every individual is an important goal.[22] Woo also describes the nature of Western thought as 'scientific,' and greatly influenced by Cartesianism, which traditionally separates mind and body. He argues that the four basic principles of bioethics directly reflect the consumer-driven 'individualist' society that is described by Hofstede.[23]

[19] Hofstede.p.150
[20] Hofstede.p.58
[21] Hofstede.p.59
[22] K. Woo. *Care for Chinese palliative patients*. **Journal of Palliative Care** 1999;15(4):p.71
[23] Woo.p.71

The ideas that may form part of the physician's view arise primarily from the value placed on 'the principle of respect for autonomy'. From the physician's point of view, it may be 'wrong' to respect the family's wishes and not offer information to Mr. Wong (by way of an interpreter) because of her ideas about why we should have information about our bodies, including information about things which will affect or shorten our lives.

Respect for autonomy is one of the four guiding principles which were identified in 1979 by Beauchamp and Childress in their first edition of *Principles of Biomedical Ethics*.[24] The word *autonomy* originated from the Greek words *autos* and *nomos*, and it is literally translated as 'self-rule' or 'self-governance'. The idea originated mainly from the work of Immanuel Kant and John Stuart Mill. Kant argued that all persons have "unconditional worth," and to violate someone's autonomy is to treat them "in accordance with others' goals without regard to that person's own goals".[25] Mill was concerned that "society should permit individuals to develop according to their [own] convictions".[26] These original ideas emphasise the importance of *individuals*, and allowing these individuals to make their own decisions.

Utilising these concepts in their principle of respect for autonomy, Beauchamp and Childress' state that

> to respect an autonomous agent is, at a minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs.[27]

There is an emphasis in their account on the *choices* that people make, and they argue that in some cases the principle creates an obligation to

[24] T. Beauchamp and J. Childress. **Principles of Biomedical Ethics** 1st ed. Oxford: Oxford University Press; 1979
[25] T. Beauchamp and J. Childress. **Principles of Biomedical Ethics** 5th ed. Oxford: Oxford University Press; 2001.p.64
[26] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.64
[27] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.63

> build up or maintain others' capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt their autonomous actions.[28]

Stated as a negative obligation, "autonomous actions should not be subjected to controlling constraints by others."[29] As a positive obligation, respect for autonomy

> obligates professionals in health care…to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision-making.[30]

They thus call for health professionals to resist the temptation to "foster or perpetuate patients' dependence," and instead to equip patients with the information and options to take "as much control as possible and as they desire".[31] From their account of this principle come some moral rules, which include to tell the truth, and to obtain consent for any interventions.[32]

From the above discussion, that is, according to Beauchamp and Childress' account of autonomy, an analysis of the scenario involving Mr. Wong would look something like this:

The doctor values the principle of respect for autonomy, and does not wish to be 'paternalistic' and try to 'protect' Mr. Wong from bad news. This therefore involves 'telling the truth,' because Mr. Wong has a right to know about his terminal prognosis. This would then allow Mr. Wong to make choices concerning, for example, saying goodbye to his family/friends, and setting his affairs in order. In this scenario 'telling the truth' may involve going around the family by way of a translator to inform Mr. Wong that his cancer is not treatable and it is possible he could die soon from a haemorrhage.

[28] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.63
[29] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.64
[30] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.64
[31] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.65
[32] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.65

It should be noted that an argument concerning *informed consent* does not feature in the above analysis. It would certainly be a consideration if, for example, there was a decision to make between undergoing invasive treatment with little hope for cure, or having no treatment and only palliative care. However, as there are no treatment decisions to make in this particular scenario, an argument from informed consent is not as important.

Apart from reasons to do with respect for autonomy, there may be other reasons that the doctor values informing Mr. Wong about his condition and the likely prognosis. These can perhaps be explained as notions to do with truth and death that are embedded in Western culture.

1. The intrinsic value we place on knowing the 'truth'. The value of truth in Beauchamp and Childress' account of autonomy is a value that is linked with being given the truth in order to make choices. I will call this the *instrumental* value of truth – that is, knowledge that will perhaps result in a certain action or behaviour. However, we also seem to value truth for its own sake, that is, a more *intrinsic* value. There seems to be a tendency to 'just want to know' certain things, even if it will not objectively change anything. In a 2001 study on attitudes toward truth-telling across different cultures by Blackhall *et al.*, a theme that emerged amongst the European-American and African-American respondents was that they wanted any news, bad or good, simply because it was about *their* body. This is illustrated by the response of one patient, who said, "I'd want to know the worst because it's *me*".[33]

2. Ideas of what constitutes a 'good death.' Ideas about what is involved in achieving a good death are present in all societies, with a range of different expectations. In a study conducted by Steinhauser *et al.* in the United States, factors

[33] My emphasis, Blackhall, Frank, Murphy, et al.:p.62

rated as important by more than eighty percent of patients included feeling prepared to die, believing that one's family is prepared for one's death, and knowing what to expect about one's physical condition.[34] This and other empirical work on the factors that people consider important in the realisation of a good death also reveals notions of dying with dignity, having a sense of control, and having an open awareness and acceptance of dying.[35] If these ideas can be taken as a general reflection of Western beliefs, the lack of satisfaction of some or any of these criteria may cause the doctor to feel that Mr. Wong's lack of knowledge would prevent him from achieving a 'good death'.

These ideas about the importance of individual autonomy, knowing the truth and achieving a good death form part of the cultural context in which the doctor lives and works. Whilst it is beyond the scope of this paper to attempt to give an account of Western culture as such, these brief observations will help to set the scene for a comparison with the 'Chinese view' in the next section.

