

# Addressing cultural diversity in health ethics education

Final Report 2013

The University of Melbourne (Lead institution)  
University of Queensland  
La Trobe University

Project leader:

Dr Giuliana Fuscaldo, The University of Melbourne  
and Victoria Institute, Victoria University

Team Members:

Dr Sarah Russell, Research Matters  
Associate Professor Lynn Gillam, The University of Melbourne  
Dr Clare Delany, The University of Melbourne  
Professor Malcolm Parker, The University of Queensland  
Dr Greg Murphy, La Trobe University  
Mr Paul Stewart, The University of Melbourne  
Professor Marilys Guillemin, The University of Melbourne  
Ms Georgina Hall, The University of Melbourne

Report authors:

Giuliana Fuscaldo  
Lynn Gillam  
Clare Delany  
Malcolm Parker

Weblink:

[http://chs.unimelb.edu.au/programs/ethics\\_in\\_human\\_research\\_practice/projects/addressing\\_cultural\\_diversity\\_in\\_health\\_ethics\\_education](http://chs.unimelb.edu.au/programs/ethics_in_human_research_practice/projects/addressing_cultural_diversity_in_health_ethics_education)

Support for the production of this report has been provided by the Australian Government Office for Learning and Teaching. The views expressed in this report do not necessarily reflect the views of the Australian Government Office for Learning and Teaching.



With the exception of the Commonwealth Coat of Arms, and where otherwise noted, all material presented in this document is provided under Creative Commons Attribution-ShareAlike 3.0 Unported License (<http://creativecommons.org/licenses/by-sa/3.0/>).

The details of the relevant licence conditions are available on the Creative Commons website (accessible using the links provided) as is the full legal code for the Creative Commons Attribution-ShareAlike 3.0 Unported License (<http://creativecommons.org/licenses/by-sa/3.0/legalcode>).

Requests and inquiries concerning these rights should be addressed to:

Office for Learning and Teaching  
Department of Industry, Innovation, Climate Change, Science, Research and Tertiary  
Education

GPO Box 9880  
Location code N255EL10  
Sydney NSW 2001

[learningandteaching@deewr.gov.au](mailto:learningandteaching@deewr.gov.au)

2013

ISBN 978-1-921916-81-6 print  
ISBN 978-1-921916-82-3 online

## Acknowledgements

We offer our thanks to our colleagues and to the health professionals and students who participated in this project. Their interest and willingness to share their experiences and ideas about health ethics education provided valuable insights and made a rich contribution to our work.

We acknowledge The Victoria Institute for Education, Diversity & Lifelong Learning at Victoria University (The Victoria Institute) which, although not a project partner, generously supported writing of this report.

We would also like to thank the Australian Government Office for Learning and Teaching for its staff's collegial support and also for financial support. We found the workshops for project managers and leaders particularly useful and have appreciated the friendly support offered by the project administrators.

The preparation of this report was also supported through the Australian Government's Collaborative Research Networks (CRN) program.

## Executive summary

**Introduction:** Current health ethics curricula in many national and international universities are based on ‘western’ developed bioethics frameworks such as the ‘four principles’ approach or ‘principlism’. However, there is significant debate about the universality and neutrality of this pedagogical framework. Some health ethics educators question the notion of universal truths and some claim that Western bioethics largely ignores the diversity of multiple cultural and religious traditions. A frequent criticism is that Western bioethics is based on American ideals such as the importance of individual rights and self-determination.

**Aim:** The aim of this project was to develop pedagogy and teaching materials for health ethics education that address cultural diversity and are applicable to health care situations across a broad range of cultural contexts.

The project comprised two stages:

- Stage 1: broad consultation with key stakeholders via questionnaires, including
- health ethics educators in Australian and international universities;
  - early career health professionals; and
  - local and international students in medicine, nursing and allied health.

These consultations together with a review of the literature and current thinking, informed

Stage 2: the development of a pedagogical framework and teaching materials.

**Key Findings:** Our findings from consultations with stakeholders can be summarised as follows:

- In the practice of teaching, there is much more agreement about universal principles than has been suggested in literature.
- The way principles are adopted is not always sensitive to cultural norms.

In addition our survey results clearly indicate a desire amongst both students and educators to be respectful of cultural differences. One of the most significant findings from our consultations was that:

- educators, practitioners and students expressed uncertainty, caution and sensitivity about how to approach or resolve ethical issues that arise when health care involves culturally divergent approaches, beliefs and values.

The theoretical debate over the cross-cultural application of universal approaches to health ethics (such as principlism) is frequently couched as a tension between the acceptance of *either* universal values *or* cultural norms. However, our consultations suggest that:

- acceptance of universal values is not necessarily incompatible with respect for cultural norms; and
- a significant source of tension for health practitioners, students and educators is not *whether* to, but rather, understanding *how* to, mediate between agreed-upon universal values and culturally specific norms.

Our consultations also suggest that:

- many educators and students would find it helpful to have a framework to assist them to negotiate between abstract principles and particular cultural contexts.

**Our teaching framework:** Based on our stakeholder consultations and our review of the current literature, we have developed a novel approach to health ethics education. Our approach draws on the work of Benatar and aims to teach students to negotiate culturally based differences in values through a ‘moral partnership’.

Our pedagogical approach requires that cultural difference in values should be *addressed*, not automatically either rejected or accepted. Analysis should aim to arrive at a *middle ground* from both a top-down and bottom-up approach, where important cultural contexts are acknowledged and overarching universal values are respected. This middle ground reflects a fundamental belief that we are more alike than different and that cultural norms are not incompatible with universal principles.

This involves

- teaching health practitioners to learn to identify and reflect on their values and those of their patients; and
- teaching health practitioners to negotiate from shared values.

Our approach acknowledges that culture is not static and avoids cultural stereotypes. The pedagogical framework that we have developed is consistent with influential scholarship such as Macklin’s approach, Nie’s interpretive bioethics and Benatar’s reasoned contextual universalism.

**Outcomes:** Our project has:

1. documented and reviewed approaches to health ethics education;
2. analysed issues in cross-cultural health ethics relevant to health practice;
3. identified ethical tensions that students and practitioners experience in their clinical encounters;
4. developed a philosophical approach to health ethics pedagogy that addresses culturally-based differences in values;
5. developed health ethics teaching materials, including case studies and scenarios that draw from culturally diverse clinical experiences (our new teaching modules); and
6. established a website and discussion forum to disseminate and share resources and to engage colleagues in a health ethics network for ongoing curriculum development.

Our new teaching modules for *Ethical Decision-making as Moral Partners* are provided at Chapter 7 of this report, and also available via the project’s weblink.

This report and other details about our project outcomes can be found at [http://chs.unimelb.edu.au/programs/ethics\\_in\\_human\\_research\\_practice/projects/addressing\\_cultural\\_diversity\\_in\\_health\\_ethics\\_education](http://chs.unimelb.edu.au/programs/ethics_in_human_research_practice/projects/addressing_cultural_diversity_in_health_ethics_education)

## Table of Contents

Acknowledgements.....	3
Executive summary.....	4
Chapter 1 Introduction to the Project .....	8
1.1 The project team .....	8
1.2 Overview.....	10
1.3 The project aims and rationale.....	10
1.4 Project background .....	11
Chapter 2 The Project Plan .....	16
2.1 Consultations.....	16
2.2 Developing pedagogy and teaching materials .....	18
Chapter 3 Consultations with Health Ethics Educators .....	19
3.1 Findings from consultations with health ethics educators .....	20
3.2 Take home messages for health ethics education .....	34
Chapter 4 Consultations with Early Career Practitioners .....	36
4.1 Findings from consultations with early career practitioners (ECPs) .....	38
4.2 Take home messages for health ethics education .....	44
Chapter 5 Consultations with Students in Health Professions .....	46
Introduction.....	46
5.1 Findings from consultations with students in health professions .....	47
5.2 Take home messages for health ethics education .....	69
Chapter 6 Developing a New Health Ethics Pedagogy .....	71
6.1 What is the problem? .....	71
6.2 Principlism is too rigid .....	72
6.3 A flexible approach .....	73
6.4 Finding a middle position .....	75
Chapter 7 Teaching Module.....	83
Introduction.....	83
Teaching materials .....	84

Chapter 8 Project Dissemination .....	123
Overview.....	123
8.1 World Bioethics Congress.....	123
8.2 11th World Bioethics Congress .....	125
8.3 10th Interdisciplinary Conference, Communication, Medicine and Ethics.....	126
8.4 UNESCO Chair in Bioethics: 8th International Conference on Bioethics Education Contents, Methods, Trends.....	128
Chapter 9 Project Evaluation .....	130
Chapter 10 The Project Continues.....	135
References .....	136
Appendix .....	138

# Chapter 1 Introduction to the Project

## 1.1 The project team

**Dr Giuliana Fuscaldo**, The University of Melbourne and Victoria Institute, Victoria University  
Giuliana is a Research Fellow at The Victoria Institute for Education, Diversity and Lifelong Learning at Victoria University. Prior to joining The Victoria Institute, Giuliana taught health ethics at the University of Melbourne and Monash University.

Giuliana's research projects and publications are focused on ethical issues in health and society, ethical conduct of research, cross-cultural ethics and more recently on the ethical challenges related to education. In her role at The Victoria Institute, Giuliana is focusing on inclusive education and the challenge of ensuring that education is meaningful and rewarding for students and educators from increasingly diverse cultural backgrounds.

**Associate Professor Lynn Gillam**, The University of Melbourne

Lynn Gillam is an ethicist with particular interests in clinical ethics, research ethics and ethics education. Lynn is Associate Professor in Health Ethics at the Centre for Health and Society, in the Melbourne School of Population and Global Health, where she teaches health ethics. Lynn also has an appointment at the Royal Children's Hospital, where she is the Clinical Ethicist and Academic Director of the Children's Bioethics Centre, an initiative of the Royal Children's Hospital, in partnership with the Murdoch Children's Research Institute and the University of Melbourne.

Lynn's current research interests include pre-natal diagnosis; ethical decision-making and the role of trust in research ethics; end-of-life decision-making in paediatrics; and controversial medical treatments in paediatrics, in particular, treatment of disorders of sex development. She also has a strong interest in the intersections between ethics and sociology, and the development of inter-disciplinary qualitative methods suitable for research in ethics.

**Associate Professor Clare Delany**, The University of Melbourne

Clare Delany lectures in ethics, law and qualitative research methods at the Department of Physiotherapy, The University of Melbourne, and is a Clinical Ethics Fellow in the Children's Bioethics Centre, The Royal Children's Hospital. Clare's research and teaching interests include examining the nature and scope of clinical ethical decision-making for physiotherapists and other allied health practitioners. Clare has developed a particular interest in narrative ethics as an approach to ethics education in clinical settings.

**Professor Malcolm Parker**, University of Queensland

Malcolm Parker is Associate Professor of Medical Ethics in the School of Medicine, The University of Queensland (UQ), and teaches ethics, law and professional issues in the Bachelor of Medicine and Surgery (MBBS) program. He has qualifications in medicine, philosophy and health law, and was in general medical practice for over thirty years. He is the current president of the Australasian Association of Bioethics and Health Law, and is a member of the editorial boards of four journals in bioethics, medical law and medical

education. He has published nationally and internationally in philosophy of medicine, bioethics, medical ethics, health law, and medical education. His current research interests include medical professionalism and regulation, the regulation of complementary medicine, education in medical professionalism, ethics and law at the end-of-life, the bioethics–law interface, and methodology in bioethics.

**Professor Greg Murphy**, La Trobe University

Greg Murphy is the coordinator of the Professional Doctorate Program, Professor in the Faculty of Health Sciences, School of Public Health and Human Biosciences He has a long-standing interest in the application of psychology to such diverse fields as those of work, rehabilitation, management, education and sport. His research interests include vocational rehabilitation following serious physical impairment, job attitudes of nurses, and consumer satisfaction with a health service provider.

**Professor Marilys Guillemain**, The University of Melbourne

Marilys Guillemain is the Director of the Centre for Health and Society. Marilys teaches postgraduate subjects in qualitative research design and research methods, and health ethics. Marilys is a sociologist of health and illness. She has published widely in the areas of sociology of health, illness and technology, innovative research methodologies, research practice, narrative ethics, and ethical practice in research and in health care. She has completed a number of key research projects that include the management of menopause within specialised clinic settings; mid-age women and heart disease, particularly focusing on women's understanding of risk and prevention of heart disease; deafness and genetic testing; and research on how ethics committee members and health researchers understand research ethics and how they address ethical issues in practice. She is the author (with Lynn Gillam) of *Telling Moments: Everyday ethics in health care* (2006). Her current research focuses on the role of trust in human research from the perspectives of researchers and research participants.

**Mr Paul Stewart**, The University of Melbourne

Paul Stewart is a Taungurong man from Central Victoria, who has 10 years experience working in Aboriginal Community Organisations. Paul commenced with Onemda at The University of Melbourne in April 2002. Previously, Paul worked with the Aborigines Advancement League and the Victorian Aboriginal Health Service. Paul has a Graduate Diploma in Indigenous Health Promotion (University of Sydney) and a Master of Public Health (Deakin University).

Paul's research focuses on health research methodologies and ethics in Aboriginal Communities.

**Dr Sarah Russell**, Research Matters, Fitzroy, Victoria

Sarah Russell is the principal researcher of Research Matters and has completed many projects in the field of public health. Her research interests focus on consumer experiences of health and illness. Sarah has published numerous academic articles, community articles, government reports and frequently writes letters to and opinion pieces for newspapers. A lifelong journey: staying well with manic depression/bipolar disorder, is her first book.

**Ms Georgina Hall**, The University of Melbourne

Georgina Hall is a PhD candidate at The University of Melbourne and a Research Associate at the Children's Bioethics Centre, The Royal Children's Hospital. Her research interests include ethical issues arising from advances in reproductive technologies. She previously worked as journalist in both radio and print media in the Middle East, London and Melbourne. In this role, Georgina endeavoured to stimulate, inform and reflect public debate on issues ranging from end-of-life decisions to reproductive autonomy, organ transplantation across borders, embryonic stem cell research and pre-implantation genetic diagnosis (PGD). She established and writes and edits the monthly MelBERN newsletter for colleagues interested in the field of bioethics in Melbourne.

## 1.2 Overview

Health ethics is a compulsory requirement for the accreditation of medical and allied health curricula and its application is particularly sensitive to cultural context. However, to date, little attention has been paid to the complexities of teaching health ethics in culturally diverse contexts or to student populations with increasingly diverse experiences and backgrounds.

The aim of this project was to develop a pedagogy and teaching materials for health ethics education that address cultural diversity and are applicable to health care situations across a broad range of cultural contexts.

Current health ethics curricula in Australian universities are based on western-developed bioethics frameworks. However, there are concerns about the appropriateness of delivering a homogenous western-developed health ethics education to students who come from, or will practise in, non-western settings. Our project addressed these concerns explicitly. We engaged our national and international colleagues in the debate about the appropriateness of western-developed medical ethics in diverse contexts and have developed a cross-cultural approach to health ethics education that is informed by the insights, experiences and needs of both health ethics educators and health profession students.

We believe that our teaching framework can enhance teaching and learning in health ethics by providing a pedagogy and teaching materials that are responsive to the increasing cultural diversity of student cohorts. The project outcomes include a practical health ethics module that addresses cultural diversity and is relevant across a range of health disciplines (medicine, nursing, allied health) and teaching contexts (urban, rural, international). The outcomes of this project are also applicable to other non-health-related disciplines.

## 1.3 The project aims and rationale

It is important that health ethics teaching is relevant and up-to-date, that it is taught in a culturally informed and meaningful way, and reflects student needs. However, there has not been national curriculum development in health ethics since the formulation of the National Medical Ethics Consensus Curriculum in 2001 (Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools, 2001).

Health ethics curricula have not kept pace with many recent developments, notably:

- increasing cultural diversity of student populations;
- the diversity of contexts in which health ethics education is delivered;
- the greater numbers of international students enrolled in medicine, nursing and allied health;
- the internationalisation of health care practice;
- the ever-increasing diversity in patient populations;
- the increased focus on interdisciplinary health care practice; and
- policies that address inequities in Indigenous education and health.

Our project is timely and relevant in the current Australian context for the following reasons. Firstly, course accreditation for health professional degrees requires graduates to be able to work effectively in diverse cultural contexts. For example, the Australian Medical Council guidelines for the assessment and accreditation of medical schools (2006) state that medical graduates “must be able to work effectively, competently and safely in a diversity of cultural environments including a diversity of Indigenous health environments” (p. 1). These guidelines also state that “doctors must be aware of the impact of their own culture and cultural values on the delivery of services” (p. 1).

Secondly, the increasingly global nature of health education entails that cultural diversity is the norm, and not the exception. Finally, there is increasing emphasis on evidence-based teaching. However, currently there is a lack of evidence to support the curriculum content and methods of teaching of health ethics to culturally diverse students.

The project aims were to:

1. document approaches to health ethics teaching and the extent to which current curricula accommodate cultural diversity;
2. identify ethical tensions that students encounter in their clinical placements;
3. develop a philosophical approach to health ethics pedagogy that addresses culturally-based differences in values (i.e. a cross-culturally informed health ethics curricula framework); and
4. develop health ethics teaching materials, including case studies and scenarios that draw from culturally diverse clinical experiences.

## 1.4 Project background

### Culturally based differences in values

Consider the following scenario:

An international medical student from Malaysia experiences her first clinical placement in Melbourne. In her ethics classes she was taught that it is important to respect patients’ autonomy. On her clinical placement she finds it challenging when a Malaysian family requests that the doctors conceal the diagnosis of a terminal illness from their elderly father. The student is aware that it might be acceptable to respect this request in a hospital in her own country. She is also aware that there are

guidelines and ethical principles in Australia that require patients to be told the truth about their health status.

This scenario results in a tension between the ethical principles that the student has been taught, her own culturally based values and an obligation to respect pluralism. This scenario illustrates an example of what we refer as “culturally based differences in values”. We use this term as an ‘umbrella term’ throughout this report to acknowledge that cultural background is an important influence on health values, practice and decision-making. However, we also acknowledge that people’s values, beliefs and practices are not solely based on their cultural background and that cultural diversity is more than simply geographical diversity. Further, cultural values and practices are dynamic and continuously evolving.

In our work we make a clear distinction between ‘cultural competence’ or ‘cultural sensitivity’ and ‘negotiation of culturally based differences in values’. While cultural sensitivity and cultural competence are mandatory requirements and a national priority in health care (National Health and Medical Research Council 2005), we argue (as does Paasche-Orlow 2004) that ethical practice requires more than merely ‘following the rules’. It requires an understanding of the ethical implications of different cultural practices and critical reflection about their justification.

In some cases, respecting and accommodating cultural norms may require negotiation with other deeply held commitments to avoid moral tension. For example, a Muslim nursing student undertaking a clinical placement in a women’s hospital may find it morally distressing to support patients prior to their pregnancy terminations. Similarly, some health professionals may find it difficult to accommodate Jewish parents’ request to circumcise their son.

This project, and the curriculum material that we have developed, aims to teach students to identify the impact of ‘culture’ on health values, and provide them with strategies for negotiating culturally based differences in values.

## Current approaches to health ethics education

Health professional education in Australia is expected to teach students to be both culturally competent and to have a commitment to ethical practice. These requirements are reflected in medical, nursing and allied health curricula and professional guidelines. The principles that underpin health ethics curricula in Australia are drawn from western-developed bioethics frameworks. Key elements of these frameworks include teaching students to respect patients’ decisions, to ensure informed consent and to respect privacy.

Arguably the most prominent example of a western ethical framework is the ‘four principles’ approach or ‘principlism’ as described by contemporary moral philosophers Beauchamp and Childress (1979). Australian ethics curricula are largely based on principlism. Principlism was put forward as a simple, accessible, and culturally neutral approach to teaching ethical issues in health care (Beauchamp and Childress 1979). It is based on the claim that shared moral understandings are commonly recognised and

understood across all cultures. However, there is significant debate about the universality and neutrality of this pedagogical framework. Some health ethics educators, including some members of our project team, question the notion of universal truths and some claim that Western bioethics largely ignores the diversity of multiple cultural and religious traditions. A frequent criticism is that Western bioethics is based on American ideals such as the importance of individual rights and self-determination (reviewed in Hongladarom 2008).

Some scholars argue that Asian bioethics is essentially different from American and European approaches. They propose a distinctive 'Asian ethos', characterised by concern for holistic wellbeing and the welfare of groups and communities (Fan 1997; Sakamoto 1999; Qiu 2004). Some of these scholars argue that a moral framework based on Asian traditions is more suitable to the demands of Asian societies. According to Qiu, universalistic approaches to bioethics should be rejected. He has described the domination of bioethics by American approaches as a type of Western 'ethical imperialism' on developing countries (Qiu 2004).

Some European scholars have also criticised the emphasis that American bioethics places on patient autonomy as the central value. They argue that this is foreign to many European and non-European cultures and that alternative understanding of doctor–patient relationships based on notions of community and relationships are important (Justo and Villarreal 2003; Veatch 2000).