[34] K. Steinhauser, N. Christakis, E. Clipp, et al. *Factors considered important at the end of life by patients, family, physicians, and other care providers*. **Journal of the American Medical Association** 2000;284(19)
[35] See P. Singer, D. Martin and M. Kelner. *Quality end-of-life care*. **Journal of the American Medical Association** 1999;281(2); E. Tong, S. McGraw, E. Dobihal, et al. *What is a good death? Minority and non-minority perspectives*. **Journal of Palliative Care** 2003;19(3); B. McNamara. *Good enough death: Autonomy and choice in Australian palliative care*. **Social Science and Medicine** 2003;58; E. Vig, N. Davenport and R. Pearlman. *Good deaths, bad deaths, and preferences for the end of life*. **Journal of the American Geriatrics Society** 2002;50

2.2 - The Family

In literature describing the possible 'Chinese' philosophies and social structure that form the foundations of a request such as that of Mr. Wong's family, some common themes emerge. Most pertinent to this scenario are firstly the emphasis on collective values and interdependence (including maintaining family harmony and group cohesion), and secondly on the avoidance of and protection from extreme emotion or anxiety.[36] Other concepts such as 'cheng', or sincerity[37], and that of 'filial piety', carry with them a strong notion of a duty of protection toward the sick patient, which may include withholding information. There is also a belief that negative information causes harm and deterioration because of loss of hope, which is seen as very important in recovery (however slight the chance of recovery may be).[38]

In a paper discussing 'Chinese Bioethics', Bowman and Hui state that

> in traditional Chinese culture, greater social and moral meaning rests in the interdependence of family and community, which overrides self-determination.[39]

In contrast to the individualist societies described previously, in collectivist cultures most people grow up living with, or at least in direct contact with their extended family. According to Hofstede, they "learn to think of themselves as part of a 'we' group," which provides their only protection, a major part of their identity, and to which they owe lifelong loyalty. There is a great emphasis on the maintenance of 'harmony' within the 'we' group, and as such, "personal opinions do not exist: they

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[36] Woo.p.72; Tai and Lin.p.52; J. Muller and B. Desmond. *Ethical dilemmas in a cross-cultural context: A Chinese example*. **The Western Journal of Medicine** 1992;157(3):p.3
[37] M. Pang. *Protective truthfulness: The Chinese way of safeguarding patients in informed treatment decisions*. **Journal of Medical Ethics** 1999;25(3):p.6
[38] Woo.p.72; Muller and Desmond.p.3
[39] K. Bowman and E. Hui. *Bioethics for clinicians: 20. Chinese bioethics*. **Canadian Medical Association Journal** 1997;163(11):p.1481

are pre-determined by the group".[40] Ultimate goals in a society are 'harmony and consensus', and private life is the business of the group.[41]

Chinese thinking is largely based on the teachings of Confucius, but is also influenced by Buddhism and Taoism. Confucian teachings include the notion that a person is primarily a *member of a family*.[42] Harmony in the family is achieved by maintaining everybody's 'face' in the sense of dignity, self-respect and prestige.[43] This concept of face is also discussed with relation to disclosure of 'distressful' medical information. 'Saving face,' in a study of Singaporean Chinese, may involve "filtering out information that may embarrass or evoke feelings of shame or shyness because such information does not preserve or enhance the status or prestige of the individual or the group."[44]

Another concept that has relevance to this scenario is that of 'filial piety,' which represents the responsibility a person bears towards one's parents. The notion of filial piety includes "respect for parents, care of parents, obedience to parents, protection and glorification of parents, and worship of deceased parents".[45]

The protection demanded by filial piety and the harmony achieved by maintaining 'face' may thus be two important foundations of the request of Mr. Wong's son to withhold his prognosis.

A further reason for the family's request (and indeed the one stated by the son in the scenario) may be the belief that the information will harm him. In Chinese culture, discussing death openly is regarded as "harmful and discouraging to patients and as potentially precipitating or hastening death".[46] There is an expectation that families will absorb negative information, and filter it as necessary for the protection of the patient from emotional turmoil. This notion of harm from negative information

[40] Hofstede.p.59
[41] Hofstede.p.73
[42] Tai and Lin.p.52
[43] Hofstede.p.165
[44] Ow and Katz.p.621
[45] Woo.p.70
[46] Woo.p.72

relates in part to the belief that hope is integral for the survival of a patient. Any action that diminishes hope causes the patient to despair, and risks hastening death or making an illness worse.[47]

The traditional role of a doctor in China is also different to that of a contemporary Australian doctor; the traditional role of the Chinese doctor is more paternal, and disclosing a 'truthful' prognosis could be seen by both family and patient as "an abandonment of a protective relationship".[48]

I have explored at least some of the cultural background from which the request of Mr. Wong's son may have arisen. Of course, his son may not endorse all of these ideas, or have consciously considered them in responding to the doctor. But the discussion offers at a minimum some context for understanding the possible values and motivations behind his position.

[47] Muller and Desmond.p.325
[48] D.A. Campbell. *Hope and harm: A delicate balance*. **Medical Journal of Australia** 2001;175(10):p.541

CHAPTER 3: "COMPLICATIONS"

The previous chapter sets out the considerations of both parties in a relatively simplistic manner. However, as with most things, the situation is more complicated than it may appear at first. Complications include the particular account of autonomy one accepts, the fact that the rise of autonomy and the accompanying imperative to tell the truth is relatively recent, and the obscure notion of 'truth' itself. Other considerations include avoiding the conflation of what Chinese *people* believe with what Chinese *patients* want for themselves, and the fact that we are comparing empirical data on Chinese 'opinion' with what is largely Western academic (philosophical or ethical) theory. In this chapter I will discuss each of these complexities in turn.