Conversely, some academics reject the notion of distinctive European, Asian or African bioethics and caution against dichotomy in cross-cultural studies (Nie 2007; Hongladarom 2008; Kim 2005). It is claimed that the widely accepted generalisations of Western-individualistic and Eastern-communitarian bioethics overly simplify or ignore the variation within cultures. Nie argues that neither Chinese nor American bioethics are fields with single perspectives. He points out that Chinese medical morality is neither static nor monolithic, but a combination of Maoism-Marxism-Leninism, Confucianism, Taoism and Buddhism. Nie (2007, 2000) also argues that while principlism has dominated American bioethics, there is also a substantial following of communitarian perspectives.

In defence of the four principles approach, Gillon (2003) argues that this framework is neither an attempt at moral imperialism nor an attempt to impose a regimented method of applying ethics. He argues that this framework accommodates cultural difference and reflects common and shared *prima facie* values.

These debates are more than just theoretically interesting. They have important practical implications for teaching health ethics, effective learning and patient health outcomes. Ignoring culturally based approaches to health ethics risks alienating students, teaching and delivering ethnocentric health care, and accusations of moral imperialism.

Our project acknowledges the current theoretical debates in health ethics and has developed a theoretically rigorous health ethics curriculum that accommodates these concerns, and is relevant to culturally diverse students.

## Health ethics education: theory in practice

Our previous project in Malaysia demonstrated some of the difficulties of accommodating or justifying some non-western cultural practices within a western ethical framework (Fuscaldo, Russell and Delany 2009). We investigated the impact of 'western-developed' medical ethics teaching on the learning of forty medical students in Malaysia. These students predominantly identified as Malaysian, Indian or Chinese. We examined the cultural relevance and appropriateness of the western-developed medical ethics curricula, and the impact of their ethics education during clinical placement.

Our findings indicated that students experienced some difficulties when translating western health ethics into their clinical practice. They described contradictions between the ethical theories that they had been taught and the accepted day-to-day Malaysian clinical practices that they observed. These included cultural understandings of truth telling, involvement of family in decision-making, and the idea that doctor knows best (Fuscaldo, Russell and Delany 2009). Similarly, Westra et al. (2009) have challenged the cultural neutrality of principlism. Their study suggests that patients from Muslim backgrounds bring different principles to health decisions.

Some of the conflicts that students described illustrated different cultural understandings of the concepts 'confidentiality' and 'autonomy'. For example, students said that they commonly observed doctors disclosing information about patients to patients' relatives. Students also described the doctor-patient relationship in Malaysian hospitals as different to the ideal they had been taught in ethics tutorials. Students also described a cultural context in which patients accept paternalism. Students observed that patients did not always make their own decisions about their treatment. They said that most patients accepted that doctors made all the decisions about their treatments.

The Malaysian project indicated the importance of curricula taking into account students' culturally based values to ensure that health ethics education is effective. The project highlighted a number of negative consequences for students when tensions between cultural values remained unresolved. For example, students experienced moral distress because they were unable to practice in the way that they had been taught. Some dismissed their ethics education as irrelevant. Others resolved the ethical dilemma by simply following the ethical rules that they had been taught. Significantly, the end result of unresolved ethical tensions may entail that patients are given less than optimal treatment or treated in ways that are culturally inappropriate.

Our current project is in response to, and an extension of, our health ethics teaching work and consultations with students in Malaysia. We suggest that improving the cultural relevance of teaching materials may facilitate health ethics education that is more applicable to increasingly international clinical practice and that in turn this will improve health outcomes for patients.

## Significance

Health care professionals and medical students are expected to be aware of and have a commitment to ethical practice. Health ethics has an impact on practical matters, such as how consultations are carried out, and what role the patient has in diagnosis and in deciding on treatment. Health ethics education can also impact on clinical practice in the following ways:

- improving communication between doctors and patients;
- facilitating the empowerment of patients and their families;
- enhancing patient understanding; and
- enabling patients to share responsibility for their medical treatments.(Goldie et al 2002, Du Val et al 2004)

Ignoring cultural difference in education is in general a poor teaching strategy. In health ethics education, it risks sending students the message that ethics is irrelevant to them and their practice, or that their own deeply held values do not matter. These messages may produce student disengagement, mistrust or cynicism, none of which will promote ethical behaviour in clinical practice or enhance practitioner–patient relationships.

There is a need to develop ethics education curricula that educates health care professionals in both ethical theory and the application of this theory in practice. It is important that ethics curricula accommodate students' own culturally based beliefs, and provide them with a framework for making ethical decisions that both reflect universal ethical values and are relevant within a variety of cultural settings.

## Chapter 2 The Project Plan

Our aim was to produce a culturally informed approach to health ethics education that is workable and effective. The project was designed to enhance teaching and learning in health ethics by developing teaching materials that are responsive to the increasing cultural diversity of students. The materials have been developed after consultation with health ethics educators, students and early career health practitioners. These consultations have provided scenarios, experiences, insights and evidence that have informed the theoretical framework and the development of the teaching materials.

The active engagement of key stakeholders has contributed to both the development and dissemination of the cross-cultural curriculum framework. Members of the project group had expertise in health education, health ethics education, and clinical practice in nursing, physiotherapy and medicine.

The project comprised two stages: a consultation phase which informed stage 2 and the development of a pedagogical framework and teaching materials.

### 2.1 Consultations

The consultation stage involved broad consultation with key stakeholders via questionnaires.

The key stakeholders were:

1. health ethics educators in Australian and overseas universities;
2. local and international students in medicine, nursing and allied health; and
3. early career medical, nursing and allied health practitioners.

#### Health ethics educators

The project team had established extensive networks with health ethics educators both locally and internationally. These networks were used to invite colleagues to share their views. As well, the Onemda VicHealth Koori Health Unit, University of Melbourne, was consulted to provide input on issues relevant to Indigenous health care educators and students in Australian universities.

The project team canvassed the views of health ethics educators from local and overseas universities via a questionnaire (see Chapter 3). The aim of the questionnaire and our consultations with health ethics educators was to:

- identify the challenges faced in delivering health ethics education to culturally diverse student populations;
- identify strategies for addressing these challenges; and
- obtain a comprehensive picture of existing approaches for accommodating cultural diversity in health ethics education.

The final component of our consultation with health ethics educators was carried out through four interactive workshops:

1. The International Association of Bioethics Conference, Singapore, June 2010;
2. 11<sup>th</sup> Congress of Bioethics Rotterdam, June in 2012;
3. Tenth Interdisciplinary Conference Communication, Medicine & Ethics (COMET), Trondheim, Norway, June, 2012; and
4. UNESCO Chair in Bioethics International Conference on Bioethics Education, Tiberius, September 2012.

The project team was successful in its submissions to hold interactive symposia at all of the above international conferences and facilitated these as pedagogy and teaching workshops. The aim of the workshops was to:

- invite international discussion and to compare international approaches to health ethics education;
- share and compare experiences, to collect insights and ideas for the development of teaching approaches to address cultural diversity;
- receive feedback on our teaching materials; and
- form networks for ongoing collaborations on health ethics teaching.

### Early career practitioners

Our rationale for surveying early career practitioners (as well as students) was to highlight gaps between theory and practice. Unlike students, early career practitioners have some decision-making authority and sometimes work without direct supervision. As such, they are well placed to comment on the transition between theory and practice. Early career practitioners may have reflected on their ethics teaching and may have developed strategies to negotiate tensions between theory and practice.

Early career practitioners with 1- 3 years clinical experience were invited to participate in the consultation phase. The aim of these consultations was to:

- explore the types of ethical issues that early career practitioners face in their day-to-day clinical practice, and how these ethical issues are negotiated; and
- assess the appropriateness, applicability and transferability of current ethics curriculum in different contexts.

We used alumni databases to invite graduates to complete a questionnaire (see Chapter 4). Although it proved very difficult to recruit early career practitioners and only a small number of questionnaires were collected, their insights were useful in the development of the teaching materials, because they identified some health care issues that arise due to culturally based differences in values.

## Local and international students

The project team undertook consultations with local and international students of health professions from three Australian universities and canvassed students' views via a questionnaire (see Chapter 5). The aim of these consultations was to

- investigate how students navigate cultural diversity;
- determine students' views about their ethics education;
- determine students' understanding of culturally based differences in values;
- apply students' insights to the development of the new teaching module; and
- develop teaching materials that were relevant and responsive to student needs and experiences.

## 2.2 Developing pedagogy and teaching materials

The consultations with health educators' students and early career practitioners in stage 1 provided the project team with examples of:

- teaching approaches for health ethics;
- how ethical theory is applied in practice;
- 'real-life' ethical issues and scenarios;
- gaps between ethical theories and clinical practice; and
- tensions between what students learn in current ethics curricula and culturally accepted practice.

These examples allowed the project team to identify the key issues related to the delivery of culturally relevant health ethics education and in turn informed the development of a culturally informed health ethics pedagogy that specifically addresses cultural diversity.

Together the pedagogy and teaching materials offer an innovative approach to cross-cultural issues. The teaching materials include case scenarios, tutorial guides and teaching outlines. Our teaching module helps to bridge the gap between ethics teaching and clinical practice by mediating between 'the universal neutrality' of principlism and 'the particulars' of the cultural, or cross-cultural, medical context.

# Chapter 3 Consultations with Health Ethics Educators

## Introduction

To develop health ethics pedagogy and teaching material that address cultural diversity we consulted with health educators around the world. We were interested to learn about their experiences of cultural diversity and its impact on health ethics teaching and their approaches and pedagogical frameworks as health ethics educators. We were particularly interested to learn how our international colleagues negotiated the ‘universal versus particular’ debate and their views about western-developed ethical frameworks, such as principlism, in cross-cultural teaching.

We distributed surveys through a variety of bioethics networks to colleagues involved in health ethics education. These included colleagues that teach health ethics in its various guises, colleagues working in curriculum development, professional courses and clinical teaching. Questions from our survey tool are presented in Figure 3.1 below.

This section presents the findings from our consultations with health ethics educators and is followed in section 3.2 by a summary of what we believe to be the key messages, as they relate to health ethics pedagogy and the development of teaching resources. (Direct quotes are given in blue italics. The label ES denotes Educator Survey. For example, ES Q1 is Question 1 of the survey).

**Figure 3.1 Questionnaire for health ethics educators**

1. Please state the country in which you work.
2. In which health discipline(s) are you involved in providing health ethics education?  
Medicine  
Nursing  
Allied Health  
Other (please state)
3. How many years have you been involved in health ethics education?  
Less than 1 year  
1-5 years  
5-10 years  
Over 10 years
4. Please indicate your role/s in teaching health ethics.  
Tutor  
Lecturer  
Curriculum Development  
Curriculum Coordinator  
Other
5. In which subject/area is health ethics education provided in your curriculum?
6. Please indicate the ethical framework(s) on which you base your health ethics curriculum?  
Communitarianism  
Confucianism  
Feminism  
Principlism  
Other (please state)
7. Please explain your reasons for using these frameworks.
8. The student population in our health ethics program is very culturally diverse.  
Agree/ Strongly Agree/ Disagree/ Strongly Disagree
9. Please describe this diversity.
10. It is very important for health ethics teaching to address cultural difference.  
Agree/ Strongly Agree/ Disagree/ Strongly Disagree
11. My institution's health ethics curriculum explicitly addresses cultural differences in ethics.  
Agree/ Strongly Agree/ Disagree/ Strongly Disagree  
Please give examples.
12. The values and principles of health ethics are universal and are not culturally based.  
Agree/ Strongly Agree/ Disagree/ Strongly Disagree
- 13 "Principlism" is a framework that adequately deals with cultural difference in health ethics.  
Agree/ Strongly Agree/ Disagree/ Strongly Disagree
- 14 In your view, what are the challenges facing cross-cultural health ethics education?
15. What are your ideas for addressing these challenges?

## 3.1 Findings from consultations with health ethics educators

### Demographics

The following table summarises responses to Questions 1 to 4 of our survey of health ethics educators, which collected demographical information.

		n	%
Discipline*	Medicine	68	70.8
	Nursing	24	25.0
	Physiotherapy, Dentistry	14	14.6
	Other		
Country	Europe	10	13.3
	USA	10	13.3
	UK	5	6.7
	Australasia	23	30.7
	Asia	17	22.7
	Other (South America, Africa, Israel)	10	13.3
Years in ethics education	0-5	38	40.4
	6-10	18	19.1
	10+	38	40.4
Role	Teaching	79	82.3
	Curriculum developer/coordinator	49	51.0

As highlighted in the table above, our survey reached colleagues in a wide spread of countries around the world. Most of the educators that responded were involved with teaching medical students (70.8%) and most had either less than five (40.4%) or more than ten years of experience (40.4%).

### Where is health ethics taught?

#### **ES Q5. In which subject/area is health ethics education provided in your curriculum?**

Interestingly, health ethics is provided in a wide range of academic areas as highlighted below:

- 73% teach in health ethics/bioethics.
- 40% teach health ethics in Professional Studies,
- 30% teach health ethics in Professional Development,
- 26% teach health ethics in Reflective Practice.
- Others areas include research ethics and bioscience.

### Health ethics frameworks

We were interested to hear from our colleagues not only about the frameworks they draw on, but also about their reasons for doing so and, more specifically, their views on principlism as a cross-culturally applicable framework.

**ES Q6. Please indicate the ethical framework(s) on which you base your health ethics curriculum.**

As shown in the table below, while some health educators did not identify any particular frameworks and some referred to multiple approaches, it is noteworthy that principlism is widely used.

Principlism	68	91%
Feminism	21	28%
Confucianism	4	5%
Communitarianism	24	32%
Other	39	52%

Not surprisingly, health educators working in Asian countries were significantly more likely to report drawing on Confucianism as an ethical framework than participants working in other countries. However, it is more interesting to note that 70.6% of Asian respondents indicated that they used principlism and sometimes other frameworks as well. Our data does not suggest that principlism is used more widely in Western than in Asian countries.

**ES Q7. Please explain your reasons for using these frameworks.**

The reasons educators gave for using principlism are summarised below:

**Simple and useful (and familiar) and straightforward, systematic framework for students**

*Principlism seems to be an appropriate generic platform upon which to build audiology students' understanding of ethics. Our students tend to be unsophisticated in this area (science graduates) and respond well to the structured approach provided by an introduction to bioethics and ethical decision-making. (32)*

**Set of tools for thinking**

*Provides the essential knowledge, tools and methods of ethics that assist students to make ethical decisions in their professional practice. (52)*

**Internationally recognized and commonly used**

*The principles are generally accepted within the medical community in which I work, and when I discuss them in the wider community, I haven't encountered much dissent. (66)*

**Mandated to use this framework**

*(Principlism is) provided in the set curriculum that I teach. (48)*

**Culturally adaptable**

*I ordinarily encourage students [in Nigeria] to adapt the universal ethical principles at their disposal to the particular cultural setting in such a way that would make the principles relevant and of moral import. (71)*

In summary, educators gave the following reasons for not using principlism in their health ethics teaching:

**Not culturally appropriate**

*Bioethics comes from Anglo-Saxon cultures where for instance autonomy is the main principle while in our country the social view is prevalent. (10)*

**Too rigid, too narrow, too simple**

*No 'single' approach to bioethics problems that they will encounter every day, in their future work, can be adequate. (76)*

**Difficult to apply to clinical situations**

*Principlism fails to help in providing workable solutions to actual problems. (57)*

**Too vague to resolve issues**

*Principlism is the most compatible framework with all cultural backgrounds; however, it is vague and does not prioritize any principle and we need our conscience and our professional duties to decide what is the right thing to do. (77)*

Educators also referred to some of the other frameworks they draw on in their teaching:

**Other frameworks**

- Reflective equilibrium (28)
- Narrative ethics (44, 49, 94)
- Liberalism (75)
- Consequentialism (52, 76)
- Casuistry (68)
- Egalitarianism (69)
- Discursive ethics (75)
- Religious frameworks (22, 34, 75)
- Gandhism (84)
- Deontology (84)
- Virtue ethics (43, 52, 53, 84, 94)
- Phronesis (86)

Some educators suggested that these other frameworks were more culturally suitable for health ethics teaching or that students should be aware of many different approaches as highlighted below:

**More culturally suitable**

*I found Eastern worldview of spirituality and dharma as the most appropriate framework in the Indian setting. Not only it is respectful toward moral traditions of the Indian sub-continent, it also includes voices of 'religious' and 'secular'. (20)*

**Provides critical tools to assess social and ethical issues**

*Feminist discourse has been a critical tool in assessing the universal applicability of paradigms adopted across a range of fields including law, health and social work. (26)*

### **Mixed frameworks**

*No one approach is adequate. The world is not one but many in terms of cultural differences. One set of values cannot reflect and meet the needs of the world; therefore, the approaches have to be multi-dimensional. (43)*

### **Students should be aware of different approaches**

*I want to introduce my students to a range of theoretical and intellectual approaches, and don't find any one theory particularly useful or dominant. (66)*

## Addressing cultural diversity

We were interested to learn if our international colleagues share the Australian experience, where student populations are becoming increasingly international, mobile and culturally diverse. Questions 8 and 9 of our questionnaire explored diversity.

### **ES Q8. The student population in our health ethics program is very culturally diverse.**

#### **ES Q9. Please describe this diversity**

The responses suggest that increasing cultural diversity is a feature of many international programs in health ethics. Of the 111 survey respondents, 98 educators answered this question and 70% (N=68) agreed that their student population was culturally diverse. In summary, educators described the diversity among their student cohorts as follows:

- Local 'versus' international students
- Diversity of religion
- Indigenous students
- Migrants
- Gender diversity
- Socioeconomic diversity

We have a very diverse public in our Master of Bioethics programme. (Europe 38%; South America 5%; North America 9%; Middle East 5%; Africa 12%; Asia 31%) (105)

### **ES Q10. It is very important for health ethics teaching to address cultural difference.**

We included this question in the survey to learn whether other educators around the world shared our view that cultural diversity had a significant impact on health ethics and health care practice.

Participants strongly endorsed the importance of health ethics teaching addressing cultural difference with 97% agreeing or strongly agreeing with the claim that it is very important for health ethics teaching to address cultural difference.

There were no significant differences between participants working in different regions in the degree to which they felt it was important for ethics teaching to address cultural diversity. There was no significant effect of years of experience on the extent to which participants felt that it was important for health ethics to address cultural diversity.

Educators gave the following reasons for their view that it is important to address cultural diversity in health ethics education.

### **Important for health practice**

Some educators thought that addressing cultural diversity had important practical implications in health care, namely to prepare students for their work with diverse groups of patients who come from different backgrounds to their own.

*Not only is it a good example to show that moral intuitions may differ, but we also have culturally diverse patients, and our doctors should be able to recognise that patients therefore may not share their preferences. (28)*

*It was also important for decision-making and behaviour in health care. I think it is important for students to understand how culture operates in societies and influences decision-making, including in healthcare and bioethics. (95)*

One participant suggested that it was also important for getting on with other students.

*Mainly to develop understanding of the impact of cultural variation in delivering good care, but also to address and understand differences within the student body itself. (88)*

### **Important for health outcomes**

One participant described the importance of addressing cultural diversity to improve health practice, doctor–patient relationships and health outcome.

*Several studies have shown that different cultural groups respond differently to different types of health measures based on cultural ideologies about the human body and its relationship with nature and invasive medical responses. ... The extent to which a recipient of health care is comfortable with particular measures adopted will necessarily affect the effectiveness of their response to health care measures. In the circumstances, cultural difference in this context is to be appreciated and responded to with urgency. (41)*

### **Philosophically important**

Some educators suggested that it is important to address cultural diversity in health ethics, because this discussion of diverse views encourages students to reflect on their beliefs. It also provides a mechanism to engage in theoretical analysis and to challenge beliefs and principles including those that are considered to be universal.

*Local cultural values have been found to be both useful as well as challenging in solving problems in bioethics. The conflict of values is exposed and it makes students re-examine their own intrinsic values and value systems. (34)*

Some educators suggested it was important for both philosophical reasoning and practical application.

*Encouraging appreciation of a multiplicity of views toward theoretical and clinical issues not*

*only facilitated student exploration of the foundation and validity of their (sometimes unexamined) positions but better prepares them for differing perception, attitudes and reactions of health care team members, patients and families when issues are encountered in the clinical arena. It also allows students to better identify the ethical aspects of situations they may otherwise see as purely clinically problematic. (3)*

## Contextualising health ethics

Some educators expressed the view that addressing cultural diversity is important because health ethics needs to be taught in context.

*Different cultures will have different priorities or ways of applying ethical principles that fit with their cultural context. The presence of the ethical construct within their philosophical base does not relate directly to how it is applied in practical situations. (56)*

Some educators thought that it is very important for health ethics teaching to address cultural difference because different cultures have different views about ethical issues.

*What is 'ethical' in one culture may not be in another—e.g. it is more important in some cultures for there to be community acceptance of the research (it's not so much an individual decision). (70)*

*... because, my students need to understand the different cultures, in order to understand why certain people in certain countries have different views on the same ethical issues. (109)*

Some educators thought that it is important to address cultural difference because culture impacts on values.

*Because the patient population (and future peers) are so diverse, our graduates must have some preparation for this. (63).*

While some educators agreed that it was important to address cultural difference, they also stressed that this does not entail a culturally relativist position.

*Ethics is often seen as depending on culture. I do not think this is correct but you have to address the issue anyhow. (2)*

*If we ignore the cultural differences, then it would be so difficult to be persuasive about absolutism and the existence of universal values which we can agree on. (84)*

It is not surprising that all but 6% of participants agreed with the claim that it is very important for health ethics teaching to address cultural difference. Two participants who disagreed said that it was not the job of health ethics to address cultural difference.

*We address cultural difference through other areas in our program—I do not consider that it is a specific responsibility for health ethics. (87)*

**ES Q11. My institution's health ethics curriculum explicitly addresses cultural differences in ethics.**

We included this question in the survey to test the hypothesis that current health ethics curricula do not adequately address cultural diversity.

While most educators agreed that addressing cultural difference in health ethics is important, 35 educators (40%) stated that their curriculum did not explicitly address cultural difference. This suggests a need for health ethics curriculum development.

*Our curriculum does not [address cultural] diversity. The concepts covered in Ethical Practice, include but are not limited to things such as consent, end-of-life decisions, confidentiality, respect for religious beliefs (specifically Jehovah's Witnesses), compassion fatigue. There is no coverage of cultural awareness/competence, or discussion of a framework for cultural values, relevant to dealing with patients and health professionals from different cultures. There is almost no discussion of the Indigenous culture. (65)*

Some educators noted that, while not explicitly addressed in health ethics, cultural diversity was addressed elsewhere (e.g. cultural competency, research).

*There is some discussion of cultural competency in the medical curriculum but it does not fall within the program in which I teach. (83)*

Some educators suggested that the failure to specifically address cultural difference was a weakness of their curriculum.

*Students work on projects relating to international health, for instance Female Genital Mutilation or international clinical trials. But we have not explicitly brought cultural issues into the curriculum. This is a definite weakness. (103)*

Although 54 of respondents (60%) said that their health ethics curriculum addressed cultural diversity, only a few participants described how their curricula did so. The following gives an example:

*In our curriculum African ethics of ubuntu or umunthology is emphasised as this is an approach or way of life that our students are very familiar with. Hence, our curriculum addresses this cultural ethic in order to contextualize ethics and to highlight some of the major differences to be aware of when dealing with patients or participants that hold different world-views. (69)*

Some educators described addressing cultural diversity by discussing other philosophies and religious teachings during health ethics classes. However, these approaches appear to be ad hoc.

*I have a special session on yoga, Indian philosophy ...and one on ethics in traditional medical systems. (17)*

*We dance around it and discuss socioeconomic disadvantages. (52)*

Some educators said that cultural diversity was discussed appropriately and that there was ample opportunity for discussion about cultural difference in their curriculum. They mentioned a variety of ways to include discussions about cultural difference. These approaches include guest speakers, case studies, problem-based learning. However, only a few said that it was a formal part of the curriculum. In many cases it appears that whether or not cultural diversity was addressed is dependent on the individual educator.

*We try to raise these issues in looking at case studies and the ways in which both cultural diversity is a part of the client and practitioner experiences and the ways in which the theories applied to understanding these experiences are often restricted to Western, white theories of human experience. (64)*

*Guest speakers from different cultural and religious communities are invited to address the medical students. Students are encouraged to talk about their particular cultural backgrounds. But there's lots of room for greater development. (80)*

### Are there universal principles?

The theoretical debate over the application of the four principles approach is frequently couched as a tension between the acceptance of *either* universal values *or* cultural norms. Questions 12 and 13 of our questionnaire explored the views of health educators and their positions in relation to this debate.

#### **ES Q12. The values and principles of health ethics are universal and are not culturally based.**

Question 12 asked participants whether or not they agreed that the values and principles of health ethics are universal. The question inferred that these principles are either universal or culturally based.

The results indicate that educators are divided on this question; just under 60% of respondents disagreed with the claim that principles are universal. Strikingly, many of the participants' comments—for both those who agreed *and* disagreed with the claim that the values and principles of health ethics are universal—suggest that principles can be *both* universal and dependent on cultural norms.

The comments illustrate two different ways of understanding the question:

1. As an empirical question (i.e. is health care across diverse cultures practised according to universal principles?)
2. As a theoretical (normative) question (i.e. are there principles that should guide health care universally?)

All but two of the comments reflect the belief that there are some principles that *should* apply across all cultural contexts. Many of the educators said that principles reflect universal expectations, or should act as universal guidelines. Their comments suggest an understanding of principles acting as universal 'bench marks' or best practice guidelines.

However, while many comments suggest that some of the ethical principles relevant to health care are universal, they also point out that health care practice across different cultural contexts does not always reflect, adhere to or comply with universal principles.

Several participants commented that, while principles should be 'aspired to', there are a variety of factors that confound or undermine this aspiration. They suggested that the way in which a principle is specified, understood or applied, varies across-cultural contexts and that this can confound the notion of universality or universal application.

Some participants postulated that both cultural and prudential factors undermine the universal application of given principles. Moreover, it was suggested that bioethics is a growing field and that understandings of the concepts and principles might "still be developing" or be less well understood in some cultural contexts.

*The majority of ethical principles exist within all cultures and could be universally present; however, this does not translate into being applied in a universally similar manner. Some cultures tend towards autonomy-influenced application or prioritisation and others tend towards beneficence. (41)*

*The notion of 'good' is universal but how it is conceptualised, understood and practised is culturally based. (20)*

*Should be applied universally and not forsaken due to differences in their cultural acceptability. (38)*

*Broad principles are universal. Cultures specify, interpret or apply the principles in numerous ways. (111)*

Only two participants' comments disagreed entirely with the claim that universal principles exist either in practice or as a theoretical construct. They both suggested that cultural diversity *entails* diversity of values.

In summary the comments in response to Question 11 suggest broad agreement that at least some values and principles in health ethics are universal in an abstract and theoretical sense, and should apply cross-culturally. However, the comments also acknowledged that cultural practices and beliefs strongly influence how principles are understood and applied.

### **ES Q13. "Principlism" is a framework that adequately deals with cultural difference in health ethics.**

Question 13 of our questionnaire for educators reflects and explores one of the critiques of principlism, (or Western bioethics in general), that it ignores the diversity of multiple cultural and religious traditions. A frequent criticism of principlism is that this framework is based on Western ideals and therefore prioritises individual rights and self-determination (reviewed in Hongladarom 2008).

Question 13 asked participants for their comments on whether principlism adequately accommodates cultural diversity. The results, summarised below, again show a significant divide: 64% of respondents disagreed or strongly disagreed with the claim. Twenty-two participants who disagreed with the claim provided comments. Many of these agree with the critiques commonly cited in the literature and in anecdotal accounts. For example, several participants describe principlism as problematic in some cultures because, they suggest, this framework privileges individual autonomy over community or family values.

*Principlism's privileging of individual autonomy does not adequately address situations in which decision-making is more family- or community-based. (53)*

Some participants suggested that principlism is not cross-culturally relevant or applicable, because it is based on American or particular cultural traditions-

*Principlism has a tendency to re-enforce monocultural models of thinking and behaviour. It favours ideological approaches to ethical thought, which by definition cannot be culturally inclusive. (57)*

*Principlism is American invention and it works well in rich health care in a society with strong emphasis on individual self-determination. (75)*

A few participants disagreed with the claim on the basis that principlism is too simple to capture the complexity of real-life situations. It is worth noting that this critique is not unique to principlism. No theory to date has captured the complexity of real-life situations or cultural diversity.

*Real-life situations need much more than a set of 'principles'. (20)*

*Simple principlism is too basic to deal with cultural differences. For example, a fundamentalist Muslim might give a great deal less weighting to the principle of respect for autonomy. (86)*

Several respondents, both those who agreed and disagreed with the claim (that principlism adequately addresses cultural difference), suggested that principlism was useful as a tool or teaching aid.

*I think that principlism is a very useful platform for the beginner practitioner, but it ignores rather than deals with cultural difference. (32)*

*I agree to a certain extent. It is up to individual teachers to explain cultural difference within the framework that they use. (67)*

Several respondents found the question difficult to answer because they both agreed and disagreed with the proposition in the question. As seen in Question 12, this conflict reflects the view that universal principles either exist or should be aspired to, but that the way in which principles are understood, specified or applied is culturally dependent. For example, one participant explains that he/she understands principlism as a normative framework; a

set of principles that should be respected or that should guide health care 'regardless of cultural or religious beliefs'. However, he/she also suggests that how a principle is understood can vary across cultures.

*It is hard to answer such a question with agree/disagree. My understanding of principlism as a practical approach to ethical practice leads me to believe that doctors, regardless of the cultural values and beliefs, can use it as a universal set of guidelines in their dealings with patients, at least as we expect them to do in an Australian setting. However, this isn't to say that cultural differences should be ignored. What is meant by "justice" in one culture may mean a different thing in another culture, for example. Probably the area which is most easily seen as conflicting is that of autonomy versus patriarchy. (50)*

*...my response is a bit both ways—ideally it can, [accommodate cultural diversity] in upholding core human experiences/qualities as the essential components of wellbeing etc., but these qualities and experiences are not necessarily valued universally as the core human components of experience. So it's a useful framework to get students (and educators) to continually think about the ways in which these core principles are both liberating and helpful, and potentially oppressive or harmful in some contexts given the wider cultural/structural contexts of people's lives. (49)*

In summary, responses to Questions 12 and 13 suggest that there is more agreement than the debates in the literature suggest. Most educators agree that some ethical values are shared cross-culturally. However, participants also point out that how these principles are applied can vary across cultures. A number of responses suggest that it is important to mediate between the universal and the particular. Importantly, these responses suggest the view that universal principles are not inconsistent with cultural norms.

## Challenges facing cross-cultural health ethics education

### **ES Q14. In your view, what are the challenges facing cross-cultural health ethics education?**

We asked this question to explore our colleagues' views about approaches to health ethics and how we might address the impact of increasing diversity and globalisation. Fifty-five (55) respondents described a range of challenges, highlighted below.

#### **Interest in health ethics**

Some educators described getting students interested in health ethics as challenging. One respondent described a general lack of academic or philosophical knowledge within their faculty.

*Lack of social and philosophical sophistication of practitioners, faculty and students. (37)*

#### **Teaching materials**

Two respondents described a lack of suitable teaching materials that explicitly address cultural diversity.

## **Current frameworks**

Three respondents described the dominance of the western/principlist paradigm in health ethics education.

*We tend to provide a one-view-only ethics referring to principlism. This is a biased approach. (32)*

Respondents described the challenge of distinguishing between local/relative and universal values.

Respondents suggested the need to avoid falling into relativism or postmodernism, stating that health educators need to encourage objectivity or universality.

*The main challenge is trying to wean students off their preconceived notions of subjective morality and attempting to get them to be ethically objective. (8)*

*When we emphasise the importance of cultural values, the most important thing is to be careful about not to serve postmodern/relativist approaches. (14)*

*Each people have their own culture and if they give importance to their culture, general ethical values may not be adhered to. (49)*

*The challenge is to arrive at a uniform health ethic that avoids culture. (53)*

## **Tensions**

Respondents described the need to understand and represent other cultures fairly, avoiding stereotyping culture. They also described a tension between meeting professional practice requirements and encouraging respect for cultural difference.

*There is a dilemma over getting them to practise as we want them to in the UK and respecting any cultural difference. (43)*

Respondents described getting students to recognise that there are different beliefs and values as a challenge.

*Getting young students to appreciate the diversity and difference of opinion that may be contrary to their own beliefs. (20)*

## **Meeting challenges**

### **ES Q15. What are your ideas for addressing these challenges?**

We asked this question to explore our colleagues' ideas about how to better address cultural diversity in health ethics education.

Responses to this question can be summarised in four main categories:

### **Appropriate aims for teaching**

A few of the responses implied that the aims of health ethics education are to promote certain values and attitudes among students, especially mutual respect or tolerance and self reflection.

*Health ethics aims: to promote certain values and attitudes among students, especially mutual respect and tolerance and reflection on own attitudes. (28)*

*I think critical reflection is the key strategy—for students and educators to continually engage in individual and group reflections that challenge and help unpack the assumptions that we all must live and work within, but can't become constrained by when participating in ethical processes/situations that have the potential to profoundly affect people's lives. (26)*

### **Suggestions for teaching styles, methods**

*Use many cases and examples, allow sufficient time for exploration, discussion, give practical tasks that include dilemmas of cross-cultural nature ... and encourage to come to decisions ... using group work and discussions. (11)*

### **Suggestions/statements of a particular normative or metaethical theory to use as the basis for teaching:**

- i. Universalism (i.e. rejection of cultural relativism)

*There should be a common view about cultural diversity and how it can be applied in health ethics. I personally agree with the view that there are some basic principles that are totally universal, for example, human rights. Cultural differences should be seen as factors that [are important for] interpretation and application. (47)*

- ii. Theories that incorporate or deal with cultural difference in values

*We need to understand more about how concepts of culture are understood and constructed through academic discourse... We need to better understand culture in health care practices - both from the perspectives of the practitioner and the patient before we start applying pre-determined ethical frameworks in our teaching (53)*

### **Teaching resources, practices**

*Establishing a network of qualified professors in the country in order to provide them with training activities ... and opportunities to grow professionally. Meet with professionals in medical schools responsible for the design of the ethics curricula, in order to determine a standard set of goals and priorities for the country. (46)*

A number of educators indicated that health ethics education would benefit from culturally specific curriculum materials.

*Find the right person as resource person. (52)*

*Expressly acknowledging the health ethics beliefs and principles of the non-dominant cultures. (18)*

*Good literature written by experts coming from the culture in question. (4)*

*To meet and people from diverse background and try and understand where they are coming from. (28)*

*Having cross-cultural seminars. (30)*

*Incorporating cultural expertise into our conversations around ethics in order to build 'modified' curricula. (34)*

In summary, we suggest that many of the above responses reflect a desire to negotiate between universal and cultural values. We suggest that the key problem that educators have identified in addressing cultural diversity is not whether universal *or* cultural norms should prevail, but *how* to negotiate between these two.

### 3.2 Take home messages for health ethics education

Our consultations with health ethics educators from around the world provided rich insights into health ethics curricula and approaches and attitudes towards culturally based differences in health values. We were particularly interested in whether, and how, our colleagues addressed cultural diversity in their teaching and how they negotiated the tension between upholding universal principles and respecting cultural norms.

The following is a summary of the key findings from our consultations with health educators as they relate to our foci on health ethics education and culturally based differences in values.

- Educators agree that it is important that health ethics education addresses cultural diversity because:
  - a. Cultural values impact on health practice and health outcomes; and
  - b. Understanding cultural diversity promotes reflection and philosophical analysis.
- Principlism is widely used across a number of different regions (i.e. not only used in the west).
- According to a number of educators, principlism does not adequately address cultural diversity because it privileges western social structures.
- There is a lack of curriculum materials that address cultural diversity.
- There is no strategic approach to addressing cultural diversity and current approaches are ad hoc and educator dependent.

- Educators identified the need for curriculum materials in health ethics that specifically address cultural diversity
- Educators made a number of suggestions about how to address the challenges of cross-cultural education including curricula that increase understanding of cultural diversity and culturally diverse approaches to ethical reflection.
- Educators acknowledge that there is a tension between universal approaches to health ethics principles and respect for cultural norms and that this has implications for health ethics education and health practice.
- Most educators agree with, and underpin their teaching with, frameworks that acknowledge universal principles.
- Many educators cautioned against cultural relativism or cultural stereotyping.
- Many educators accept that cultural norms are not inconsistent with universal principles.

In summary, our consultations with health educators suggest broad agreement that it is important to address culturally based differences in values because these differences can impact on health practice and outcomes. However, our consultations also suggest a need to develop curriculum material that specifically addresses cultural diversity. While existing frameworks such as principlism are widely used, our consultations are consistent with critiques in the literature, that principlism privileges Western ideals and does not adequately accommodate or acknowledge cultural diversity.

In addition, the educators that we consulted acknowledge that universal principles are both abstract and broad and require specification in practice. Importantly, they reiterate suggestions in the literature that universal principles are not incompatible with cultural norms. Their comments suggest that an important role for health ethics education is to raise students' awareness of cultural contexts and to provide opportunities to reflect and practise on, and strategies for, negotiating between cultural contexts and universal principles.

We conclude from our consultations with health ethics educators and our review of the current literature that there is broad agreement that:

- a) there are some universal or overarching principles that guide health practice;
- b) cultural norms are not incompatible with universal principles; and
- c) current approaches to health ethics do not adequately address cultural diversity.

Therefore, it would be useful to develop health ethics curriculum materials that provide strategies for addressing and negotiating between universal and culturally important values.

# Chapter 4 Consultations with Early Career Practitioners

## Introduction

The project team was interested in consulting with early career practitioners to explore their insights about the ethical issues they had encountered in cross-cultural health practice. We were interested to learn whether, and the extent to which, their health ethics education had been useful and applicable in a clinical context and their insights for navigating cross-cultural differences in values.

Our aim was to produce pedagogy and teaching material that were clinically relevant and applicable. We reasoned that early career practitioners would provide useful insights and ideas with a combination of hindsight about their ethics education and broader clinical experience than either educators or students might have had.

We attempted to recruit graduates of medicine, nursing, physiotherapy and dentistry with 1–5 years of experience through alumni and health professional networks. However, only a very small number of early career practitioners responded. We canvassed their views through an anonymous questionnaire (see Figure 4.1 below).

This section presents the findings from our consultations with early career practitioners and is followed in section 4.2 by a summary of what we believe to be the key messages, as they relate to health ethics pedagogy and the development of teaching resources. (Direct quotes are given in blue italics. The label ECS denotes Early Career Survey, for example, ECS Q1 is Question 1 of the survey).

**Figure 4.1 Questionnaire for early career practitioners**

1. From which of the following health professions did you graduate?
    - Medicine
    - Nursing
    - Dentistry
    - Physiotherapy
    - Other (please specify)
  2. How many years ago did you graduate?
  3. Do you identify yourself as belonging to any particular cultural background?

All health professions include some health ethics education. The following questions ask you to comment on your health ethics education. There is no right answer. We want to know what you think.
  4. Have you found your health ethics education relevant and applicable to your training and practice as a health professional?
  5. Please describe what you found useful about your health ethics classes.

In your health ethics classes, you would have been taught some general principles that should guide clinical practice (for example, patients should make their own decisions, tell patients the truth about their health).
  6. Do you agree with the values that you were taught to respect?
  7. It has been suggested that health professionals from culturally diverse backgrounds might not agree with the values they are taught as students in health ethics? What do you think?
  8. Do you think there are other important values that should also guide professional practice (i.e. values that you were not taught)?
  9. It is sometimes said that the way health ethics is taught in western countries is not culturally relevant or helpful in other cultures. What do you think?
  10. It is sometimes suggested that health values are universal and shared by all cultural groups. What do you think?
- The next 3 questions are about the following hypothetical scenario:  
Florence is a resident doctor from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patient's decisions. On her clinical rounds, a family, who shares her cultural background, asked her to conceal the diagnosis of a terminal illness from their elderly father.
11. What do you think Florence should do?
  12. Have you ever experienced this type of conflict, (i.e. where your own cultural beliefs clash with what is expected of you in your profession?) How did you handle this conflict?
  13. Finally, what ideas do you have for improving health ethics education that might make it more relevant or applicable to your work?

## 4.1 Findings from consultations with early career practitioners (ECPs)

### Demographics

We were successful in recruiting 21 doctors to consult with. This group included 12 respondents working as interns (i.e. first year post-graduation); the other 9 respondents were registrars with a range of 4–6 years of clinical experience.

Nine respondents indicated that they identified with a specific cultural group. Cultural groups included Chinese (N=4), Greek (N=2), Persian (N=1), Hong Kong (N = 1), Malaysian (N=1), English (N=2). Eleven respondents did not identify with a specific cultural group.

### Relevance and applicability of health ethics education

In the following two questions, we were interested to learn if ECPs had applied what they had been taught in health ethics classes to their clinical encounters.

**ECS Q4. Have you found your health ethics education relevant and applicable to your training and practice as a health professional?**

**ECS Q5. Please describe what you found useful about your health ethics classes.**

Twelve respondents answered this question, with eight indicating that they had found their health ethics education relevant and applicable.

*There were healthy discussions about differing viewpoints and understanding the complexities behind issues. (4)*

*Learning principles such as Autonomy, Beneficence, Non Maleficence, and Justice is applicable to everyday practice and help sort through some very complex ethical questions. (15)*

*Ethics education was useful in areas that I am not familiar [with]—Indigenous, Asian cultures, attitudes to health, disability issues. Classes helped me to understand cultural diversity, decision-making abilities, competency issues, and family interactions. (21)*

### Culturally diverse backgrounds and ethics education

We were interested to learn whether ECPs accepted the ethical principles that they were taught. Our aim was to tease out whether any tension exists between the values that underpin health ethics education and any culturally-based values and obligations.

**ECP Q6. Do you agree with the values that you were taught to respect?**

Eleven respondents answered this question, with 9 respondents indicating that they agreed with the values that they were taught to respect.