The most widely accepted account of respect for autonomy as an ethical principle is that proposed by Beauchamp and Childress, as outlined in chapter two. If the doctor accepts this account it should be noted that it holds that a patient's wishes *with regards to what they want to know about their illness* are to be respected. Beauchamp and Childress state that they defend "a principle of respect for autonomy with a correlative *right* to choose," not a "mandatory *duty* to choose".[49] According to this account, then, it is not telling the truth that follows from respecting autonomy (which is a common interpretation), but rather telling as much as the patient wants to know. It thus carries no prerogative to impart information, but it does require finding out somehow what the patient's wishes are in order to respect them. It should be noted that there is evidence that talking to patients' relatives does not accurately

[49] Beauchamp and Childress. **Principles of Biomedical Ethics** 5th ed.p.61

predict the wishes of the patient, and therefore to respect the choices of a patient it is necessary to talk directly to them rather than a family member.[50]

It is also important to be aware that Beauchamp and Childress' account of respect for autonomy is not the only one that has been proposed. Some philosophers hold that we have an *obligation* to know important information about ourselves. David Ost argues that the refusal of information relevant to oneself is itself an irrational act, and since irrational people do not have rights, there is no such thing as a "right not to know".[51] He claims that

> the right to be informed is … a *mandatory* right – i.e., it is not an option which one may or may not exercise; rather, it is a right which we are *obliged* to exercise.[52]

According to Ost, we cannot surrender our status as autonomous agents, and accordingly cannot surrender the accompanying obligations. Rhodes also argues that we have an obligation to know information about ourselves. She sees autonomy as *requiring* carefully thought out and informed decisions about oneself. In her view, autonomy cannot therefore be the basis of a right *not* to know, as knowledge is needed for an informed decision. Her argument is in relation to genetic information, and she further contends that since what we know influences the choices we make regarding our obligations to others, we cannot fulfil these obligations *without* this important information.[53] According to *these* accounts of autonomy, Mr. Wong has an obligation to know his prognosis; his family, whilst undeniably well-intentioned, are interfering with this obligation. Although these accounts are more controversial than Beauchamp and Childress', they are worth considering, as some people (including

[50] A. Schattner and M. Tal. *Truth telling and patient autonomy: The patient's point of view*. **The American Journal of Medicine** 2002;113 See also: S. Orpett Long. *Family surrogacy and cancer disclosure: Physician-family negotiation of an ethical dilemma in Japan*. **Journal of Palliative Care** 1999;15(3)

[51] D.E. Ost. *The 'right' not to know*. **The Journal of Medicine and Philosophy** 1984;9:p.305

[52] Ost.p.307

[53] R. Rhodes. *Genetic links, family ties, and social bonds: Rights and responsibilities in the face of genetic knowledge*. **Journal of Medicine and Philosophy** 1998;23(1)

some doctors) may accept them. This could subsequently have considerable bearing on the outcome of the scenario, as will be explained in chapter four.

Another important complexity with regard to the doctor's 'view' is the relatively *recent* advent of the perceived importance of patient autonomy in the West. The moral importance currently attributed to respect for autonomy emerged as recently as the 1960s, as a response to the widespread paternalism within the medical field. This is often demonstrated by reference to two studies examining the attitudes of physicians towards telling patients a cancer diagnosis, the first in 1961 and the second in 1979. In 1961, 88 percent of doctors surveyed in a study by Oken reported a preference to withhold cancer diagnoses from their patients.[54] By 1977 the usual policy for 98 percent of doctors in a similar study was to definitely *disclose* a diagnosis.[55]

Various explanations have been put forward for this radical reversal of 'truth-telling' norms. For example, it could be seen as a change which mirrored societal and corresponding legal movements in the U.S. from the 1960s onwards.[56] There has also been research conducted which indicates that patients would much prefer to be told the 'truth' from the beginning, and indeed fare better when they know what their situation is.[57] As the underlying reason that justified the withholding of information appeared to be the avoidance of harm, it is possible that the emergence of evidence showing this instinct to be mistaken may have also contributed to the change.[58]

The vast improvement in cancer treatment has also been suggested as a reason for the change in 'truth-telling' attitudes, as it means that a diagnosis of cancer no

[54] D. Oken. *What to tell cancer patients*. **Journal of the American Medical Association** 1961;175(13)
[55] D. Novack, R. Plumer, R. Smith, et al. *Changes in physicians' attitudes toward telling the cancer patient*. **Journal of the American Medical Association** 1979;241(9)
[56]According to Faden and Beauchamp, medical ethics was previously derived almost entirely from *within* the medical field. From the middle of the 20th century, however, outside influences, especially case law, began to affect medical policies and practice. See R. Faden and T. Beauchamp. **A History and Theory of Informed Consent**. New York: Oxford University Press; 1986
[57] L.J. Fallowfield, V.A. Jenkins and H.A. Beveridge. *Truth may hurt but deceit hurts more: Communication in palliative care*. **Palliative Medicine** 2002;16:p.297-303
[58] Novack, Plumer, Smith, et al.:p.899

longer implies a poor prognosis.[59] This is important when we consider that the literature on truth-telling focuses mainly on telling a *diagnosis*, and that the research specifically on *prognosis* disclosure is limited.[60] Some studies may confuse or may not distinguish between diagnosis and prognosis, and some concentrate only on early stage cancer patients; late-stage and terminal prognosis truth-telling data is patchy at best.[61] What data there is suggests that hope is an indelible component of the considerations of oncologists; whilst diagnosis is almost 100 percent 'disclosed', prognosis is much more likely to be withheld.[62] One study done in the United States examined the attitudes and practice of oncologists who cared for advance cancer patients. It found that there was a definite reluctance to 'hit someone in the face' with prognostic information.[63]

It is interesting to note that in this same study a decision to disclose prognosis regardless of these reservations seemed to come from doctors' respect for the patient's self-determination, and the perceived importance of a patient making their own end-of-life decisions. An indicator for doctors being more 'brutally honest' with regard to prognosis was when patients had unrealistic expectations in terms of how long they would live, or in terms of the chances of cure.[64] That is, doctors wanted to correct mistaken beliefs; not to make patients feel better, but rather to forestall misguided planning and decision-making.

Overall, it seems that whilst doctors are now comfortable with disclosing diagnoses, they are still reluctant to be forthcoming about a terminal prognosis. Reasons found for this trend are the need to maintain trust in the doctor-patient

[59] Gordon and Daugherty.p.147
[60] M. Kagawa-Singer. *Negotiating cross-cultural issues at the end of life*. **Journal of the American Medical Association** 2001;286(23)
[61] Gordon and Daugherty.p.151
[62] Surbone.p.7
[63] Gordon and Daugherty.p.155
[64] Gordon and Daugherty.p.158

relationship, *the maintaining of hope*, and the judgement that it is futile sometimes to tell someone, and ultimately can be harmful.[65]

This leads us to an interesting point. It appears from this perspective that a similar concept of 'hope' is apparent in both Western and Chinese cultures, and that the difference between them is the value that each party places on Mr. Wong's self-determination; how important respecting his autonomy is when *balanced* with him potentially losing hope.

A closer look at the Western discourse on hope reveals that there is yet another element to this balance between hope and autonomy; notions about the importance of 'truth' and 'knowledge' appear to be linked to some Western concepts of hope, whilst protectiveness is linked to an 'Eastern' concept of hope. Gordon and Daugherty describe the doctor's dilemma as the "tension between physician's reluctance to disclose prognosis, yet maintain hope within *realistic* proportions".[66] Fallowfield describes higher rates of depression and anxiety in patients "not told the truth about their condition", and Simpson contends that "hope is based on knowledge, not ignorance."[67] One oncologist in a study on hope distinguishes between optimism from "the positive things in a situation" and instilling false hope; hope from "lies" is "wrong".[68]

Interestingly, this connection between truth and hope in the West is matched by that between hope and the notion of sincerity in Chinese thought.[69] Sincerity, a cardinal virtue of Chinese medical ethics, is strongly bound to a notion of protectiveness. Pang writes that "truth-telling would become an insincere act if a patient were to lose hope and confidence in life after learning of his or her disease."[70]

[65] Kagawa-Singer. , Gordon and Daugherty.
[66] Gordon and Daugherty.p.160
[67] Fallowfield, Jenkins and Beveridge.p.302; M.A. Simpson. *Theraputic uses of truth*. In: Wilkes, (ed.). **The Dying Patient**. Lancaster: MYP Press; 1982
[68] Good, Good, Schaffer, et al.:p.71
[69] Pang.p.252
[70] Pang.p.247

So we see two differences; the tension between harm and self-determination is balanced differently between the two cultures, and it seems that whilst there is a Western preference to be 'truthful,' there is a corresponding 'Eastern' value in protectiveness. These differences, however, are framed by an over-arching similarity – the great importance both cultures place on maintaining the hope of a patient.

The link between hope and truth in the West leads us to reflect on the concept of 'truth' and what it constitutes. Firstly, in deciding what 'telling the truth' is, there needs to be a perception that a piece of information is factually correct, as well as an assessment about the importance of the information to the patient. There is an obvious problem with the former perception, as the doctor's 'truth' *will only ever be what she has good reason to believe.* She has good reason to believe that Mr. Wong's cancer has reached a point where will cause his imminent death. There is of course the chance that he will survive the odds and live much past the 'expected' period. The question therefore arises whether the information that the doctor could offer is actually 'true' in the first sense of the word.

Secondly, the method of 'telling' may not actually impart the whole of this 'truth'. The expectations about how much of the 'truth' it is necessary to *explicitly* impart differs between cultures as well; in a recent Blackhall study, many Korean-Americans would want to know they had an incurable disease, but only in an *indirect* manner – never by being 'informed' in a Western sense.[71] Even in the West, it has been found that 'disclosing' a terminal prognosis for many doctors means talking in terms of a cancer not being curable.[72] In Mr. Wong's case, this would still avoid a key issue; the perceived 'right' to know the possible *imminence* of his death. This is the very fact that seems most relevant to him at this time. It is therefore questionable whether telling him 'the truth' would actually result in him knowing the very piece of information that was the motivation for telling in the first place.

[71] Blackhall, Frank, Murphy, et al.:p.67-9
[72] Gordon and Daugherty.

A further complication is the apparent conflation in some of the literature between what Chinese *families* or Chinese *people* believe or value, and what they want when they are *patients.* The literature mainly discusses the 'Chinese' philosophies or views without discussing the possible wishes of the Chinese patient. If we are at all concerned with respecting the autonomy of Mr. Wong, this point deserves considerable attention. In a 1996 study in Hong Kong, Fielding interviewed 1136 members of the population and found that 95% wanted information regarding diagnosis and prognosis even if it was 'bad' news.[73] Similarly, in a study in Japan, where it is accepted practice to inform a family member first of a diagnosis of cancer, 69.6% of participants responded that they would want to be told a diagnosis of cancer, whilst only 28.5% said that they would disclose a diagnosis to a family member.[74] Whilst there is little empirical data collected on the views of patients who are Chinese and living in Western countries, data such as that described above point to the potential for a significant difference between the view and values of a family versus those of an individual patient.[75]

Along with the conflation of a culture's values with those of the individual, there is an implicit assumption that the patient belongs in some kind of 'general Chinese' category, and not a 'general Western' category, or a 'Chinese philosophical' category. The discussion of the patient has focussed on empirical data collected from a variety of studies which elicited the *opinions* of Chinese people in China, Hong Kong, Singapore, the United States, and Australia. Whilst some of the 'doctor' discussion includes empirical information, or opinions, collected from health professionals, it is largely a more philosophical view that we are expecting the doctor

[73] R. Fielding and J. Hung. *Preferences for information and involvement in decisions during cancer care among a Hong Kong Chinese population*. **Psycho-Oncology** 1996;5(4)
[74] Orpett Long.p.36
[75] C. Tse, A. Chong and S. Fok. *Breaking bad news: A Chinese perspective*. **Palliative Medicine** 2003;17:p.339

to take; that which reflects views that are accepted within bioethical discourse. Whilst these are the likely positions of the parties in question, these are ultimately assumptions about which 'category' we are putting the doctor, the patient and the patient's family.

As Mr. Wong is part of a Chinese family living in Australia, the lines between these 'categories' become somewhat blurred by the process of enculturation. The extent of Mr. Wong's enculturation will naturally determine to what degree he has taken on 'Western values'. However, there is an indication that the degree of enculturation of Chinese people into 'mainstream' society may be low, especially if they speak no English. For example, one study conducted amongst Singaporean Chinese suggested that although the last two generations have been exposed to an English education system and so-called 'Western' beliefs about illness, most families in the study (15) avoided discussing illness to minimise disruption and stress.[76] That is, they held on to traditional values regarding medical information despite exposure to a more 'Western' way of thinking.