*Yes. I still find it useful in complex pressured situations at work to think about what ethical principle ought to apply to a given situation. (1)*

*I was born in and grew up in Australia and have had a very 'Australian' upbringing through school, friends and local community activities. Whilst I identify and relate to the cultural values of my family [Chinese background], I also identify with Australian values and have not had problems with health ethics taught through medicine. (17)*

**ECP Q7. It has been suggested that health professionals from culturally diverse backgrounds might not agree with the values they are taught as students in health ethics? What do you think?**

Nine respondents answered this question, with 8 respondents indicating that health professionals from culturally diverse backgrounds might not agree with the values that underpin western health ethics.

*I am of Chinese background but born and raised in Australia, so I identify much more with Western than Asian culture. I generally agree with the values taught ... However I can understand that those from other cultures may not. (6)*

*There are possible disagreements in people with culturally diverse backgrounds in area like the idea of palliative management, idea of not letting patient knowing their terminal illness as per their family member wishes etc. (13)*

One respondent stated that values are universal.

*I think the values are universal across different cultural backgrounds. It certainly does not conflict with any values I may have based on my cultural background [Asian]. (7)*

**What values should guide professional practice?**

We asked the following question because we were interested to learn how ECPs related to the ethics education they received, whether ECPs hold important culturally based beliefs that are not addressed in their education and which values guide their decision-making as health professionals.

Summaries and highlights from ECPs' responses to this question are given below:

**ECP Q8. Do you think there are other important values that should also guide professional practice (i.e. values that you were not taught)?**

Five respondents indicated there are other values that should also guide professional practice; these include acceptance and understanding of diversity. One respondent suggested that health ethics should teach "indigenous values, Asian and African values".

Two respondents suggested that there are diverse ways to learn professional values, and health ethics education does not teach all of these values but instead, provides a framework for making ethical decisions.

*There are probably lots of values that an individual develops as part of their professional development by observing and imitating their superiors. I'm not sure lectures on things (e.g. courtesy, promptness, communication, respect) would be particularly helpful. (1)*

*Perhaps—however, teaching ... provided more of a framework to allow students to guide their own ethical decisions. (7)*

## Is 'Western' health ethics teaching relevant?

We were interested to learn whether ECPs agreed with the claims made in the literature and anecdotally that 'western' developed bioethics is not relevant outside the west.

### **ECP Q9. It is sometimes said that the way health ethics is taught in western countries is not culturally relevant or helpful in other cultures. What do you think?**

Nine respondents answered this question and 5 respondents agreed with the claim reflected in Question 9.

*... some health ethics may not be applicable to Asian countries. (13)*

*I agree. Western ideas are not relevant in most other cultures. (21)*

Two respondents expressed the view that health ethics needed to be contextualised.

*I think general principles such as beneficence/non maleficence/informing decision-making etc. can be interpreted in different ways and that is the most obvious difference to me. The way it is taught through lectures/tutorials using case scenarios is appropriate to understanding the concepts. It was culturally relevant to me. (17)*

One respondent indicated the way health ethics is taught in western countries is culturally relevant; however, health professionals need to apply these principles with sensitivity.

## Are health values universally shared?

In Question 10, we were again investigating ECPs, understanding of ethical principles and whether they accept that ethical principles represent values that are shared across all cultures, or whether they are culturally relative. We accept that this is not necessarily a question that can be answered empirically, but we were interested in students' perceptions for the purpose of informing curriculum development.

### **ECP Q10. It is sometimes suggested that health values are universal and shared by all cultural groups. What do you think?**

The responses to this question, highlighted below, are consistent with responses to the previous question. Nine respondents answered this question and only 4 respondents disagreed with its claim.

*I think the values are universal when applied to individuals. (15)*

Four respondents disagreed.

*In my limited experience this is not correct. I am aware of very different attitudes to ethical principles of autonomy and confidentiality in Japan for instance, where a terminal diagnosis is often withheld from the patient at the request of their family, who are told before the patient is themselves aware. (1)*

*I disagree. Health values certainly differ depending on one's culture, health beliefs and other values. (6)*

*Some health values are universally shared, not all. (17)*

## The Florence vignette

For Questions 11 and 12 of the ECP survey we asked ECPs to respond to a vignette to investigate how they would respond to a clinical situation that exemplifies a cross-cultural difference in values and whether they had experienced this type of situation in practice.

*Florence is a resident doctor from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patient's decisions. On her clinical rounds, a family, who shares her cultural background, asked her to conceal the diagnosis of a terminal illness from their elderly father.*

### **ECP Q11. What do you think Florence should do?**

Nine respondents answered this question. The responses to the Florence vignette suggest that Florence should act on the basis of doing what is best for the patient. One group of ECPs argued that acting in the patient's best interest entails finding out and respecting his wishes. A second group suggested that the right course of action is based on the legal and professional guidelines of Florence's workplace

#### **Patient's wishes override (morally and legally)**

*Florence should ask the patient if whether or not he wants to know everything regarding his condition and whether or not he wants his family to make decisions for him. (15)*

*She should diplomatically inform the family that she will always hold the patient's interests at heart and that her first duty is to him. She should ask the patient how much he would like to know about his illness and how much of the decision-making he would like his family to do. It may turn out that he does not want details, and is happy for the family to call the shots. If he wants to be fully informed, then Florence should tell him. (6)*

Two respondents referred to health professionals' legal and ethical obligations under the current Australian health system. Both of the following responses illustrate the view that some ethical principles are overarching in the face of conflicting cultural expectations.

*Practically, Florence cannot conceal the diagnosis because, even if she wanted to, she is part*

*of a whole health system ... There is a clear clash here between a widely respected ethical principle and a minority cultural custom. It would usually be right to follow the ethical principle. Whilst this cultural custom might be seen by some as harmless (although I would disagree), there are many which are more obviously harmful/wrong (e.g. female genital mutilation, honour killings, etc.). Just because something is widely practised or customary for a particular group, does not make it right (or wrong). (1)*

*Florence would be expected, as a medical practitioner in Australia, to be guided by ethical and legal principles of patient autonomy. Florence should explain this to the patient's family and help them understand her obligations in this regard. She may be able to discuss with the patient regarding the level of information he would like to know regarding his own health—if he expresses a desire to know the diagnosis, then he should be informed; if he is happy to allow his family to make decisions on his treatment on his behalf and would prefer not to know of any serious/terminal illnesses then these wishes should be respected. (7)*

One respondent suggested that it is not appropriate for Florence to make decisions for her patient because she would be influenced by her own cultural experience.

*Ask her superiors—she would be influenced by her culture and not reveal the diagnosis but in Australia she would be expected to advise ... so it would be best to get someone else involved. (21)*

Interestingly, the responses to Question 11 suggest that legal and professional considerations are overriding and that cultural norms are important and should be respected, but only if they do not significantly conflict with established norms. As well, one of the respondents suggested that doctors should not allow their own cultural values to influence their decision-making. Taken together these again illustrate a practical manifestation of the 'universal vs culturally relative' debate and suggest that ECPs may not have strategies to resolve this kind of conflict.

## Cultural differences and moral conflict

In the following question, we were interested in whether ECPs had experienced the type of issue illustrated in the Florence vignette.

**ECP Q12. Have you ever experienced this type of conflict, (i.e. where your own cultural beliefs clash with what is expected of you in your profession)? How did you handle this conflict?**

Six ECPs responded that they had experienced the type of conflict illustrated in the Florence vignette (i.e. where their own cultural beliefs were in conflict with what is expected of them in their profession). The following quotes describe how they navigated this conflict.

*You wrestle and struggle and reflect. You ultimately do what may be required (by law/professional [code]). You grow. (3)*

*By going ahead with what the patient wanted rather than what I believed in. (4)*

*Always think from patient perspective instead of your own cultural beliefs. Discuss with more experienced people to see how to go around those conflicts. (13)*

*The above scenario has happened to me on multiple occasions and I handled it by asking patients what they want. The families were not always happy with me. (15)*

*A senior withheld information from a patient per the family's request. However, it was important that the patient be aware of the diagnosis in order to make decisions on their management. On further discussion with a consultant—it was made clear to the family that the patient should be informed and he was subsequently informed. (17)*

*Depends on the situation ... but at times you need to break cultural barriers (your own). (21, 5)*

As the above quotes illustrate, the ECPs described significant conflict and tension arising from situations where they must navigate between cross-cultural differences in values. Their responses suggest that in these scenarios solutions are not negotiated, but rather that one of the parties' wishes is overridden.

## Improving health ethics education

Finally, respondents were asked their ideas for improving health ethics education that might make it more relevant or applicable to their work. Ideas included:

### **ECP Q13. What ideas do you have for improving health ethics education that might make it more relevant or applicable to your work?**

Highlights from ECPs' responses to Question 13 are given below.

*Strategies for difficult situations where doing the right thing means 'dobbing in' or contradicting a senior colleague. Emphasise that we should not allow patients or colleagues to railroad us into action that is against our better judgment ... Highlight the importance of meeting professional standards even when they come into conflict with our personal beliefs, e.g. referring on to another health professional when we conscientiously object to a request/service. (6)*

*Real-life exposure, involve student in family meeting whenever possible. (1)*

*Ask different cultures to teach students and doctors. (21)*

One respondent noted that health ethics education has an important role in teaching health professionals to be aware of their own values.

*It is about being able to see things from another point of view, without necessarily giving up your own values. (4)*

## 4.2 Take home messages for health ethics education

Our consultations with early career practitioners provided useful insights into their experiences of health ethics education and how this relates to their clinical encounters. We were particularly interested in whether, and how, ECPs negotiated cultural diversity and how they understood ethical principles in light of culturally based differences in values.

The following is a summary of the key findings from our consultations with ECPs as they relate to health ethics education and culturally based differences in values.

Most ECPs agreed that health ethics education was useful in:

- provoking reflection and discussion about different point of view;
- providing skills in decision-making and patient care; and
- providing frameworks for thinking about ethical issues.

Most ECPs agreed with the principles that underpinned their ethics education. Some argued against relativist positions and reasoned that ethical principles are universal. Noticeably, however, there was disagreement on this point and some ECPs also argued that health values vary with cultural diversity.

As illustrated by the ECPs' responses, in particular to the Florence vignette, it is clear that ECPs seek to be respectful of culturally based differences in values and are conflicted about how to balance clashes between universal principles, what they were taught and important cultural norms. Many of the responses we received suggest that the decision cannot be made without overriding one of the parties' wishes. The ECPs in our sample seem to refer to legal and ethical rules or principles to decide what Florence should do.

We suggest that the ECPs' responses to the survey illustrate moral confusion and demonstrate a gap in our current health ethics education. We suggest that ECPs' responses show that they do not have and would benefit from skills for thinking about and negotiating decisions in situations that exemplify cross-cultural differences in values. As articulated by one ECP:

*I have no doubt there are differences in culture and values of different health professionals. I think there are differences of values within cultures too. I don't think that it is useful to delineate which values may be universal and which ones local. I think aiming to find an alternative set of 4 values to be rabbitied out by another group of students will have similar issues to our current values. Rather, get people involved and engaged with the issues and each other. Use the diversity that is sitting in the classroom. ... Ethics shouldn't be taught like medicine. (3)*

Interestingly, the quote above seems to suggest that labelling values (as universal or culturally based) is irrelevant and that ethical issues need to be negotiated rather than resolved using top-down or bottom-up approaches.

In summary, our consultations with early career doctors suggest:

- general agreement that health ethics education is useful and relevant;
- 'Western' health ethics is not (always) cross-culturally applicable;
- general agreement that some ethical principles are widely shared;
- culturally based difference in values can lead to
  - confusion, uncertainty
  - clashes between personal values, family values, what is taught in health ethics, and/or professional guidelines
  - moral distress.

We conclude that consultation with ECPs reveals general agreement with what they are taught; however, they are not prepared and do not have strategies for situations involving a clash between principles and cultural norms, and may be left feeling like they must 'follow rules'.

- To be more effective health ethics education needs to provide health professionals with strategies for negotiating cross-cultural differences in values.

# Chapter 5 Consultations with Students in Health Professions

## Introduction

The project team undertook consultations with local and international health profession students of from three Australian universities. We canvassed students' views via an anonymous questionnaire (see Figure 5.1 below).

The aims of these consultations were to explore students' experiences of health ethics education, to inform the development of the new teaching module and to ensure that we developed teaching materials that were relevant and responsive to student needs and experiences.

Students were invited to participate during health ethics lectures, seminars and tutorials. The project team targeted students from medicine and nursing, the two largest health professions, as well as from allied health disciplines with explicit health ethics teaching, namely physiotherapy, occupational therapy and dentistry.

Consultations with international, Indigenous and local students were undertaken to explore students' attitudes to their health ethics education, to investigate the extent to which health ethics education is useful and relevant to professional practice, to identify the ethical issues that students encountered in clinical placements and the ways in which cultural background influences their interpretation of their health ethics education.

We were also interested in understanding how students navigate between their own culturally based values, those that underpin health ethics teaching and the extent to which these are in agreement or conflicting.

This section presents the findings from our consultations with students and is followed in section 5.2 by a summary of what we believe to be the key messages, as they relate to health ethics pedagogy and the development of teaching resources. (Direct quotes are given in blue italics. The label SS denotes Student Survey, for example, SS Q1 is Question 1 of the student survey).

**Figure 5.1 Questionnaire for students of health professions**

1. What course are you studying?
2. What year of your course are you in?
3. Do you identify yourself as belonging to any particular cultural background?  
No/Yes  
Please specify.

The following questions ask you to comment on health ethics education.  
There is no right answer. We want to know what you think.

4. Have you found your health ethics education relevant and applicable to your training as a health professional?
5. Please describe what you find useful about your health ethics classes.  
In your health ethics classes, you will have been taught some general principles that should guide clinical practice (for example, patients should make their own decisions, tell patients the truth about their health).
6. Do you agree with the values that you were taught to respect?
7. It has been suggested that students from culturally diverse backgrounds might not agree with the values they are taught in health ethics. What do you think?
8. Do you think there are other important values that should also guide professional practice (i.e. values that you were not taught)?
9. It is sometimes said that the way health ethics is taught in western countries is not culturally relevant or helpful in other cultures. What do you think?
10. It is sometimes suggested that health values are universal and shared by all cultural groups. What do you think?

The next 3 questions are about the following hypothetical scenario:

Florence is a resident doctor from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patient's decisions. On her clinical rounds, a family, who shares her cultural background, asked her to conceal the diagnosis of a terminal illness from their elderly father.

11. What do you think Florence should do?
12. Have you ever experienced this type of conflict, (i.e. where your own cultural beliefs clash with what is expected of you in your profession?)
13. How did you handle this conflict?
14. What ideas do you have for improving health ethics education that might make it more relevant or applicable to your work?

## 5.1 Findings from consultations with students in health professions

### Demographics

The following table summarises the responses to Questions 1 to 3 in our survey of students in health professional courses, which collected demographic information. A total of 183 national and international students enrolled in health professional courses (as listed below) completed some part of our survey.

#### SS Q1. What course are you studying?

Student Discipline	Number	%
Medicine	56	30.5
Nursing	76	42
Physiotherapy	17	9
Dentistry	15	8
Other Health administration, public health, oral health, medical science, traditional Chinese medicine, prosthetics, nutrition chiropractic	19	10.5

#### SS Q2. What year of your course are you in?

Of the students that responded to this survey question, the table below shows that most were in the early stages of their courses.

Student year level	Number	%
1	18	10
2	31	17
3	77	43
4	42	24
5	9	5
>5	2	1

## Cultural Background

### SS Q3. Do you identify yourself as belonging to any particular cultural background?

Of the 179 responses, 60% of students replied no, while 40% gave one or more of the following responses.

Aboriginal, Afghan, African  
American, Asian, Australian, Anglo- Saxon,  
Bangladeshi, Canadian, Chinese,  
English, European, Ghanaian, Greek, Indian,  
Indonesian, Islamic, Iranian, Irish, Japanese,  
Latin, Latvian, Malaysian, Mauritian,  
Middle Eastern, Pacific Islander, Polish,  
Pakistani, Vietnamese.

Most of those students gave a specific cultural background. They identified as Asian (29/179), Middle Eastern (9/179), or Australian (9/179). While numbers are small for some groups, no significant differences were found when students' self-identified cultural identity was cross-tabulated with other questions.

## Relevance and applicability of health ethics education

### SS Q4. Have you found your health ethics education relevant and applicable to your training as a health professional?

### SS Q5. Please describe what you find useful about your health ethics classes.

While ethics education is a compulsory part of many curricula, we were interested to know if students found health ethics useful and whether they applied what they had been taught in class to their clinical encounters.

Total responses	Yes	No	Unsure
129	107 (83%)	6 (5%)	11 (8.5%)

Students explained that their health ethics education was useful and applicable to their training as a health professional for the following reasons:

#### Preparation for clinical practice

Eight respondents said that their health ethics education helped prepare them for their clinical practice.

*... Yes. I found it useful in my application to placement and training (56)*

*It allowed me to examine complex ethical issues in a comfortable environment in different ways before being hit with them on entering the workplace. I now feel more confident in my ability to make ethical decisions. (6)*

### **Skills and knowledge**

Seven students described their health ethics education as giving them skills and knowledge to make ethical decisions.

*Yes, [health ethics] gives me a good basis for understanding and making decisions. (22)*

*Yes. The learning content outcomes and skill/knowledge are useful in clinical placement. (7)*

*Yes. I found that the Ethics coursework gives insight into ethical dilemmas, and for those situations where the decisions may be controversial, the learning materials allow me to make up my own mind, and the materials cover all sides of the argument. (99)*

### **Frameworks**

Eleven respondents described their ethics classes as useful because they provided frameworks and ways to act in difficult situations.

*Health ethics classes gives you a framework from which to determine 'how' to practice your medicine, which compliments the 'what' to do that is usually thought of when thinking about studying medicine. (101)*

*... I find it more and more essential to have a solid grounding in professional ethics and ethical decision-making. It has helped me make sense of extreme situations where life and death were at stake as well as coping with the often challenging and confronting choices of patients in addition to medical treatment issues. It has helped me negotiate ethically dubious practices in a recent post-grad course and has helped me in many ethically sticky situations in acute care nursing by providing me with a very clear ethical framework from which to respond. (128)*

### **Multiple perspectives**

Nine students described their ethics education as useful because it provided them with examples of different perspectives and practice in thinking critically about different situations.

*It is helpful in these classes that we look at many perspectives, whether it be the perspective of the patient, doctor or other parties involved. (181)*

*They identify the unspoken grey areas that come into practical decision-making and provide a forum for discussing various aspects of these areas. Participating in discussions within a course group that has great diversity of culture, knowledge and experience broadens my perspective and alerts me to possibilities that I was previously unaware of. (154)*

*Gives all sides of arguments and the medico-legal sides, without forcing one opinion. (170)*

*Hearing different opinions. (57)*

### Case studies and class discussions

Several students referred to class discussion about case studies as being useful:

*Clinical scenarios that enable critical thinking. (32)*

*I enjoyed the debates within the class. Ethics has many shades of grey and I enjoyed discussing other students' opinions and how they develop their opinion. (10)*

### Standards

2 respondents found health ethics classes useful for understanding what is expected of a clinician.

*Helps to show the necessary criteria we have to meet as practitioners. (137)*

### Interesting but not applicable

One student explained that health ethics provoked “*Stimulating thought processes, critical self-reflection.*” However, the student did not find health ethics particularly relevant or applicable “*as it only seems to provide questions rather than answers.*” (40)

In summary, 66 students provided comments and described health ethics classes as relevant, useful or applicable for the following reasons:

- prepares students for clinical practice and patient care;
- provides skills and knowledge and decision-making frameworks;
- provides guidelines for clinical practice and decision-making;
- fosters critical thinking and multiple perspectives;
- teaches students what to do and provides standards; and
- stimulates thinking through case studies and class discussions.

### Health ethics values

#### SS Q6. Do you agree with the values that you were taught to respect?

We were interested to investigate whether students accept and agree with ethical principles that they are taught. Our aim was to tease out whether any tension exists between these values and any culturally-based values and obligations. Most of the students who responded to this question replied yes, that they did agree with the values they were taught and none indicated that they did not agree with the values they were taught.

Total responses	Yes	No	Unsure
122	114 (93%)	0	8 (7%)

Students gave a range of reasons for accepting the values they were taught to respect in health ethics classes. Highlights from these responses are given below:

### **Universal values**

Some respondents suggested they agreed with the values that underpinned their health ethics education, *because* these values are universal and any 'reasonable' person would or should accept them, because they are universal values which everyone would or should agree with.

*I agree with the values, they should be inherent in every health practitioner's role. (93)*

*Yes. I already respected these values, as any reasonable person would. (138)*

*I strongly agree with the values because nurses are advocates for the patient and it is vital to respect the values. Patients trust nurses; therefore, nurses should obey these values. (5)*

*The general ideas that have been presented to us coincide with my own ethical and moral values so I have no issues with them. (158)*

### **Practical application difficult**

Strikingly, several responses suggested that students believe that they are being taught 'the right thing to do', although they also suggest that it is not practically possible to uphold the principles they are taught. For example, some students suggested that they have difficulty with the practical application of these values or suggest there is room for interpretation, or that principles act only as a guide or framework for action and decision-making. Others referred to the difficulty of knowing what to do when principles clash.