So although the disagreement initially appeared to be a clear-cut clash of values, the values of the two cultures may not be as different as first assumed. It is not clear whether autonomy requires the doctor to tell the truth, and not totally obvious what constitutes the truth in any case. The assumption earlier that whilst a Western view privileges autonomy, a Chinese view gives greater value to preventing harm doesn't seem to hold either. One assumption in the 'doctor' section was that truth-telling is the preferred option of the doctor; the limited empirical evidence suggests that although diagnosis is by and large disclosed, a terminal prognosis is a different matter all together[77]. Examining this difference leads us to the *similar* value that both cultures place on maintaining hope. It also needs to be remembered that whilst in the

[76] Ow and Katz.p.621
[77] Gordon and Daugherty.p.148

‘Chinese’ section I talked about purportedly ‘Chinese’ views, these views might best be seen as what people want for their families (as distinct from what they want for themselves). This is important because *Mr. Wong* is the patient, that is, the individual that the doctor is most concerned with when considering the problem.

We are left with a disagreement that no longer seems to be a simple black and white clash of Chinese versus Western values. However, the problem remains, and the doctor still needs to make a decision. The next section looks at some possible options and how to go about deciding between them.

CHAPTER 4: HOW SHOULD THE DOCTOR DECIDE?

4.1 – The Options

Now that the disagreement is in context, we can see that the opposing sides aren't quite as distinct as may have been originally assumed. However, we are still left with a disagreement, albeit less stark, and thus it remains to be considered what the doctor should do. To me, it seems that the doctor has roughly three options.[78]

1. The first would be to go ahead and tell Mr. Wong his prognosis through an interpreter. As Mr. Wong is an outpatient and is always accompanied by at least one member of his family, this may be very upsetting to the family at the time and afterwards, however, Mr. Wong would then know this important information about his body, and would be able to make autonomous choices and prepare for his death based upon that knowledge.
2. The second choice is to respect the family's wishes and say nothing to Mr. Wong, and let the family deal with the news in their own way. This would mean that Mr. Wong may die suddenly without warning and without any knowledge that it could happen. However, his family will encourage him to keep up hope; he will not become depressed and possibly die sooner because his doctor has 'given up on him'.
3. The third choice lies somewhere in between the other two options, and that is that the doctor could 'offer' the truth to Mr. Wong.[79] As Mr. Wong is constantly accompanied by his family and this option would also involve going around

[78] It could indeed be argued that there are more than three options available to the doctor, however it is beyond the scope of this paper to suggest every possible alternative. These are therefore provided to represent a reasonable range for discussion.
[79] This approach is outlined in detail in B. Freedman. *Offering truth: One ethical approach to the uninformed cancer patient*. **Archives of Internal Medicine** 1993;153:p.572-6

them and using an interpreter, the family may see this as inseparable from option one. However, it would give Mr. Wong a choice: whether to be told information about his illness and his prognosis or not. If he chooses not to know, it would in effect authorise his family to make decisions on his behalf, with regard the level of information they give him as well as preparing for his death.

On first appearances, it might seem that most people would instinctively choose option three. This may indeed be the best option for the doctor to take. My aim, however, is to examine the options within an ethical framework and find justification for a course or courses of action which goes deeper than intuition.

Firstly, in order to frame the problem, the doctor needs to take a position on how much weight to give values which are not a part of her culture. Does she dismiss them entirely? Does she simply consider them as different, with no way of comparing them to 'Western' values? If she thinks this, what other considerations are necessary to make a decision? Or does she think that some 'non-Western' values are worthy of moral consideration? If so, how should she decide on which values are important and how to weigh them up against her own?

One way of discussing this debate is to use the concepts of relativism and universalism. The options at the beginning of this chapter may appear to correlate directly with the ongoing philosophical debate between these two theories; the first option looks like a universalist position and the second looks like a relativist position, with option three somewhere in between the two. However, a more in-depth analysis shows that this attribution of the theories to these specific options is superficial, and that in fact other moral concerns may end up being more integral to the doctor's decision. I begin this analysis by a broad outline of the relativist/universalist debate.

4.2 - The great debate

The history of the idea of moral relativism dates back to the 5th century BC. Herodotus, whilst visiting the King of Persia, observed that whilst the Greeks cremated their dead, the Callatians, (an Indian tribe), ate their parents' dead bodies. Furthermore, each group reacted with horror when the other practice was suggested.[80] Based on these and other observations, Herodotus declared that "if all men were asked to name the best laws and customs, each would choose his own".[81] Over the centuries, as opportunities for travel and for exposure to many diverse cultures increased, much debate over the implications of seemingly 'different' moral systems has occurred. Many forms of relativism have emerged within philosophy, three of which are particularly pertinent to this paper. The first is *descriptive* relativism, which is the observation that different cultures have different moral codes.[82] *Meta-ethical* relativism is the theory that there is no one morality which is true or justified – there are lots of different ones. Two cultures may thus have two opposing statements about morality "*without either of them being wrong*."[83] *Normative* relativism holds that it is morally wrong to pass judgement on any such opposing statement, on grounds that it is outside one's own cultural understanding.[84] This is perhaps the most contentious of the three, as neither descriptive nor meta-ethical relativism logically require tolerance of any sort – and must in fact allow for intolerance. The existence of these different types of moral relativism easily leads to confusion in discussion. To avoid this, from here on when I talk about 'moral relativism,' it should be thought of as the *meta-ethical* variety.[85]

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[80] N. Levy. **Moral Relativism: A Short Introduction**. Oxford: Oneworld Publications; 2002; J. Rachels. **The Elements of Moral Mhilosophy** 3 ed. Boston: McGraw-Hill Companies; 1999
[81] G.B. Kerferd. **The Sophistic Movement**. Cambridge: Cambrigde University Press; 1981.p.105
[82] D. Wong. *Moral Relativism*. In: Craig, (ed.). **Routledge Encyclopaedia of Philosophy**. London: Routledge; 1998
[83] Levy.p.21
[84] Wong. *Moral Relativism*.p.442
[85] As this is a bioethics paper, I am obviously using *moral* relativism in my discussion. It should be noted however, that anthropology and bioethics can overlap in some areas. The extent to which

Modern day moral relativism needs to be distinguished from cultural relativism - the anthropological theory that emerged in the 1930s and 40s. Just as anthropology and moral philosophy are two very distinct disciplines, so the applications and implications of relativism as a concept are quite different.

Cultural relativism within anthropology emerged in response to the social Darwinist notion prevalent at the time that culture was an evolutionary process and the 'West' was the most developed culture in existence.[86] Cultural relativism thus rejected ethnocentrism, the "belief that one's own patterns of behaviour are always natural, good, beautiful or important, and that of strangers, to the extent that they live differently, live by savage, inhuman, disgusting, or irrational standards".[87] According to cultural relativism, the way we see the world is ultimately a product of our culture, and therefore any beliefs, values and social norms which govern our behaviour are first and foremost *cultural constructions*.[88] Given this, it is ridiculous for any society to claim "a monopoly on moral truth"[89] or credit any of their moral standards with universal validity, and a given belief or practice may only be understood relative to the cultural context within which it arises.

According to Lane and Rubinstein, the United States was ethnocentric and "profoundly xenophobic at the time that this theory arose."[90] In this historical context it was a theory that promoted tolerance and respect for diversity, by "insisting that

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anthropology/the social sciences should be considered in making ethical judgments has been a much-contested topic in the literature. Whilst some social scientists argue that any moral judgement we make must take into consideration the cultural context from whence our moral guidelines came, moral philosophers such as Nagel liken solving a moral problem using anthropological arguments to solving a mathematical problem without using mathematics. (T. Nagel. *Ethics*. In: Moser and Carson, editors. **Moral Relativism, a Reader**. Oxford: Oxford University Press; 2001) This is an interesting debate, but unfortunately beyond the scope of this paper to discuss further. See Weisz, (ed.) ; D. Callahan. *The social sciences and the task of bioethics*. **Daedalus** 1999;128(4); Turner.

[86] C. Baker. *Cultural relativism and cultural diversity: Implications for nursing practice*. **Advances in Nursing Science** 1997;20(1):p.4

[87] M. Harris. **Culture, People, Nature**. New York: Harper and Row; 1988.p.124

[88] J. Monaghan and P. Just. **Social and Cultural Anthropology: A Very Short Introduction**. New York: Oxford University Press; 2000.p.50

[89] Monaghan and Just.p.50

[90] Although it may be difficult to qualify this as a state of affairs which has significantly changed with regard to the United States, this should merely be considered as setting a context within which a push for tolerance in the form of relativism arose. S. Lane and R. Rubinstein. *Judging the other: Responding to traditional female genital surgeries*. **The Hastings Center Report** 1996;26(3):p.31

cultural values and beliefs have meaning and must be understood within the context of each culture"[91], and furthermore that different cultural patterns were "intrinsically as worthy of respect" as all others.[92] Following World War II, however, cultural relativism came under fire for its failure to provide a basis for condemnation of the Nazi regime, and has continued to be criticised for being seemingly incompatible with a basic human rights movement.[93]

Thus whilst anthropological relativism was a reaction to the ethnocentrism that pervaded research into lesser 'developed' societies, and may be a necessary position for a person observing or researching another culture, moral relativism is a part of the philosophical debate concerning whether there are universal values applicable over time and cultural groups, or whether the rights and obligations of a person are relative to the construction of morality that the person's culture has.

From the above discussion it emerges that there are two fundamental leaps in logic that anthropology makes which philosophy does not –

1. from the observation that different cultures have different moral codes (i.e. descriptive relativism) to the assumption that there are different and irreconcilable moral codes (meta-ethical relativism), and
2. that it is therefore *wrong* to make moral judgements about the practices of people who operate under a different cultural construction of morality (i.e. normative relativism).

The philosophical theory which opposes moral relativism is universalism, which holds that there are some moral values which apply to all cultures.[94] In a moral conflict these same values apply to both sides, but one side may have a better interpretation of these values than the other.[95] According to universalism, the mere

[91] Lane and Rubinstein.p.31
[92] Harris.p.125
[93] Baker. *Cultural relativism and cultural diversity: Implications for nursing practice*.p.4
[94] J. Tilley. *The problem for normative cultural relativism.* **Ratio Juris** 1998;11(3):p.273
[95] Levy.p.52-3

fact that we disagree about what these universal standards may be is not proof that they cannot exist. A universalist approach therefore states that

> some moral judgements are transculturally valid, where 'valid' means, not 'believed' or 'complied with', but something akin to 'true' or 'correct'.[96]

Critics of universalism argue that it is either too general/ too abstract to be of any use in specific cases, or that the principles prescribed by the theory are too 'uniformly binding'.[97] Another criticism of the theory is the problem of who identify these universal values, or mediate debates using "universals," without being subject to obvious cultural biases.

One focus of the debate within philosophical literature over whether relativism could be true has been the issue of 'female circumcision' in North African countries.[98] The conclusion people arrive at seems to be heavily dependant upon which definition of relativism they have chosen to defend, or, if criticising it, upon the theory they would propose in its place. Proponents of moral relativism tend to compare it to absolutism rather than universalism, citing examples of where a specific absolute rule is inappropriate to judge a different culture.[99] Critics of relativism tend to point to extreme examples and argue that a line has to be drawn somewhere, and that relativism does not allow for this. A defender of relativism may argue that all

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[96] Tilley.p.273

[97] O. O'Neill. *Universalism in Ethics*. In: Craig, (ed.). **Routledge Encyclopaedia of Philosophy**. London: Routledge; 1998; D. Callahan. *Universalism and particularism: Fighting to a draw*. **Hastings Center Report** 2000;30(1):p.41

[98] See Lane and Rubinstein.; R. Macklin. **Against Relativism**. New York: Oxford University Press; 1999; Baker. *Cultural relativism and cultural diversity: Implications for nursing practice*.; R. Macklin. *Ethical relativism in a multicultural society*. **Kennedy Institute of Ethics Journal** 1998;8(1) One difference between these cases and the case of Mr. Wong is that the harm or pain in the female circumcision examples is much more *tangible* and we know with all certainty that it will occur. In Mr. Wong's case, the doctor is not sure which action will result in the most harm for him. She has a theoretical notion that depriving him of the 'truth' is harmful, but is afraid that he will be upset if she tells him of his prognosis. The situation is only made more complicated by the prospect of greatly upsetting Mr. Wong's family if the doctor chooses option one or three.