*Yes because it reminds health professionals of what their role is and emphasises the patients' rights to exercise their beliefs. (24)*

*Most of them ... make sense, but how applicable or realistic some of these guidelines are in frantically busy environments is sometimes in question? Sometimes there is a struggle just to meet basic needs of patients. (1)*

*Yes, they make it easy to analyse ethical responses to situations. (26)*

*The values underpinning professional ethical practice for my profession are abstract or generic enough to allow 'ethical mindfulness' of the individual practitioner while at the same time, clearly setting the standard of professional behaviour and conduct. (128)*

*Yes, but this does not mean that they should be blindly applied to all situations. (154)*

*I agree with it but sometimes it's different when you practise. (79)*

## Culturally diverse backgrounds and ethics education

**SS Q7. It has been suggested that students from culturally diverse backgrounds might not agree with the values they are taught in health ethics. What do you think?**

Total responses	Yes	No	Unsure
124	73 (59%)	39 (31%)	(10%)

As with the prior question, we were interested to see how students think about culturally based differences in values and whether they could comment on their own experiences or observations of how students from diverse cultural backgrounds relate to health ethics teaching. Our aim was to tease out whether any tension exists between these values and any culturally-based values and obligations.

### **Health values are culturally determined**

More than half of the students agreed with the claim. Many of their responses, as highlighted below, suggest that moral norms are relative to culture.

*Rightness and wrongness also lie in the viewer perspective. The western culture is more focused on individual and the Asians more focus on family and culture. (87)*

*Every culture has their own values and we must try to respect all cultures and abide by their decisions. (14)*

*I believe each culture has its own set of 'norms', and define what is 'acceptable' and what's not 'acceptable', and may impact what ethics is to each culture. (48)*

*I would agree with that statement as I have observed patients and families from diverse backgrounds have very different values, such as not telling a family member they are going to die because the majority of the family believe it is in the patient's best interest. (6)*

### **When in Rome<sup>1</sup>**

Several responses imply that students believe that local norms should be accepted whether or not these are consistent with students' own beliefs, as illustrated in the following quotes. We refer to this line of reasoning as a 'when in Rome' approach to cultural diversity.

*They may not agree, but they have to accept the culture they are working in. (33)*

---

<sup>1</sup> The proverb "When in Rome, do as the Romans do" is understood to mean; "*Don't set your own rules when you are someone's guest.*" The proverb is often attributed to Saint Ambrose (c.340-397), whose advice to Saint Augustine read: *Si fueris Romae, Romano vivito more; si fueris alibi, vivito sicut ibi* ('When you are in Rome live in the Roman style; when you are elsewhere live as they live elsewhere'). English divine Jeremy Taylor (1613-67) also used the proverb. From *Random House Dictionary of Popular Proverbs and Sayings* by Gregory Y. Titelman (Random House, New York, 1996).

*... the culture in every country is different and if we were in their country we may not agree with their values but we would still have to practise according to their ethical standards and the same should be for the health system. They may not agree with the values that we define important but they still need to practise within our ethical guidelines. (113)*

*The more specific ethics [e.g. of a country] ... may conflict with those from a different culture, yet are necessary for any medical professional to understand to operate effectively within [that country]. (158)*

### **Health values are universal**

In contrast, many other students disagreed with the suggestion in Question 6, and their responses either state or imply acceptance that many ethical principles are in fact universal and apply across all cultures. Strikingly, several students who identified themselves as 'from a different cultural background' also argued for universality.

*I am from a different culture background ... and I do not agree with this statement. All values in health ethics are similar and we should respect each other in order to be respected. (8)*

*Some ethics like confidentiality, doing no harm, are universally the same no matter cultural backgrounds. (45)*

*No I don't think so. We are taught the same values back home which are for the respect and benefit of the patient. (78)*

*I am an overseas student and am from a different background but I agree with what I was taught. (81)*

*I am from different cultural background but I strongly agree with the values. We all are human beings and expect to have same services. (5)*

*I think most of the ethics values are basic human rights and would be applicable across many cultures. (94)*

The responses to Questions 6 and 7 reflect opposing views about ethical principles and confirm that the problem our project investigated is one that is not just reflected, in the literature or among educators, but also creates confusion for students.

What values should guide professional practice?

### **SQ Q8. Do you think there are other important values that should also guide professional practice (i.e. values that you were not taught)?**

We asked this question because we were interested to learn how students relate to the ethics education they receive, and whether they believe that there are important values that are not addressed in their education. We were interested to learn whether students hold important culturally based beliefs that reflect values not addressed in their education and whether students believed these to be important in guiding health professionals' decision-making.

Summaries and highlights from student responses to this question are given below:

Total responses	Yes	No	Unsure
93	42 (45%)	37 (40%)	14 (15%)

### **Respect for cultural diversity**

A few students suggested that it is important for health professionals to respect cultural diversity and that this is not always taught or practised. Some specifically mentioned negative experiences for international students.

*Perhaps, concentrating on approach to different culturally diverse background. (170)*

*... I wonder if there could be something to be done [to reflect] truly respecting other cultures not only some dominant cultural practices. (25)*

*They should understand us from a different culture background and different language. English is not our first language and we might have problems understanding and expressing. It is so upsetting when you work with someone who doesn't like international students. (8)*

*During this course, I have noticed that international students are not treated as part of team by fellow students because of cultural background. Therefore, there should be values which will explain and encourage locals to treat them equally and as part of the team. (5)*

### **Altruism**

A couple of students referred to a need to teach students the value of altruism and social conscience.

*We're not taught about giving back to the community or volunteering to society or professional association—ALTRUISM (88)*

### **Ongoing, in-depth**

A few students suggested that more ethics teaching was required or that more in-depth analysis would be helpful

*I think more formal emphasis on ethical difficulties and general principles is needed. (1)*

### **Interdisciplinary**

One student referred to difficulties in interdisciplinary practice and suggested that ethics teaching should include strategies for dealing with issues that arise in these types of interactions.

*Intra and inter profession ethics. There are some big issues regarding the way therapists interact with one another and I think this should be taught. Not sure about what kind of literature there is regarding it but I would hope there are things regarding this topic. (183)*

### Values can't be taught

Interestingly, one student suggested that values cannot be taught after an individual has passed the formative years.

*I can't think of any. In any case, most of our formative years are past so the opportunity to teach the basic values (honesty, integrity etc.) has already passed for the most part. It's not something that a lecture in medical school would teach. (136)*

The students' responses to this question are interesting; the students did not identify major omissions in terms of the values that they believe should be taught or are important to their training.

Is 'Western' health ethics teaching relevant?

### SS Q9. It is sometimes said that the way health ethics is taught in western countries is not culturally relevant or helpful in other cultures. What do you think?

We were interested to hear whether students agreed with claims made in the literature and anecdotally that 'western'-developed bioethics is not relevant outside the West. The results for this question given in the table below indicate a significant split between students who agree or disagree with the claim made in the question, and a significant number of students were unsure.

Total responses	Yes	No	Unsure
108	54 (50%)	30 (28%)	24 (22%)

### Universal values

As with Questions 6 and 7 above, many students either stated or responded in a way that suggested that 'Western' health ethics teaching is relevant across all cultures because the values that underpin this teaching are general and shared across all cultures.

*I disagree, ethics concepts translate across all boundaries, that has been my experience. (115)*

*I think it applies to everyone; the principles are very considerate of individual rights. (26)*

*I think that there are ethical problems that arise in other countries more frequently than western countries due to lack of resources etc. (e.g. justice/allocation of resources) but the principles still remain. (115)*

*I think the principles are universal. (104)*

*No, for medical and nursing care are the same despite culturally different (7)*

### Application is important

Four respondents described values as universal but also acknowledged that universal values need to be applied differently in different cultural contexts.

*... it makes sense to teach an ethics from the majority perspective. In addition to this, ethics does attempt to encapsulate "universals"; the cultural bit happens in the application—this would be impossible to teach every variant on that theme. (116)*

In contrast, a number of students reasoned that it would be impractical to include all of the diverse cultural norms and approaches to ethical issues in health ethics education.

*We live in a multi-cultural world, it would be too hard to teach all cultural ethics, I believe what we are taught is relevant and enough information. (14)*

*You still have to teach them something. It's not reasonable to try to cover all the different cultures. Teach them about cultural relativity, tolerance and communication. Then the students will be equipped with a way to solve any issues arising from difference in culture (I think). (169)*

One student suggested that his/her classes were relevant because the diversity in the classroom ensured that different cultural perspectives were shared.

*That was not my experience. The subject—nursing ethics—discussed culturally diverse subjects. And given the cohort of students from different cultural backgrounds the discussions were therefore relevant and expansive. (9)*

#### **‘Western’ health ethics not universally applicable –‘when in Rome’**

Approximately half the responses agree with the claim that Western health ethics are not applicable across all cultures. Some students’ responses suggested, as in Questions 5 and 6, the view that ethical norms are culturally relative and that practitioners should abide by local norms—a ‘when in Rome’ approach.

*That may well be the case but practising a profession here in Australia requires a commitment to practising within the ethical guidelines proposed by that profession. The ethics courses offered here are part of becoming a member of that particular professional group. (128)*

*It may be helpful, but applying western ethics to non-western countries presents with several difficulties. Any professional needs to be aware of the cultural requirements in an area in which they work. (158)*

*If studying/working in Australia I feel it an obligation to respect ethics and moral values of Australia. (48)*

Some students’ responses suggested that there would be a clash between what they are taught in the ‘West’ and what would be expected in other cultures.

*True, I believe if I go back to my home country, there might be a clash in ideas/opinions and beliefs especially in medical field. (37)*

*Can be difficult working with patients of other cultures who follow a different set of*

*behavioural practices e.g. ... [in a culture where] husband makes decisions for ... wives. (88)*

One student reiterated ideas expressed in the literature that ‘Western’ ethics are *imposed* and may reflect a type of cultural arrogance.

*Yes this is true. Western health ethics are not the ruler of the world’s healthcare, although they are well researched and supported with relevant information they may be like trying to fit a square peg in a round hole when it comes to introducing the ethics into culture. (113)*

*I think there are some differences in opinion; however, I think it is important to be exposed to how other cultures view particular ethical issues. It certainly isn't acceptable to assume that everyone has the same values and understanding of a particular situation, however. (170)*

In summary, students’ responses to this question demonstrate a wide diversity of beliefs about ethics and the values that underpin Western approaches. Some students accept that these values are universal even if their application may be dependent on cultural contexts. Other students suggest that western approaches are not relevant precisely because health values are culturally dependent. A number of students suggest that health professionals should practise according to the norms appropriate for their work place—‘when in Rome’. Students referred to clashes and conflict that can arise due to differences in cultural values and the need to be respectful or sensitive to cultural diversity.

Overall, the responses to this question and those above suggest a significant degree of confusion over how to approach cultural diversity and about whether some values apply universally.

Are health values universally shared?

**SS Q10. It is sometimes suggested that health values are universal and shared by all cultural groups. What do you think?**

In this question we were again investigating students’ understanding of ethical principles and whether they accept that ethical principles represent values that are shared across all cultures or whether they are culturally relative. We accept that this is not a question that can be answered empirically, but we were interested in students’ perceptions to inform curriculum development.

The responses to this question agree with the previous question and suggest a significant disagreement.

Total responses	Yes	No	Unsure
117	49 (42%)	60 (51%)	8 (7%)

### **Health values are universal**

Just under half of the students who responded to this question agree that health values are universal. Some students suggested that this is because they are based on human nature.

*Nowadays, we live in a global world and so health values have become universal. (83)*

*I think some key health values are universal, which should correspond to human nature which is more important than culture. (99)*

Other students also agreed with the claim in the question, but added that there is a need to be sensitive to cultural diversity in applying or balancing universal principles and that their relative importance can vary over time and in certain contexts.

*The values are universal but need to be adapted to different contexts. (81)*

*I think the health values of well-being, curing, caring are a few of the health values that are reflected throughout all cultures, although each culture's interpretation of each value may vary. (113)*

*Largely yes, but no in the sense that different cultures place different emphasis on the balance between individual/family/community. Further, the attitudes to this balance tend to vary in different ways across a lifetime ... I do tend to think that the underlying values are universal— it is just variable as to which particular aspects are emphasised and which are sacrificed in different situations. (154)*

*There are certain values that are present in all societies. These values can be taught to all societies. The other aspects (population specific/based on the nation's legal system) are not shared. (137)*

*I believe everyone shares the values of do good and do no harm. The right to autonomy can be very different between cultures. (10)*

### **Values are not universal**

On the other hand, many students rejected the claim in the question. Their responses suggested the idea that universal values reflect one way of thinking and that people from diverse cultures might think differently about health and ethical issues.

*No, I think some values may be shared ... but many cultures have their own values. (14)*

*I believe ... every individual has different beliefs and values therefore the health values may not be universal. (16)*

*I disagree. There is not one universal culture, not one universal way of thinking. There are a multitude and we need to learn about some of the other cultures and their ideas—especially if we deal with many patients from those cultures. (21)*

*There are very different views about health and wellbeing across cultures so I don't think the*

*values are universal. There is possibly a preoccupation in health in western cultures. In other cultures this is embedded with spiritual dimension that affects health. (84)*

## The Florence vignette

For Questions 11 , 12 and 13 of the student survey, we asked students to respond to a vignette to investigate how they might respond to a clinical situation that exemplifies a cross-cultural difference in values.

*Florence is a resident doctor from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patient's decisions. On her clinical rounds, a family, who shares her cultural background, asked her to conceal the diagnosis of a terminal illness from their elderly father.*

### **SS Q11 What do you think Florence should do?**

Students gave a large variety of responses to this question. Unsurprisingly, many students suggested that more information was necessary or that they would need to discuss the situation further with the family or colleagues and to ascertain everyone's wishes. It is interesting to note, however, that students gave many different suggestions regarding who they would discuss the case with, as seen in the summary below:

- discuss further N=55
- with bioethicists N=2
- with family N=24
- with patient N=14
- with colleagues N=10
- with senior clinician N=5

*Have a robust discussion with the family about the two perspectives and be clear that they are sure that this would be what their father would want. (75)*

*I think Florence should not rush in and disclose information. There should be a family meeting with medical staff and each should be educated about the other's view and why. The decision is not clear cut. (9)*

*Talk to the patient about their wishes, it is more important to consider their beliefs and rights than their family's. (26)*

*Talk to other members of the health care team to gain their view. Talk to the family to find out why they want to conceal the diagnosis. (115)*

*Decide on what's best for the patient. Gauge what the patient wants; if the patient himself wants to know, tell him; if he doesn't then don't tell him. Also, can discuss with bioethicists in the hospital for an appropriate course of action. (172)*

Other responses are summarised below (and illustrated further with student quotes):

- Tell patient N= 30 (including 4 respondents who included the proviso “where patient is capable of making such a decision”)
- Follow professional guidelines N=25
- Respect cultural background/family's wishes N=20
- Do what the patient asks you to do N= 7
- Do as taught N=3
- Pass case to another clinician N=3
- Unsure N=4

The students’ responses to the Florence vignette generally fall into 3 categories, all of which suggest that Florence should act on the basis of doing what is best for the patient. Where the responses differ is in the way they determine what would be best for the patient.

One group of students argued that acting in the patient’s best interest entails finding out and respecting his wishes. Some suggest that this requires maintaining his confidentiality, or gaining his consent to talk about his diagnosis with the family.

A second group of students suggested that the right course of action is based on what would be expected in Florence’s work place or by her profession or in the country in which she is employed. For example, they argued that if Florence is working in Australia and has been taught or is expected by her profession to respect patient autonomy, then she must ascertain and comply with the patient’s wishes. However, a number of students suggest that if Florence were practising elsewhere, say in the patient’s country of origin, then the doctor could abide by the family’s request. This line of reasoning is again an example of the ‘when in Rome’ approach to health ethics issues.

A third group of students reasoned that the family’s wishes and cultural norms should be respected .They suggested that the family is best placed to know what is in the patient’s best interests, or that because Florence shares his cultural heritage she will understand what he would want. Conversely, some students argued against cultural stereotypes and suggested that Florence cannot assume that either she or his family will necessarily know what his wishes are regarding his condition.

#### **Patient’s wishes override (morally and legally)**

*Talk to the patient about their wishes, it is more important to consider his beliefs and rights rather than the family’s. (26)*

*Explain to the family. Discuss with colleagues what to do. Don't let your cultural beliefs impact on patient rights. (5)*

*Florence has a duty of care to her patients. To allow for patient autonomy the patient requires understanding of their diagnosis in order to make decisions for themselves. Florence should discuss the diagnosis with patient, maybe before discussing this with the family. (43)*

*Explain to the family that the patient has the right to know about his own health condition.*

*And that they should give him a chance to decide on how he wants to spend the rest of his life if he knows about his condition. Naturally, strong support from the family will be needed for the patient to go through this. (149)*

*Florence should respect the father's choices and leave decisions up to the father. (13)*

*... he has a right to know the diagnosis. And you have a legal obligation to tell him. (104)*

### **Confidentiality overrides**

*She [Florence] is not supposed to share the information with the family. She will be breaching confidentiality. She could discuss it with the patient and encourage him to discuss it with family if possible. (79)*

### **Consent is required**

*... discuss why they believe that they should do this, and explain the importance of gaining consent from the father himself before agreeing to conduct/not conduct treatment. But ultimately I don't believe that it is ethical to hide an illness from the patient themselves—they should have the ability to psychologically and legally/economically prepare for their own death. (174)*

### **Truth telling must be respected (if patient is competent)**

*Diagnosis shouldn't be concealed. (14)*

*It depends on whether the father asks for information on his health. If he is not able to comprehend then it may not be deliberately unethical. (94)*

*There is insufficient material here to make a decision. The mental state of the father must be known, as well as the actual illness. It may be possible to comply with the family's wishes if the father has a decreased mental capacity and will be unaware of the consequences of the illness. Generally, the patient should be told what is wrong with them ... as they come first. Would also be good to ask the patient, since they are assumed to come from the same culture and may want their family to deal with it and they don't want to know. (158)*

*... if he is conscious and physically, mentally and emotionally capable to make a logical decision he should be given the right to participate. (74)*

*I think that Florence should respect the patient's wishes. If the patient knows that the illness is terminal (without treatment), but does not wish to know that the diagnosis is (possibly following cultural standards) then she can follow the cultural belief. If the patient asks to know, then she should tell him. Florence has to understand that even though they share cultural beliefs, she needs to tailor treatment to the environment (to reduce liability should litigation arise). (137)*

### **Discipline-based**

The following quotes show that some students believe that the right thing for Florence to do is a matter of professional guidelines or specific to disciplines.

*Florence should first share the ethical burden—she needs to talk to her colleagues and seek guidance from her senior doctors. This isn't to dilute her responsibility; it is to share a problem which actually belongs to more people than the question lets on. There are multiple staff members involved in the care of this patient. Each discipline may have a method for dealing with this dilemma that Florence may find helpful. (128).*

*Florence is a registered doctor in Australia and has to abide by the ... ethics she is sworn to that allows the patient to decide. (59)*

### **Do as taught**

Some students' comments suggested that Florence should act according to the principles that she was taught to respect.

*Florence should discuss the possibility of the family telling their elderly father and mention that it would be more ethical to tell the father. Florence should recognise the family's cultural background and explain to them what she thinks that she needs to do. She should also consult another colleague and get their opinion. However, at the end of the day, I think that she is ethically obligated to tell the elderly father as it was what she was taught to do and especially if her other colleagues would do the same thing. (106)*

*Florence should use her ethical training—not her personal beliefs. (20)*

*I would firstly explain what I will do in terms of any ethics that was taught. (25)*

*Do as she has been taught in her ethics classes. (28)*

### **When in Rome**

The comments below show that many students believed that Florence should be guided by local norms, for example, the expectations of her workplace or the country in which she is working.

*Follow the guidelines of the culture/country she is practising in. She may do things differently at her home country—but as a health professional in Australia she is governed by Australia's practices. (10)*

*I suggest Florence do what is appropriate by law wherever she is working. (164)*

*Where is she? Is she now in Australia? She needs to tell the patient—so they are informed about their care and treatment and they can make an informed choice. Does this patient have someone with a medical power of attorney who will make the decision for them? (47)*

*Have a lengthy consultation with the family as to the advantages and disadvantages of concealing the diagnosis from their father, attempting to convince them that concealing the diagnosis would be ultimately hurtful to their father. The next move depends on where she is working. If she is working in the same culture as her cultural background she may find it difficult to consult with the elderly father due to cultural limitations. If she is working in Australia (or in other countries where patient autonomy is paramount), she should definitely consult with the elderly father regardless of the outcome of the consultation with the family. (181)*

*She needs to have a frank discussion with the family that while she truly understands their position (better than most), that they are in Australia now, and that is the way it is done here. (116)*

### **Respect cultural norms**

The following set of quotes illustrate some students' beliefs that cultural norms should be given paramount consideration in coming to a decision, seemingly irrespective of where Florence is practising or the principles that may underpin her education or profession.

*Should follow what patient's culture and beliefs. (83)*

*She should respect the family's decision but still provide the same level of care to the patient. (103)*

*Should accept that is right for her culture. We cannot impose our values on others. (29)*

*Follow her (and patient's) culture unless it puts the patient in dire situation—life threatening. (21)*

*In my personal opinion, Florence should not be telling the patient if the patient's family does not want it as the family is the one who gives the support and backup and try to avoid it from the patient. (77)*

*I think she needs to respect their family's opinion first. Family harmony may be helpful to patient's condition. (99)*

*I have been in that position and I always err on the side of the family because they are more in concert with the patient, they have no hidden agenda. I like to have a talk and "suss out"[explore] the situation. I have always found that the family has the best interests of their relative; I can see things from a western perspective which is often skewed. (131)*

### **Unsure**

A number of students were unsure about what Florence should do and acknowledged that the situation might cause moral conflict.

*I see that there is a conflict and it is a difficult one. I wouldn't personally conceal the diagnosis as I don't have this background. I believe in the principles we are taught. However, if I was Florence I would be conflicted and probably follow the family's wishes. (157)*

What is clear from the responses to the Florence vignette is that students do not agree on what Florence should do and, despite their ethics training, they give conflicting answers to the question. Their responses demonstrate confusion about how to deal with culturally based differences in values. While all of the students' responses demonstrate a willingness to be respectful of all the parties involved in the decision, they also demonstrate an example of moral tension caused by cultural differences in values and conflicting ideas about what is best for the patient. It is also interesting to note that students do not refer to any framework or strategy for thinking about the problem in the Florence example and most of their responses seem to reflect the dichotomy between universal and culturally based values described in the literature and academic debates (discussed in Chapter 1). Very few students considered how Florence might do both; respect the family's wishes and important cultural norms while also abiding by principles that oblige Florence to respect the patient's wishes and confidentiality.

### Cultural differences and moral conflict

In the following question we were interested to learn whether students had encountered situations like the one illustrated in the Florence vignette in their clinical encounters and how they had resolved the situation. While academically interesting, we were concerned to learn whether examples like the Florence vignette were raised in practice and resonated with students beginning their clinical encounters.

**SS Q12 Have you ever experienced this type of conflict, (i.e. where your own cultural beliefs clash with what is expected of you in your profession?)**

**SS Q13 How did you handle this conflict?**

As shown in the table summarizing the responses, many students indicated that they had experienced conflict similar to that illustrated in the Florence vignette.

Total responses	Yes	No	Unsure
79	23 (29%)	56 (71%)	0

The students that provided comments for this question gave responses similar to the responses to the Florence vignette. Students stated that in similar situations they sought advice from senior colleagues and peers, passed the case on to others, acted according to their professional guidelines and followed their institution's rules.

*Kept quiet and complied with the rules. (82)*

*Well, as a student it is easy to handpass the dilemma to a supervisor and discuss it with them later too. (183)*

*I have learned to accept it and move on. (139)*

*Just do what maintains the standards of where you are working. (164)*

Not surprisingly many of the students who had been in the types of situations illustrated in the Florence vignette described the experience as morally distressing or ‘harrowing’ as illustrated in the following quotes.

*I struggle with how a health professional can marry their personal beliefs and professional practice if their beliefs differ quite greatly from the general societal consensus—which is even more difficult if the general societal 'consensus' is also debated or controversial. (181)*

*I've been involved in many situations like this ... situations where the family want something very different for the patient than the patient does (e.g. the family of a woman in the last days of life with advanced cancer wanted full ... medical intervention). Generally, in a surgical setting, what the surgeon says goes, but I am ethically troubled by this kind of hierarchy. It discounts all the other therapeutic relationships that are involved. Primarily, my duty of care lies with the patient and indirectly (but not always) with the family. I ask myself about my planned actions and check that they are in the service of the patient and not to meet other ends. I have to be sure that what I do and say measures up to my profession's code of conduct. I also can't undermine my colleagues even if they hold competing or conflicting viewpoints. It was a harrowing situation and hard to keep thoughts and feelings from clouding things. I talked to people whose ethical thinking I trusted. (128)*

## Improving health ethics education

The final question of the student survey asked students for their suggestions about improving the health ethics curriculum that might make it more relevant to their work in the health professions.

### **SS Q14. What ideas do you have for improving health ethics education that might make it more relevant or applicable to your work?**

We received 96 responses to this question, which included suggestions about what to include in the curriculum, ideas about how ethics should be taught, comments about the amount of ethics teaching students received and suggestions aimed at enhancing cross-cultural understanding.

One of the repeated suggestions in response to Question 14 was that ethics education should include case studies and small group discussion. Student suggested that learning about ethical issues was facilitated in smaller discussion groups where students had an opportunity to reflect on their classmates’ potentially different points of view. Students suggested that case studies provide the opportunity to rehearse their thinking and decision-making for situations they would be experience in real-life.

#### **Case studies/scenarios**

*Provide more concrete information to go more into proper details of ethics and more clear examples. (40)*

*More applicable examples (i.e. case studies). (135)*

*More formal lectures on ethics that are really clinically based. (1)*

*More practical discussion. (2)*

*More scenarios—real scenarios to get an overall picture of how other people have handled it. (44)*

*More use of examples, role plays and exploration of these areas of conflict. (75)*

*Students should be presented with more case studies relevant to ethical issues and be involved in thorough discussion related to these matters. (3)*

*Taught in a more detailed manner with more practical examples it will help the graduates to tackle the situations easily in the future. (78)*

*Tutorial-based learning where situations can be discussed. I don't believe lectures are very helpful for this subject ... I would find value in smaller groups discussions. (157)*

*I think using cases would be much better than trying to teach theory. (43)*

### **Small group discussions**

*Education curriculum which allows development of one's viewpoint rather than teaching [from top-down] would be appreciated ... Small group discussion is a great way to stimulate thinking and correcting one's point of view. (169)*

*Having an occasional optional discussion group on some major ethics topics would be interesting. The lecture format is not conducive to open discussion, whereas a small group format would be ... More case-based scenarios for us to think through. (136)*

*We currently have no specific tutorials for ethics, rather only lectures and assignments. I think ethics would be better taught through tutorials, rather than in a didactic manner ... dedicated tutorials for ethics, even in the form of debates etc. would be a great way to boost knowledge and interest in the field. (168)*

### **Debriefing and clinical reflection**

*Have a chance for years 3 and 4 to debrief on real ethical situations/violations they have encountered during rotation. (116)*

*What is taught must be applicable in practice and in line with what an employer would expect with policies and procedures. Discussion, solutions, practical examples. (71)*

*Case studies and experiential learning—the lived experience. Learning in ethical practice never, ever finishes. I know that I appreciated hearing the dilemmas of others and I learned a lot from exploring these scenarios with my fellow students. A grounding in an ethical decision-making framework is absolutely essential ... A talk from the Health Services Commissioner before my post-grad course (compulsory ethics day prior to starting) was fantastic. (128)*

### **Learning about cultural diversity**

*Learn about the typical cultural needs, ethics of those patients more common in the hospital. Have people from those cultures teaching people from other cultures about their culture. (21)*

*More scenarios and more culturally relevant ones. (76)*

*Practical examples and incorporate cultural dilemmas. (90)*

*More practical aspects should be taught. Examples related to multicultural issues should be taught. (89)*

*... perhaps having an insight into other cultural beliefs from their own perspective, I think would be very beneficial to me. (170)*

*Do multicultural health ethics education. (12)*

*Give cross-cultural perspective or alternative ways of thinking about ethics. (84)*

*Include cultural background to Western ethics. (83)*

*More detailed background on cultural groups. (34)*

*Spend time throughout the course via lectures to discuss different cultural beliefs and traditions to allow for students to consider ethical decisions and how to go about reaching an answer. (43)*

*Teach comparative cultural ethics. (95)*

### **More ethics education**

*Also, starting ethics education much earlier in the course would be better to allow students to really have a good think about the dilemmas that they may face before they start being exposed to real-life clinical scenarios where they have to make decisions about what to do. (106)*

*Including it [ethics] more in the course. (68)*

*Increase the number of hours given to the subject [ethics] for nursing students. It is extremely interesting topic and worth so much study asap. (9)*

*More time devoted to looking at scenarios and how we would approach them. (24)*

Many of the responses above suggest that health ethics education could be improved by providing more exposure, more opportunities to discuss and rehearse ethical issues, and by providing strategies to help students with decision-making.

## 5.2 Take home messages for health ethics education

Our consultations with national and international students in the health professions provided useful insights into students' experiences of current approaches to health ethics education. We were particularly interested in whether, and how, students negotiated cultural diversity and how they understood ethical principles in light of culturally based differences in values.

The following is a summary of the key findings from our consultations with students as they relate to health ethics education and culturally based differences in values.

Most students agreed that health ethics education was useful in:

- preparation for clinical practice;
- providing skills in decision-making and patient care; and
- providing guidelines for practice.

Most students agreed with the principles that underpinned their ethics education but for different reasons. Some reasoned that these principles are universal, or reflect ideals that any reasonable person would aspire to. Many students also agreed that the principles they were taught in health ethics education could be applied to all patient interactions. However, as illustrated by the students' responses, in particular their responses to the Florence vignette, it is clear that students also seek to be respectful of culturally based differences in values and are conflicted about how to balance clashes between universal principles, what they were taught and important cultural norms.

We suggest that the responses to the student survey, in particular students' responses to the Florence vignette, illustrate students' moral confusion and demonstrate a gap in our current health ethics education. We suggest that students' responses show that they do not have, and would benefit from, skills and frameworks for thinking about and making decisions in situations that exemplify cross-cultural differences in values. As articulated by one student:

*... to me a plurality of values does not mean values should be avoided. The skills to understand others' values, and how to communicate your own, and the negotiation skills required in order to reach a compromise are essential skills in a multicultural secular setting. (175)*

In summary, our consultations with students in the health professions suggested:

- general agreement that health ethics education is useful and relevant;
- 'Western' health ethics is not (always) cross-culturally applicable;
- Students from diverse cultural backgrounds might not agree with the values they are taught in health ethics;
- Students seek to respect both cultural values and overarching principles;
- general agreement that some ethical principles are widely shared;
- a perception that principlism had been 'imposed' without regard for cultural

- sensitivities and is not always applicable; and
- culturally based differences in values can lead to:
  - confusion and uncertainty
  - clashes between personal values, family values, what is taught in health ethics, and/or professional guidelines
  - moral distress.

We conclude that consultation with students reveals general agreement with what they are taught; however, students are not prepared for and do not have strategies to deal with a situation where there is a clash between principles and cultural norms.

- To be more effective health ethics education needs to provide students with a framework for negotiating cross-cultural differences in values.

# Chapter 6 Developing a New Health Ethics Pedagogy

## 6.1 What is the problem?

As discussed in Chapter 1 and confirmed in our consultations with students and educators, effective health ethics education needs to accommodate an increasingly culturally diverse student population and an increasingly mobile health workforce. However, while health professionals are expected to be ‘culturally competent’ and ‘culturally sensitive’, respect for and sensitivity to cultural norms and health values sometimes challenges or competes with upholding widely agreed-upon or overarching ethical principles (e.g. truth telling and respect for individual decision-making). Our consultations confirmed that culturally based differences in health values can lead to tension and moral distress.

The practical tensions that arise for health professionals and educators navigating cross-cultural differences are underpinned by an ongoing theoretical debate over approaches to health ethics and bioethics in general. In summary, this debate pits universalism against cultural relativism.

To recap from Chapter 1, opponents of universalism in bioethics and health ethics argue that:

- universalist frameworks (such as principlism) reflect Western values;
- Asian, European, African and Latino bioethics are essentially different to American values;
- the ‘West’ is focused on individuals while the ‘East’ is concerned with what is good for the community or the family; and
- the domination of bioethics by American approaches amounts to a type of Western ‘ethical imperialism’ (Qui 2004, Justo L and Villarreal, J 2003).

However, in arguing against cultural relativism, others claimed that:

- there is no substantively distinctive European, Asian, African or Latino bioethics;
- many values are shared across cultures;
- accepted generalisations, for example, of the West as individualistic and the East as communitarian) over-simplify or ignore the variation that occurs within cultures; and
- cultures and cultural values are neither static nor monolithic (Rachel 2007, Nie 2005, 2007, 2011, Macklin 1999, Kim 2005).

These theoretical debates have significant implications for pedagogical approaches. Universal approaches to health ethics education imply that the same set of values or principles should apply in all settings, across all cultures and that health professionals should act in accord with universal values. One of the problems with such approaches, even allowing room for specification of abstract principles in particular contexts, is that upholding universal principles will sometimes entail acting or deciding in ways that are contrary to or against local values and practices.

Pedagogical frameworks for health ethics that are underpinned by cultural relativism entail that the values that health professionals hold or are taught in one cultural context need not apply in different cultural contexts. For example, if what we teach health professionals in their health ethics education is underpinned by a cultural relativism, they will have no grounds for judging or deciding which action or decision is ethically appropriate in cases where their moral judgment is different to that of their patient, the family or the community. This raises difficult questions for health professionals about whether or the extent to which they should respect local practices and values, especially where these conflict with their own values.

Both universal and relative approaches raise problems for teaching health professionals. As described by educators, practitioners and students in our consultations, applying universal principles across all cultural contexts can lead to a sense of moral arrogance, perceptions of a lack of respect for others or accusations of cultural or moral imperialism.

However, relativist approaches that teach respect for cultural values can lead to moral distress or loss of integrity. We suggest that resolving cross-cultural differences by simply following rules, or adopting a 'when in Rome' approach by simply complying with moral norms, amounts to 'stepping away' from taking responsibility for moral decisions and could lead to moral apathy. Further, as discussed in Chapter 1, many scholars point out that cultural relativism might reflect the stereotyping and dichotomising of cultures.

In this section, we describe a pedagogical approach that can assist health professionals to identify, navigate and negotiate some of the cross-cultural understandings that impact on health care and decision-making by seeking to find a 'middle position' between universalism and cultural relativism through 'a moral partnership'.

## 6.2 Principlism is too rigid

Our consultations with health ethics educators confirmed that, currently, many health ethics curricula in Australian universities and around the world are based on western-developed bioethics frameworks. However, our consultations also confirm concerns expressed in the literature about the appropriateness of delivering a homogenous western-developed health ethics education to students who come from, or will practise in, non-western settings. Our project addressed these concerns explicitly and has developed a pedagogy based on consultations with health ethics educators, students and professionals and a theoretical analysis of existing approaches to cross-cultural ethics.

Our consultation demonstrated that principlism is both widely used and described as inappropriate or difficult to apply in diverse cultural contexts. This summary of our consultations reflects the discussion in the literature and adds empirical challenge to claims that principlism reflects universal culturally neutral values and that this approach is applicable in diverse cultural contexts.

Critiques of principlism suggest it can be both restrictive and static. The principles of beneficence, avoidance of harm, autonomy and justice are often narrowly interpreted as applying to a single person and through a particular health discipline's view of what matters clinically. These ethical principles are also codified into professional ethical guidelines, or

further specified into a narrow discipline-specific focus.

Although there is room to expand the principles and to specify them more dynamically in different contexts and circumstances, their traditional development and application is grounded in the single health professional/patient encounter.

Calls to expand notions of what matters ethically are reflected in alternative ethics frameworks that identify the broader and more nuanced influences that impact on patient/practitioner interactions. Examples of these include ethical frameworks that explicitly incorporate relationships, feminist approaches to bioethics and approaches that recognise and address important cultural influences.

Common to these alternative frameworks is the claim that the bioethics pillars create a somewhat rigid and structural boundary which can act to block out many of the dynamic cultural, relational and societal factors contributing to health beliefs, behaviours and opportunities.

## 6.2 A flexible approach

To develop our approach, we consulted with health ethics educators, students and early career practitioners. The main findings from these consultations, as presented in previous chapters, can be summarised as follows:

- Health ethics educators, students and ECPs all identified a link between health ethics education, health practice and health outcome.
- In the practice of teaching, there is much more agreement about universal principles than has been suggested in literature.
- Acknowledgement that the way principles are adopted is not always sensitive to cultural norms.

As well, our survey results clearly indicate:

- a desire amongst both students and educators to be respectful of cultural differences.

Interestingly, none of the responses suggested that culturally based differences in values should be ignored or overridden. Further, none of the survey results reflected the view that ethical principles are absolute or should be followed dogmatically. In fact, one of the most significant findings from our consultations is that:

- Educators, practitioners and students all expressed uncertainty, caution and sensitivity about how to approach or resolve ethical issues that arise when health care involves culturally divergent approaches, beliefs and values.

The theoretical debate over the cross-cultural application of universal approaches to health ethics (such as the four principles approach) is frequently couched as a tension between the acceptance of either universal values or cultural norms. However our consultations suggest that a significant source of tension for health practitioners, students and educators is not

*whether* to, but rather, understanding *how to* mediate between agreed-upon universal values and culturally specific norms. Our consultations also suggest that widespread acceptance of universal values is not necessarily incompatible with respect for cultural norms.

Significantly, our consultations with both health educators and students in the health professions lend empirical support to the possibility of finding such middle ground. Many of the comments we received reiterated the ideas put forward by influential scholars that universal values can and should be applied with sensitivity to cultural contexts. For example, Macklin (1999), Nie (2011, 2007) Tsai (2005) and Benatar (2004, 2008) argue that it is possible to mediate between ‘the universal’ and ‘the particular’.

According to Macklin (1999), there is no opposition between universal principles and cultural particulars, but rather a complementary function: *“To apply any ‘abstract’ ethical principle, it is first necessary to look at the social context, to take account of who stands to be affected and in what ways, and to factor in a large array of particular circumstances”* According to Macklin, *“the ways of understanding and implementing general principles are numerous and can take different forms in different contexts, countries or cultures”*. (p.48)

Similarly, Tsai (1999) argues that Western values are not at odds with Asian norms. Tsai explored the cross-cultural plausibility of the four principles and showed that these values are clearly identifiable in ancient Chinese medical ethics dating back to literature from 581 AD.

Nie (2000; 2005) reasons that simply applying ethical principles developed in a particular moral tradition to other cultural settings, or merely respecting cultural differences in local settings, is both practically dangerous and theoretically impossible. Nie suggests that many cultural norms do in fact embody universal values. Nie (2005) cites Confucianism and Daoism as examples of universal prescriptions intended for all people, both Chinese and non-Chinese.

Like Macklin, Nie suggests that *“bioethics must find a way to address both what really matters locally and the universal moral values we share”*. He argues that *“interpretative cross-cultural bioethics promotes a richer dialogue than generally occurs among different medical moral traditions”*.

Based on our review of the literature, we conclude that the aim of finding a middle position between universalism and cultural relativism is coherent, intuitively appealing and practically applicable in health ethics teaching frameworks.

In addition, our consultations suggest that many educators and students would find it helpful to have a framework for negotiating between abstract principles and particular cultural contexts, as illustrated by the following student quote:

*[T]o me a plurality of values does not mean values should be avoided. The skills to understand others' values, and how to communicate your own, and the negotiation skills required in order to reach a compromise are essential in a multicultural secular setting. (175)*

## 6.4 Finding a middle position

Benatar has put forward a framework that is useful for conceptualising a middle ground between universal principles and cultural norms. He suggests that “*areas of disagreement in making ethical decisions may be explicable by failure to understand others and by differing perceptions of social relations*” (Benatar 2008, p. 343). Benatar reasons that applying ethical principles through moral reasoning, with appropriate consideration of morally relevant social factors, could allow us to find that a rational middle ground between ethical universalism and ethical relativism.

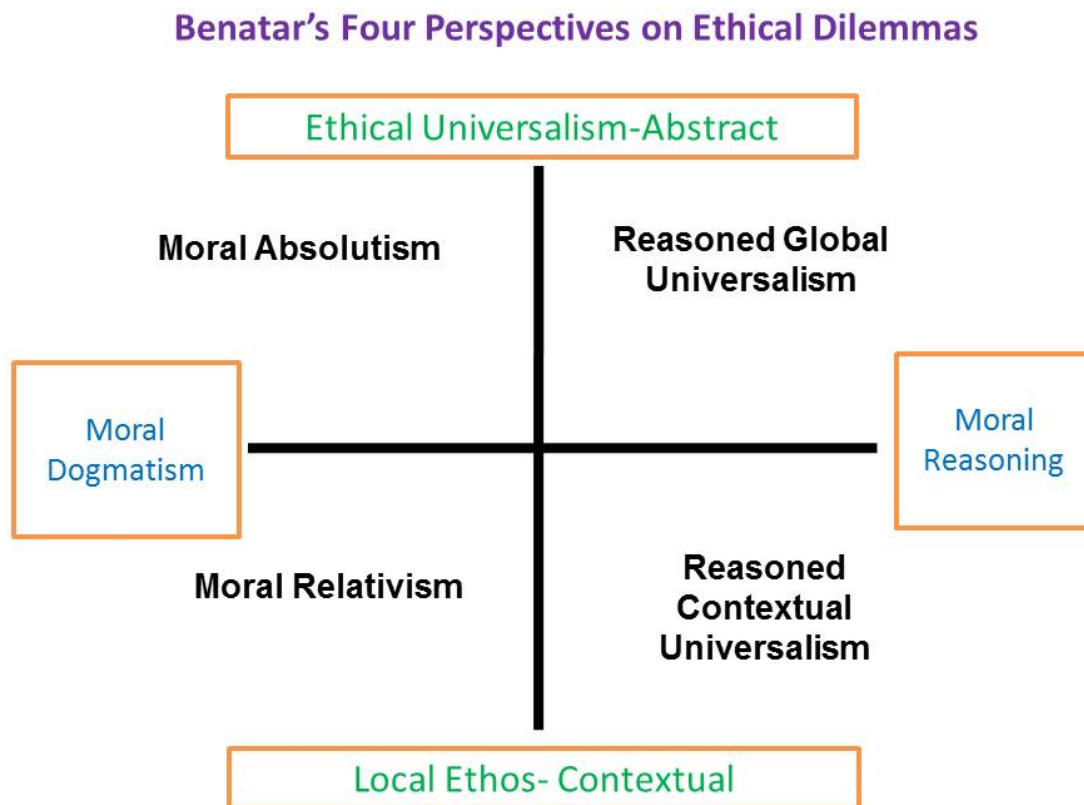
Benatar suggests two requirements for finding this middle ground. Firstly, it is necessary for agents to acquire deeper insights into their own value systems and the value systems of others. Secondly, agents should avoid uncritical acceptance of the moral perspectives of all cultures as equally valid, or rejection of them all as invalid (Benatar2008).