[99] It is quite a common mistake to assume that anyone who rejects relativism must be an absolutist. See Macklin. **Against Relativism**.p.5. For a clarification of the distinction between moral absolutism and universalism, see Macklin. **Against Relativism**.p.43, or M. Brannigan. *Cultural diversity and the case against ethical relativism*. **Health Care Analysis** 2000;8(3):p.322

criticisms are aimed at an extreme view of relativism, and that a more moderate position could "recognise that adequate moralities must promote the production of persons capable of considering the interests of others."[100] This, however, seems to draw on some kind of universal claim akin to tolerance, or perhaps something like the principle of non-maleficence.

Another problem with ethical relativism seems to be the implicit assumption that moral judgements and cultural norms are inextricably linked. That is, there is no way of separating popular opinion from 'good' or 'right'. That our practices can sometimes change under moral criticism means simply that - they have *changed*; one cannot say that they are better or worse without appealing to some form of universal code.

There is also disagreement in the literature over which view, if any, supports the virtue of tolerance. Tolerance can be defined as "a willingness to allow freedom of thought and action to others even when their opinions and conduct seem wrong".[101] Relativists argue that once someone takes the view that some things are true for one group of people, and different things true for others, it is natural to conclude that to avoid imposing one culture's morals on another, tolerance is the only answer. Whilst tolerance is therefore often seen to be a *consequence* of relativism, in fact relativism cannot logically require it.

It may be clear from the above discussion that I support a version of universalism. However, I would also argue that relativism has some important messages which should not be ignored. Hatch argues that it is important to keep in mind the legacy of the original anthropologists, who rejected the imperialistic, moral highground approach assumed by the West to less 'developed' societies.[102] Although it logically cannot *require* tolerance or interest in other cultures, the nature of a relativist stance may nevertheless *allow* for a more open-minded approach to cultural

[100] D. Wong. *Relativism.* In: Singer, (ed.). **A Companion to Ethics**. Oxford: Blackwell Publishers; 1997.p.446
[101] M. Prezelecki. *What does it mean to be tolerant in moral issues?* **Philosophica** 2000;66(2):p.57
[102] E. Hatch. *The good side of relativism.* **Journal of Anthropological Research** 1997;53:p.372

difference. I think it is also important to have an awareness that bioethics has developed within a specific culture at a specific time, and to be conscious that culture can influence our judgments.

However, the point of this discussion is not to explore my particular views. Different doctors will have different explanations for the many contrasting versions of morality. I am interested in looking at the implications of whichever theories they support. I will therefore explore the consequences of the doctor in this scenario accepting relativism, or accepting universalism. I will argue that, upon examination, whether or not the doctor accepts relativism is actually not the most important factor in making a decision.

4.3 - Implications of taking Relativist and Universalist Stances

This section will look firstly at the implications of the doctor taking a relativist stance, and then those of her accepting universalism.

One of the most important outcomes of adopting a relativist stance when it comes to the case of Mr. Wong is that it does not produce an answer. It does not allow for ethical imperialism; for imposing one's views upon others, but in the same way it cannot support simply adopting the 'other' view – according to relativism, neither is right, they are just different. If they are merely different, the doctor needs to find something else as a basis for her decision. Any argument basing a decision on, for example, achieving 'the least harm' would seem to rest on some kind of universal notion of harm, which is incompatible with a relativist position.

Having reached this point, one concept which may provide a basis for a decision is that of *integrity.* There are various accounts of what integrity is and why it is seen to have moral value. In general, it is seen as "the disposition to act in accordance with one's own moral beliefs and character."[103] Another way of expressing this same idea is in terms of a person being true to their own moral 'commitments'.[104] It is *not* claiming that one's views are more morally justified, or in any way represent a higher moral truth, but rather the commitment to do what one *believes* is morally justified, or has positive moral value.[105] This is an important distinction to make here, since if the doctor is adopting a relativist position she is necessarily rejecting the possibility of any universal values.

To continue the account, a person with integrity does not simply adhere to their own moral values with no further reflection on their validity. Most accounts of integrity also involve the recognition that one's values could be mistaken, and that

[103] This is the definition given in: N. Jecker, R. Carrese and R. Pearlman. *Caring for patients in cross-cultural settings*. **Hastings Center Report** 1995;25(1):p.8
[104] This concept of commitments is used, for example, by Halfon and Blustein; see M. Halfon. **Integrity: A Philosophical Inquiry**. Philadelphia: Temple University Press; 1989, and J. Blustein. **Care and Commitment: Taking the Personal Point of View**. Oxford: Oxford University Press; 1991
[105] This distinction is made by Halfon, p.134

they therefore require ongoing critical examination and modification where new evidence or viewpoints are considered and accepted.[106] It is thus generally accepted that a person's commitments can change over the course of their life without that person losing their integrity, as long as the changes reflect careful re-assessment of their ideals.[107] This is distinguished from a person *compromising* their values, which according to Halfon signifies a *loss* of integrity.[108] For the doctor in this scenario, careful examination of issues raised in chapter three, for example, careful formulation of the account of autonomy she herself supports, could lead to alterations of some of her values without a loss of integrity. Indeed, such reflection by her, and being prepared to modify her interpretation or weighting of her values if there seemed to be good reason, seems to be required for the maintenance of her integrity.

Another important characteristic of integrity, and a reason why it is applicable in this case, is that although it gives moral value to one who acts in accordance with their values, in no way does it specify what these values should be. It is thus possible for two people in the same situation to act differently but still both act with integrity. This feature of integrity has been criticised because it ascribes moral worth to morally wrong actions, as long as they are carried out with the *belief* that they are right. However, in a cross-cultural scenario, it is a concept that provides for a range of different moral perspectives without labelling them comparatively 'right' or 'wrong',[109] and thus allows for the possibility that each party may be acting in a morally justified way, even though they are acting differently.