Benatar proposes a two-dimensional framework along the lines of analysis by Douglas and colleagues (Douglas et al 2003) to help understanding of disagreements about some of the ethical dilemmas that arise in cross-cultural encounters, illustrated in Figure 1 below.

One dimension stretches from a pole representing abstract universal principles to a contrasting pole, where local context (influenced by time, location, culture and other social factors) defines mores.

A second intersecting dimension stretches from a position that uses moral reasoning to positions of moral dogmatism.

Figure 1: Four perspectives on ethical dilemmas. (From Benatar 2004)



Benatar, 2004

Rather than pitting universalism against relativism, Benatar's nuanced approach distinguishes four broad moral positions:

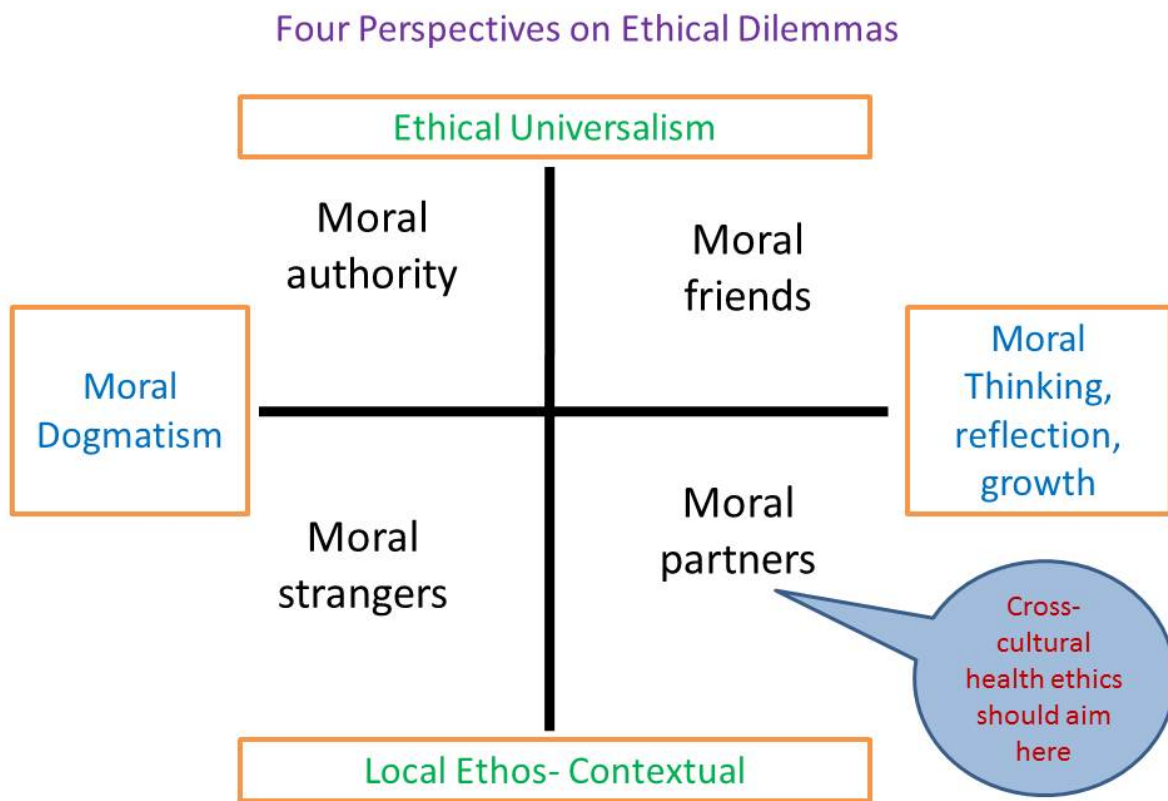
- Moral absolutism describes a position where ethics are prescribed and immutable.
- Moral relativism contends that morality is entirely relative to time, place and culture.
- Reasoned global universalism is a position arrived at through the application of a set of abstract ethical principles that have been developed and justified through a reasoning process.
- Reasoned contextual universalism is reached by taking morally relevant local factors into account in applying reasoned global universalism.

Benatar explains that reasoned contextual universalism 'avoids the perils' of ethical relativism and universal approaches that are 'blind to context'. This position finds a *middle ground* by seeking reasoned ways to specify how abstract principles are to be applied at the local level.

Benatar's approach is not only intuitively appealing, but coherent and consistent with both our empirical accounts and with arguments put forward by other influential scholars such as Macklin and Nie (described above). As well, we suggest that Benatar's framework provides the basis for a simple and useful pedagogical approach that balances both overarching universally accepted principles and important cultural practices and norms.

Borrowing from both Benatar and from Tristram Engelhardt for the purpose of developing a simple teaching framework, we have adapted Benatar’s diagram, which can be understood more intuitively as follows:

**Figure 2: A modified version of Benatar’s four perspectives**



Moral absolutism can be understood by students as a position where the right course of action or decision is one that is prescribed, for example, by a **moral authority**. This type of position does not allow for negotiation and assumes that there is only one right way of acting or deciding because ethical rules are metaphorically ‘written in stone’, or incontestable. From this position, culturally based differences in values are only acceptable to the extent that they are consistent with these absolute norms.

Moral relativism corresponds with the belief that we are, in the words of Engelhardt, ‘**moral strangers**’. According to Engelhardt, we live in a world in which our differences are so great that most of us are ‘moral strangers’ to one another; we have few moral friends. A moral stranger is someone with whom we do not share the same moral intuitions, the same interpretation of particular cases, the same view of what counts as a good or a harm, or the same rank ordering of such principles as autonomy, beneficence and justice. The idea that we are moral strangers corresponds with the idea that culturally based differences in values are inevitable (moral relativism).

According to Engelhardt, the only way that we, as moral strangers, can resolve our moral disagreements is by a consensual agreement. We come together and decide to do 'x' *not* because we are convinced through reason that doing 'x' is the right or good thing to do, but because we agree that, to make life liveable, we need policies, rules, and laws that require that we all do 'x', if not voluntarily, then through pragmatic agreement.

Conversely, we can think of *Reasoned Global Universalism* as corresponding with the notion of **moral friend**. A moral friend is someone with whom we share enough ideas about morality to resolve a moral controversy by sound moral argument. For example, moral friends can resolve moral disagreement and decide to do 'x', because they agree and are convinced through reason that doing 'x' is the right or good thing to do. Principlism, the idea that there are global and universally agreed-upon principles that all reasonable people agree on, is an example of moral friendship or reasoned global universalism. Although agreement on broad principles does not always mean that such friends will give them the same moral weight in particular situations.

As Rosemarie Tong suggests in her discussion of Engelhardt, one way to understand a bioethical theory better is to apply it to some passionately debated bioethical issues. She selects two practices for analysis: (1) euthanasia and physician-assisted suicide and (2) female circumcision/genital mutilation. She reasons that Engelhardt's moral strangers will be inclined to accept both of these practices in one form or another, while many people are opposed to both of these practices, especially the second one.

Tong suggests that if a group of moral strangers were to enter into respectful conversation with a group of moral friends, both of these groups might at least modify, if not entirely change, their respective positions on euthanasia and physician-assisted suicide and female circumcision/genital mutilation. Tong states: "*I hold out hope for this meeting of minds because I am convinced, contrary to Engelhardt, that at least some groups ... are not as morally alien to each other as Engelhardt fears they are.*" (Tong 1997, p. 63)

Tong suggests that different groups are capable of moral acquaintantship, if not moral friendship. We suggest that this idea of moral acquaintantship is synonymous with what Benatar refers to as Reasoned Contextual Universalism and that this position corresponds with the idea that even if we are not moral friends, we need not be moral strangers. We use the term moral partners to capture the idea articulated by many of the educators and students with whom we consulted, that it is possible to mediate or negotiate between a moral absolutism and a moral relativism. Our consultations suggest broad agreement with claims made by Benatar and others that universal values are not incompatible with cultural contexts. As Rosemary Tong suggests, if we approach ethical disagreement with 'friendly eyes' (Tong and College 1999) and accept that, at some level, even moral strangers are morally acquainted and have some values in common, then we can work together as moral partners to arrive at a position that preserves both what matters locally and universally.

As Benatar explains, reasoned contextual universalism, or what we refer to as entering a **moral partnership**, requires avoiding either uncritically accepting or rejecting norms and practices. It is reached by taking account of morally relevant contextual consideration in applying global universalism. Reasoned contextual universalism (a middle ground) is

achieved by rational application of universal principles to local contexts. This requires insight into how and when to take a local context into consideration in applying universal ethical principles.

We suggest that cross-cultural ethics education should teach health professionals to operate in, and aim for, a moral partnership. This pedagogical approach, which draws on the ideas put forward by Benatar, Macklin and Nie, assumes that at some level there are health values that are shared across all cultures, whilst also acknowledging individual differences. One of the difficulties in negotiating towards a middle position is that frequently ethical issues are discussed only in terms of differences without consideration of the values we have in common. In the words of one student:

*I work in women's health and encounter women from all sorts of backgrounds and cultural beliefs ... I have observed that focussing on difference obscures all the shared elements. I think to never assume anything about anyone is a pretty reliable method when caring for another person. (128) (emphasis added)*

We propose a health ethics pedagogy underpinned by a position of reasoned contextual universalism (i.e. coming to a reasoned middle ground) that translates to a process of working through ethical issues as moral partners. This position acknowledges the relevance of history, culture and economics to the interpretation of universal principles. It is underpinned by the idea that there is more similarity than difference in health values across cultures. It encourages health ethics educators to:

- identify their own value systems;
- identify values important to the patient/others;
- look for a middle ground where there is conflict or divergence; and
- be prepared to shift and grow in terms of their moral thinking by challenging inconsistencies, assumptions or moral dogma in their own ethical positions.

Importantly, a true moral partnership requires that all of the above are undertaken by *both* health professionals *and* their patients. In other words, either one or both might shift in their thinking in negotiating through ethical differences. Our pedagogical frameworks require that both patients and practitioners work together to discover the right thing to do through reasoning and mutually respectful dialogue. We suggest that some of the difficulties that arise in cross-cultural health practice are due to the establishment of professional boundaries that require that health professionals provide the answers rather than discover them with their patients. As illustrated in this sophisticated analysis from one student, in response to the Florence case study:

*Florence's relationship to the patient and family as a doctor is also affected by their shared cultural background ... The path through this is complicated by two ways of relating to the family. At best, it might be used positively to establish shared understanding and trust, but at worst, a dual relationship can complicate and distort thinking, especially about boundaries. (128)*

This quote suggests that when a doctor shares a patient's cultural background, she might be in a better position to engender trust. However, the student speculates that this shared

understanding could somehow distort a boundary that exists between patients and doctors. Interestingly, the student articulates the solution to the problem:

*There may be a way to respect the individual's decision-making while protecting the integrity of deeply held cultural beliefs. A tough one!! (128) (student emphasis)*

We suggest that the solution that the student outlines, *a middle ground*, is more likely to be found in a moral partnership, rather than in interactions where health professionals are expected to be moral authorities and are prevented from engaging or reflecting on moral alternatives by professional boundaries.

We suggest that one of the reasons that principlism is sometimes referred to as imperialistic or insensitive to cultural diversity is because it assumes common understandings or common language; in other words, that *we are all moral friends*, rather than engaging people according to their own understanding or language. Further, some of the responses to our consultations reveal the perception that principlism is 'imposed', rather than inviting people from diverse backgrounds to share in or contribute to the exploration of ethical issues. In the words of one educator:

*The sharing of power, influences and resources in developing appropriate curriculum—that is "letting others in" as opposed to merely providing courses on one's own terms. (35)*

Where our approach differs is that it accepts at the outset that we need to *find* (rather than assume or declare) the values that we agree on and work from there to negotiate through the matters we disagree about. We suggest, as did many of the educators and students that we consulted, that these differences will often reflect important contextual differences rather than fundamental disagreements about principles.

Finally, we present a diagram (Figure 3) to summarise our pedagogical approach. This diagram illustrates that working in a moral partnership is neither exclusively a 'top-down' universal nor a 'bottom-up' case-based or culturally specific approach to sorting out issues in health ethics.

Our approach describes a process for sorting through culturally based differences in values that is neither a 'top-down' deductive application of principles nor a bottom-up inductive derivation of rules. It is a process for decision-making and ethical justification that works in both directions. This approach requires that individuals acknowledge and accept moral challenges by reflecting, testing, pruning, adjusting and/or modifying their moral convictions with the goal of coming to decisions that are consistent with our shared and considered judgments.<sup>2</sup> In the context of health care, we suggest that health professionals and their

---

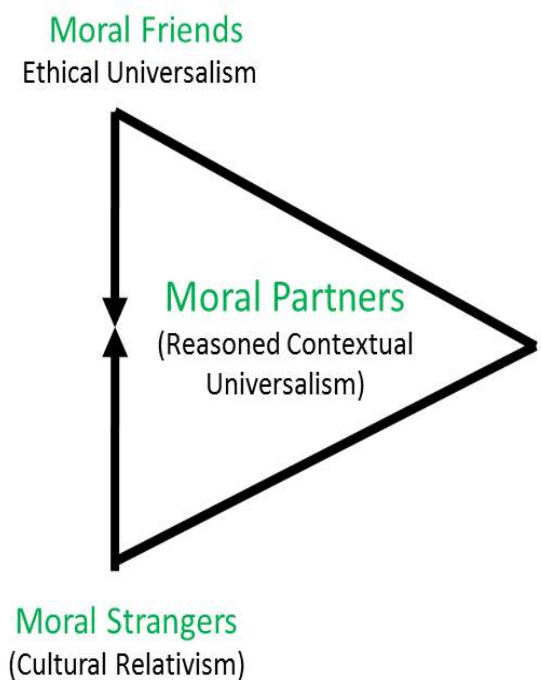
<sup>2</sup> This approach is based on 'coherentism' an idea described by Beauchamp and Childress. Coherentism is also referred to as wide reflective equilibrium, described by Norman Daniels, (1979). Wide reflective equilibrium. *Journal of Philosophy*, 76, 256-282 p257, reprinted in Daniels, N. (1996). *Justice and Justification: Reflective Equilibrium in Theory and Practice*. New York: Cambridge University Press.

patients can sort through culturally based differences in health values by undertaking this process, and coming to a middle ground, as moral partners. This process avoids imperialism and allows for moral growth and acknowledges that culturally based values are neither static nor homogenous.

**Figure 3: Addressing cross-cultural differences in values through a Moral Partnership**

Analysis of ethical issues as moral partners aims to arrive at a middle ground by considering and respecting both important cultural contexts and overarching universal values.

**A middle position: Moral Partnership**



after Benatar, 2004

Our pedagogical approach proposes that:

- culturally based differences in values should be addressed, not automatically either rejected or accepted; and
- analysis should aim to arrive at a middle ground by considering and respecting both important cultural contexts and overarching universal values.

Our moral partnership approach reflects a fundamental belief that we are more alike than different and that cultural norms are not incompatible with universal principles.

In the words of Rosemary Tong:

*“Respect and consideration for people requires an attentiveness to their differences, a readiness and willingness to give them the kind of moral space an individual needs to develop as a unique person. Certainly, we must permit each other this*

*opportunity, but we must, I believe do more than this. We must care about each other. Beneficence requires us to do more than to respect each other's voluntary decisions. It requires me, for example, to read with friendly eyes, on the look out for the kind of common moral fragments that he and I can use to create a foundation for some small consensus between us; for unless we **try** to do this, we will pave the road to a world in which people have fewer and fewer moral friends." (Tong 1997, p. 71)*

Similarly, we argue that a respectful analysis of culturally based differences in values in a moral partnership can result in *mutual* moral growth.

# Chapter 7 Teaching Module

## Introduction

Following our review of the literature and our stakeholder consultations, we concluded that universal values are not incompatible with culturally based norms and we developed a pedagogical framework for health ethics that can provide educators and students with a theoretical approach for negotiating culturally based difference in values. We refer to this approach as coming to a middle position through *a Moral Partnership*. In this section, we describe how our pedagogical approach can be applied to health ethics curricula and how it can work in clinical practice. We provide teaching materials to illustrate how cross-cultural difference in health values can be negotiated through a moral partnership.

In developing our approach we suggest, based on our consultations, that in developing ethics curricula it is important that:

1. Frameworks of ethics knowledge and thinking strategies are visible and accessible to students.
  - Students need models or concepts that provide an overview of how to consider different ethical norms, including the sources of those norms.
2. Ethical decision-making should be a transparent process where reasons for decisions can be articulated.
  - This can be facilitated by providing students with materials that help them to articulate and position their views and by providing opportunities to discuss and share perspectives.
3. Methods for naming and weighing up differing values need to be modelled and made available to students.

Our approach offers an explicit process or platform to assist students to understand and identify their position along a spectrum of ethical values and considerations, including recognizing where and how their position differs from others. It provides a theoretical map as a way for students to move between values and perspectives (including, at one end, universal principles and, at the other, specific culturally based values and beliefs).

Our teaching module aims to provide a framework for thinking about issues in health ethics and teaching materials to rehearse this thinking and make it visible and accessible to students. Our approach should enable students to:

- understand their values and how their thinking is aligned on the universalism–relativism spectrum;
- articulate their position on issues with reference to a theoretical ‘map’;
- seek to understand health contexts and reflect on conflicting points of view;
- understand where different points of view fit in the theoretical map;
- understand how to negotiate in a moral partnership;
- justify their ethical decisions; and
- develop moral agency.

# Teaching materials

## Overview

We have developed the following teaching materials as tools to assist health educators to facilitate the aims described above. Our teaching material provides reflective exercises, student exercises, case studies and worked examples for teachers.

We illustrate a process for negating culturally based difference in health values through case studies. Our teaching approach is summarised by the acronym 'ADSAN' which is described below and illustrated in the accompanying teaching materials.

### **ADSAN: A Process for Ethical Decision-making as Moral Partners**

1. **A**cknowledge the **D**ifference/s
2. Identify **S**hared value/s
3. **A**nalyse the point/s of difference
4. **N**egotiate

ADSAN assists students to identify and articulate, make and justify ethical decisions in situations where culturally based difference in values causes conflict. ADSAN is underpinned by the aim of finding a middle ground where both patients' and health practitioners can agree. This approach is presented in teaching materials below.

## List of Teaching Materials

### **Teacher Exercise 1: “What is the Purpose of Studying Ethics?”**

An exercise to help educators to reflect on the aims of health ethics education through scenarios.

### **Teacher Notes 1: What is Ethics?**

### **Teacher Notes 2: Benatar’s Boxes**

### **Teacher Notes 3: Four Perspectives on Ethical Dilemmas**

### **Teacher Notes 4: ADSAN and Sally**

Teacher notes for working through the Sally case study using ADSAN.

### **Teacher Notes 5: ADSAN and Basilia**

Teacher notes for working through the Basilia case study using ADSAN.

### **Cross-Cultural Health Ethics Case Studies**

**Case Study 1:** Sally

**Case Study 2:** Raf

**Case Study 3:** Florence

**Case Study 4:** Dylan

**Case study 5:** Maria

**Case Study 6:** Ivan

**Case Study 7:** Basilia

### **Student Exercise 1: “What is ethics?”**

An exercise to illustrate difference between ethics, law, cultural beliefs and religion.

### **Student Exercise 2: ‘When in Rome’**

An exercise to illustrate the problems with ethical relativism.

### **Student Exercise 3: “More same than different”**

An exercise to illustrate universal or widely shared values and that culturally based differences in values are not incompatible with universal or overarching principles.

### **Student Exercise 4: “Ethical Thinking Map”**

An exercise to introduce a ‘theoretical map’ to help students to identify different approaches to thinking about ethical issues.

### **Student Exercise 5: ADSAN**

An exercise to teach students a process for negotiating conflicting values through a Moral Partnership.

## Teacher Exercise 1: “What is the Purpose of Studying Ethics?”

(Also suitable for discussion with students)

Read each of the following: How would you respond to the student in each case?