In bioethical literature, integrity has mainly been discussed in relation to conscientious objection, for example, Catholic physicians who will not perform a

[106] See Jecker, Carrese and Pearlman.p.8, Halfon.p.61
[107] Jecker, Carrese and Pearlman.p.8
[108] Halfon.p.9
[109] Jecker, Carrese and Pearlman.p.8

requested abortion.[110] Although some cross-cultural literature discusses integrity, for the most part it is not mentioned, and I would suggest that it warrants more exploration as a helpful concept when dealing with culture-derived value disagreements.

In this case, the doctor may decide that even though both sides of the disagreement may be 'right,' it is ultimately her who is making the decision about how she should act. Since she cannot choose from any objective standpoint she is left with the fact that her values are *hers*, and going against them is compromising her integrity. An important question here is whether integrity is a *sufficient* basis for a decision. However, given that a relativist view does not give a basis for any substantive decision, it may be the only factor which could conceivably lead to a decision.

In this case, a decision based on integrity could lead to any of the three options. Option one would be implicated if the doctor accepts an account of autonomy that obligates people to know information about themselves. If the doctor believes that the potential harm for Mr. Wong outweighs the perceived autonomy the knowledge would give him, option two should be chosen. The third option would be appropriate if the doctor accepts an account of autonomy which is closer to that of Beauchamp and Childress, and believes that Mr. Wong should be able to choose the level of information he receives.

Perhaps surprisingly, it also turns out that the doctor taking a universalist stance may also have good reasons to decide on any of the three options. If the doctor takes a universalist view, it does not automatically mean she must impose the 'truth' on the patient. As I have discussed, autonomy does not equal 'telling', even if the doctor thinks that respect for autonomy should be a universal principle. Furthermore,

[110] M. Wicclair. *Conscientious objection in medicine*. **Bioethics** 2000;14(3), J. Blustein and A. Fleischman. *The pro-life maternal-fetal physician: A problem of integrity*. **The Hastings Center Report** 1995;25(1)

should she decide that autonomy *is* universal, it does not mean that it is *absolute*, but that other considerations, for example, harm from a loss of hope, may be more important in a particular case.

Looking back at chapters two and three, a greater understanding of some of the issues around the potential impact of truth-telling may cause the doctor to re-assess the degree of harm it might cause Mr. Wong, and how it weighs against autonomy. She may also become more aware (if she is not already) of the nuances involved in telling diagnosis versus prognosis, which may influence a decision based on autonomy as a universal notion.

She could then choose either option one or option three, depending again on the account of autonomy she believes is correct, and potentially she could also choose option two, if she believes that a universal concept of harm in this case outweighs that of autonomy.[111]

[111]Macklin argues that the most important factor in deciding whether one is morally required to disclose information is not cultural tradition, but the "*patients wish* to communicate with the physician, to leave communications to the family, or somewhere in between". This stance may be the one which appeals to the majority of Australian health professionals, and is consistent with a view that the type of autonomy advanced by Beauchamp and Childress is something close to a universal value, and should be upheld regardless of a person's cultural background. See: Macklin. *Ethical relativism in a multicultural society*.p.5

4.4 - Summary

In summary, I have found that the same decision may be arrived at regardless of whether the doctor adopts a relativist or a universalist outlook. So actual cultural difference, although that is the banner we present these problems under, may not be the most important factor in these scenarios. Consider, for example, a doctor who agrees with Rhodes – that every patient has an obligation to be autonomous and therefore know information about themselves. This would not only have implications for people of a family-oriented cultural background in Mr. Wong's situation, but also for any patient who explicitly asked not to be told a diagnosis or prognosis, regardless of their cultural heritage. We therefore need to look at the particular variables within these frameworks which may sway the doctor a certain way. It seems that in this scenario the most important factors are the doctor's individual view of what constitutes respect for autonomy; especially whether it mandates telling Mr. Wong his prognosis. For the relativist doctor it also matters whether she thinks that professional or personal integrity is a solid enough basis to justify acting on her own beliefs, not because they are more 'correct', but simply because they are her own. If she doesn't, she will need to find another basis for a decision, but I would suggest that any other reason found will have some kind of a universal basis and thus be inconsistent with the original relativist position. So even if integrity seems rather a weak basis for coming to a decision, it may be the only one available to the relativist doctor. But then the relativist is back in the same position as the universalist, trying to carefully interpret the principles she believes in, and judge their relative weight when they come into conflict.

CHAPTER 6: CONCLUSION

In this paper I have outlined a possible way for a doctor to approach a scenario in which she is requested on the grounds of cultural difference to withhold information from a patient. I have discussed the possible positions of the doctor and of the patient's family, and then explored the reasons that these positions may not be so distinctly different, and may have more in common than they first appear. Using the universalism versus relativism debate, which is often employed in disagreements that appear to be culture-based, I have shown that a stance on this issue alone does not direct any specific course of action, and that in this case the doctor's views regarding a specific account of autonomy and the importance of integrity are far more important in eventually coming to a decision. I have argued that if the doctor takes a relativist view, this alone does not direct her to any of the three options, and suggest integrity as a useful concept for reaching a decision.

An implication of my argument may be that any subsequent 'resolution' of the relativism debate will not necessarily help in resolving these individual disputes. Cross-cultural disagreements should therefore not simply be looked at in terms of the 'relativistic' or 'universalist' options, but also examine other moral factors in a given situation which are important in actually making a decision. I would also suggest that integrity is far more important than its use in the current cross-cultural medical literature would suggest, and worth exploring further in the context of other cross-cultural value disagreements. It is not generally the subject of much consideration in medical training at present. Although it should perhaps receive more attention, care would need to be taken not to inadvertently give the impression that stubbornly sticking to one's values constitutes integrity, and the nuances of the version I have outlined here would need to be emphasised and promoted.

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