### **Scenario 1: The aims of health ethics education**

You are the lecturer of a 1<sup>st</sup> year health ethics subject. Before the start of your first class, one of the student talks privately with you. She says:

“I am looking forward to this class, but I am a little worried. I am a profoundly religious person and I try to act in accordance with my religion’s teachings. What is the purpose of this subject? Are you going to challenge my fundamental beliefs? Are you trying to change my mind about what is right and wrong?”

### **Scenario 2: When things are done differently at home**

You are the tutor of a 3rd year health ethics subject for health professionals. During a discussion about clinical decision making, an international student makes the following remarks:

“That’s not how we do things at home, and I think what you are teaching us to do is ethically wrong. What you teach me in health ethics is not relevant for me because I am going home soon.”

Another international student responds by saying:

“I am going home soon too. But I know that this is a very good university, so you must be teaching us the right things. I will go home and try to enlighten my colleagues. I will follow your teachings and try to improve the way we do things back home.”

### **Scenario 3: Patients’ culturally based values**

During a clinical ethics tutorial, a student describes a confusing clinical experience.

“On my rounds, there was an elderly patient who was dying. The patient’s family asked the doctors not to tell their father that he had a terminal illness. The family said that in their culture it is harmful and wrong to tell elderly people such things; they should be given hope. In their culture, the family decides what is best. But that is not what we learnt in health ethics classes. You taught us that we should always tell patients the truth. If I was looking after this patient, what should I have done?”

#### **Scenario 4: Going abroad for clinical training**

A student in your classes shares some concerns with you:

“During your ethics classes, I have learnt about consent, confidentiality and autonomy. But now I am going to a developing country for my clinical placement. Our clinical teacher told us that things are done differently there. For example, no-one worries too much about consent because doctors make all the decisions. Patients expect doctors to tell them what to do. So how should I behave? Should I behave the way you taught me to or should I do things their way?”

## Teacher notes 1: What is Ethics?

### Some definitions of ethics

#### Ethics vs Morality

*"[Ethics] is the philosophical study of morality. The word is also commonly used interchangeably with 'morality' to mean the subject matter of this study; and sometimes it is used more narrowly to mean the moral principles of a particular tradition, group, or individual. Christian ethics and Albert Schweitzer's ethics are examples."*

*"What is ethics? The word itself is sometimes used to refer to the set of rules, principles, or ways of thinking that guide, or claim authority to guide, the actions of a particular group; and sometimes it stands for the systematic study of reasoning about how we ought to act. In the first of these senses, we may ask about the sexual ethics of the people of the Trobriand Islands, or speak about the way in which medical ethics in The Netherlands has come to accept voluntary euthanasia. In the second sense, 'ethics' is the name of a field of study, and often of a subject taught in university departments of philosophy ...*

*Some writers use the term 'morality' for the first, descriptive, sense in which I am using 'ethics'. They would talk of the morality of the Trobriand Islanders when they want to describe what the islanders take to be right or wrong. They would reserve 'ethics' (or sometimes 'moral philosophy') for the field of study or the subject taught in departments of philosophy. I have not adopted this usage. Both 'ethics' and 'morality' have their roots in a word for 'customs', the former being a derivative of the Greek term from which we get 'ethos', and the latter from the Latin root that gives us 'mores', a word still used sometimes to describe the customs of a people. 'Morality' brings with it a particular, and sometimes inappropriate, resonance today. It suggests a stern set of duties that require us to subordinate our natural desires—and our sexual desires get particular emphasis here—in order to obey the moral law. A failure to fulfil our duty brings with it a heavy sense of guilt. Very often, morality is assumed to have a religious basis. These connotations of 'morality' are features of a particular conception of ethics, one linked to the Jewish and Christian traditions, rather than an inherent feature of any ethical system.*

*Ethics has no necessary connection with any particular religion, nor with religion in general."*

Peter Singer (ed.), *Ethics*, Oxford, Oxford University Press, 1994.

### **Some common views about ethics**

The meaning of 'ethics' is hard to pin down and the views that people may have about ethics are sometimes not well founded or are difficult to articulate. One way of clarifying what ethics is, is to be clear about what ethics *is not*. The following statements summarise some common views about ethics and some reasons for rejecting these views.

- *Ethics has to do with what our feelings tell us is right or wrong.*

But feelings frequently deviate from what is ethical, a person following their feelings may still recoil from doing what is right.

- *Ethics has to do with my religious beliefs e.g. What's right is what God approves of.*

If ethics were confined to religion, then ethics would apply only to religious people, but ethical standards apply to both atheists and religious people. There are many religions and these usually set high ethical standards and provide motivation to act ethically. But even religious people seek to justify their actions with more than religious rules.

- *Ethics consists of doing what the law requires.*

Laws often incorporate ethical standards, but, like feelings, can deviate from what is ethical. Laws allowing unjustified discrimination, such as slavery and under apartheid, show that simply 'being legal' is not the same as being ethically permissible. Similarly, many actions are unethical, but there is no law against them e.g. lying or adultery.

- *Ethical standards of behavior consist of what society accepts.*

Standards of behavior in society can deviate from what is ethical; an entire society can become ethically corrupt (e.g. Nazi Germany). Ethical beliefs are not based on surveying social attitudes. Social attitudes are not homogenous and are often in conflict.

- *Moral standards differ from culture to culture.*

This view is synonymous with ethical relativism, a popular but problematic account discussed in the following section.

### **Ethical relativism**

This is the view that an action may be morally right in one society but wrong in another, i.e. there is no such thing as universal truth in ethics, only different customs in different societies and these cannot be said to be right or wrong.

Most ethicists reject ethical relativism for the following reasons:

1) The fact that some practices are relative (different in different cultural context) does not mean that all must be. Some values may be relative to culture while others are not—because some standards are relative to culture does not mean that all must be e.g. customs regarding dress or burial may depend on local custom, whereas slavery, torture or lying may be judged as wrong based on universal standards.

2) Differences in customs do not necessarily mean differences in values. Moral practices of societies may differ, but moral principles underlying these practices do not. James Rachel<sup>3</sup> gives the example of the practice in nomadic cultures of abandoning feeble old people to die of exposure. As he points out, this practice does not entail less respect for life in these cultures than in our culture. It is a practice born of necessity in a cultural context where people are forced to make choices that we do not have to make. Life in harsh circumstances may require policies and practices that would otherwise be rejected i.e. there are some values ethical cultures have in common, what they might disagree about is 'exceptions to the rule'.

3) Universal standards can exist even if beliefs vary among cultures. We can acknowledge cultural differences and still hold that some beliefs are wrong e.g. treatment of the Jews in Nazi Germany being seen as morally wrong regardless of the moral beliefs of Nazi society.

4) All cultures share some values, e.g. protecting children, truth telling, and prohibitions against murder.

5) Ethical relativism has untenable consequences: if ethical relativism is correct, there can be no common framework for resolving ethical disputes or for reaching agreement on ethical matters among members of different societies or cultural groups. Ethical relativism promotes individual conformity and does not leave room for moral disagreement, growth or reform.

6) Ethical relativism has implausible consequences: if ethics is always relative, then there is no basis for choosing between conflicting views and no need to argue—both views are right. Further, if ethics is about social consensus, how can we determine the right action when social consensus is lacking? For example, how do we make decisions when there are wide ranging social views about abortion, euthanasia, animal experimentation etc.?

As Rachel explains, differences in moral standards are like differences in other fields of inquiry e.g. some cultures may believe that the earth is flat or that disease is caused by evil spirits. We do not conclude that, therefore, there is no truth to geography or medicine. Some cultures may be better informed than others, or have access to more developed technologies. Similarly, ethical reasoning is possible. Disagreement in ethics may simply mean that some people do not have the facts or have made a mistake in their reasoning. The fact that we do not have a universally agreed-upon set of ethical standards, or that universal standards may be hard to discover, does not mean they cannot exist.

### Reason and Ethics

To be acceptable, a moral judgment must be backed by reason. Consistency is the prime requirement of rationality. The right course of action is consistent, is supported by the best

---

<sup>3</sup> James Rachel & Stuart Rachel (2007). *The Elements of Moral Philosophy*. McGraw-Hill, New York, N.Y. Chapter 2.

reasons (not just feelings or intuition), and takes a universal point of view.

Ethical judgments must take facts into account. For example, opponents of euthanasia claim that legalising it would lead to diminished respect for life, those pro-euthanasia deny this, two views disagree over facts, but the facts here are difficult to discern, rest on different estimates of consequences of legalising euthanasia.

### **What ethics is**

Ethics is an academic field of study, part of a branch of philosophy called moral philosophy. It discusses matters of right and wrong, not as a sociological study of what different cultures believe, but as an analytical inquiry into how moral judgments should be made, what methods and principles should be used, and how they should be justified. Ethics is not just a theoretical study: the point of ethical analysis is to provide action guides for specific practical problems.

Like all other academic fields of study, the goal of reasoning in ethics is to arrive at an explanation, a guiding principle or theory that has the best fit with our experiences and with other theories and principles that we have confidence in, or believe to be true. Ethical theories and principles focus on what is right or wrong or how we should act. Ethical theories cannot be 'proved' in the traditional sense, but this is also true of many theories in other fields of study. This does not mean that one ethical belief or theory is just as good as another. Just like other beliefs or theories that cannot be proved e.g. the Big Bang theory or the theory of evolution. We can have confidence in some ethical theories because they best describe our experiences and observations of the world and because they 'fit' well with other theories that we have confidence in.

## Teacher Notes 2: Benatar's Boxes

### Introduction

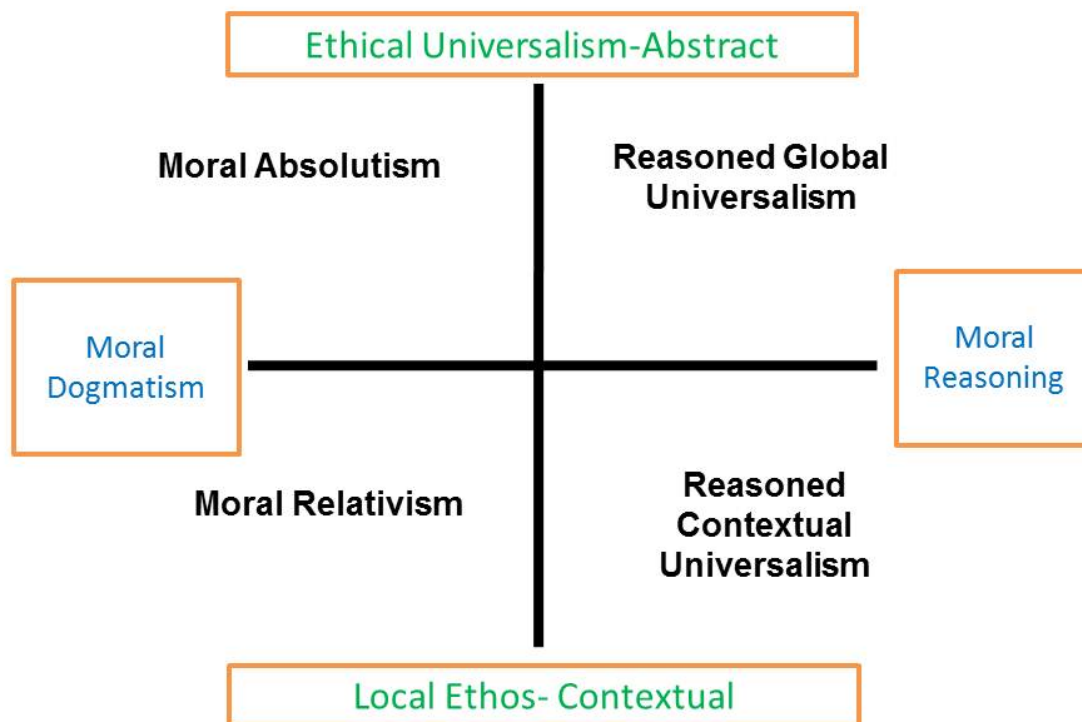
Solomon Benatar has put forward a two-dimensional framework<sup>1</sup> that is useful for understanding disagreements about some of the ethical dilemmas that arise in cross-cultural encounters. This framework is illustrated below. We will refer to this framework as 'Benatar's boxes' or an 'Ethical Thinking Map'.

One dimension stretches from a pole representing abstract universal principles to a contrasting pole, where local context (influenced by time, location, culture and other social factors) defines mores.

A second intersecting dimension stretches from a position that uses moral reasoning to positions of moral dogma.

**Figure 1: Four perspectives on ethical dilemmas**

### Benatar's Four Perspectives on Ethical Dilemmas



Benatar, 2004

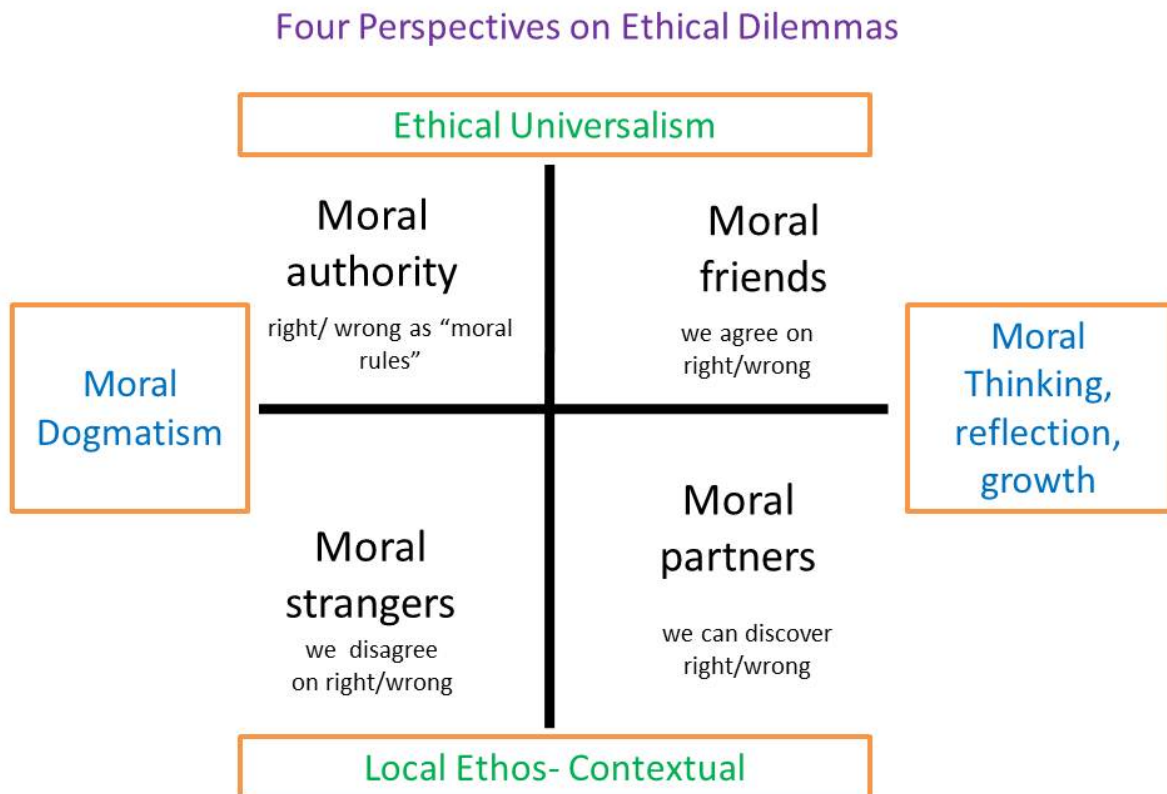
<sup>1</sup> Solomon R. Benatar (2004) . Towards Progress in Resolving Dilemmas in International Research Ethics. The Journal of Law, Medicine & Ethics 32: 4, pp 574–582.

Benatar's approach distinguishes four broad moral positions:

- Moral absolutism describes a position where ethics is prescribed and immutable.
- Moral relativism contends that morality is entirely relative to time, place and culture.
- Reasoned global universalism is a position arrived at through the application of a set of abstract ethical principles that have been developed and justified through a reasoning process.
- Reasoned contextual universalism is reached by taking morally relevant local factors into account in applying reasoned global universalism.

## Teacher Notes 3: Four Perspectives on Ethical Dilemmas

Borrowing from both Solomon Benatar<sup>1</sup> and from Tristram Engelhardt<sup>4</sup> for the purpose of developing a simple teaching framework, we have adapted Benatar's diagram so that it can be understood more intuitively as follows.



Adapted from Benatar, 2004

Moral absolutism can be understood as a position where the right course of action or decision is one that is prescribed, for example, by a **moral authority**. This type of position does not allow for negotiation and assumes that there is only one right way of acting or deciding, because ethical rules are not contestable.

Moral relativism corresponds with the idea that we are '**moral strangers**'. A moral stranger is someone with whom we do not share the same moral intuitions, the same interpretation of particular cases, the same view of what counts as a good or a harm, or the same rank ordering of such principles as autonomy, beneficence and justice.

We can think of reasoned global universalism as corresponding with the notion of **moral**

---

1 Solomon R. Benatar (2004). Towards Progress in Resolving Dilemmas in International Research Ethics. *The Journal of Law, Medicine & Ethics* 32: 4, pp 574–582.

4 Tristram Engelhardt (1996). *The Foundations of Bioethics* (2<sup>nd</sup> ed.). Oxford Uni Press Inc.

**friend.** A moral friend is someone with whom we share enough ideas about morality to resolve a moral controversy by sound moral argument. For example, moral friends can resolve moral disagreement and decide to do 'x', because they agree and are convinced through reason that doing 'x' is the right or good thing to do. Principlism, the idea that there are global and universally agreed-upon principles that all reasonable people accept is an example of moral friendship or reasoned global universalism.

Contrary to this, some thinkers have suggested that even if we are not moral friends, we need not be moral strangers. We use the term **moral partners** to capture the idea that it is possible to mediate or negotiate between a moral absolutism and moral relativism. It assumes that universal values are not incompatible with cultural contexts and that, at some level, even moral strangers are morally acquainted and have some values in common. This means that we can work together as moral partners to arrive at a position that preserves both what matters locally and universally.

As Benatar explains, reasoned contextual universalism, or what we refer to as entering a **moral partnership**, requires avoiding either uncritically accepting or rejecting norms and practices. It is reached by taking account of morally relevant contextual consideration in applying global universalism. Reasoned contextual universalism (a middle ground) is achieved by rational application of universal principles to local contexts. This requires insight into how and when to take a local context into consideration in applying universal ethical principles.

We suggest that health professionals should operate in and aim for a moral partnership. This approach assumes that at some level there are health values that are shared across all cultures, whilst also acknowledging individual differences.

This position encourages health ethics educators to:

- identify their own value systems;
- identify values important to patients/others;
- look for a middle ground where there is conflict or divergence; and
- be prepared to shift and grow in terms of their moral thinking by challenging inconsistencies, assumptions or moral dogma in their own ethical positions.

## Teacher Notes 4: ADSAN and Sally

### Teacher notes for working through the Sally case study using ADSAN

The aim of this exercise is to illustrate a case of divergent health values and to provide practice in arriving at a mutually acceptable position through a moral partnership, requiring moral reflection, mutual challenge and negotiating a solution.

#### Case study:

Sally is an experienced general practitioner, born and trained in Melbourne, Australia. Her patient today is 13-year-old Ayala, brought in by her father after a school nurse identified a hearing loss. There is a letter from the school indicating that Ayala is struggling in the classroom this year, but had previously done well. Sally confirms the hearing loss and refers them to an audiologist for hearing aids.

Ayala's father totally rejects the idea of hearing aids. If Ayala has them, it will be obvious that she has a disability. Then, within their community, it will not be possible for her to find a good husband. He explains that this is more important than Ayala doing well at school, because a good education will not help in relation to marriage. Ayala does not say anything.

#### **Process**

ADSAN: A process for ethical decision-making as moral partners

1. Acknowledge the Difference/s
2. Identify Shared value/s
3. Analyse the point/s of difference
4. Negotiate

#### **1. Acknowledge, identify and analyse the point of difference.**

Identify, as partners in this discovery, where and how the health professional and the agent diverge in their thinking.

The following questions will help you to identify aspects of the context that are important to you and to the agent. How is the shared value/rule/principle understood in the particular context?

- What does the agent think that is different to what the health professional thinks is good or best? Do the health professional and the agent have different ideas about what constitutes good health or a good life or doing what is best? What do they think differently about?

*Sally thinks that 'doing what is good for Ayala' requires intervening so that Ayala's hearing loss can be addressed and so she can hear and do well at school.*

*Ayala's father believes that what is good for Ayala is setting her up for a good marriage.*

## 2. Identify the value(s) shared by Sally and the father.

In each case determine, as partners in this discovery, what is important or valuable to BOTH the health professional and the patient, family or agent involved.

Ask yourself (Sally) and the agent (Ayala's father) each of the following questions to help you to articulate or name the principle that you share.

- What is the aim of the action?
- What is the ultimate goal of what both the health professional and the agent are hoping to achieve?
- What do you both agree is a good thing? For example, doing what is best for the patient's better health, quality of life, diminished pain, etc.

*Both Sally and Ayala's father want to do what is good for Ayala; they share the ethical belief that children should be looked after by adults and parents should do what is best for their children.*

## 3. Analyse the point of difference.

Think, reflect, challenge BOTH positions. Check and challenge the facts, reasoning and assumptions underlying both positions. For each case, ask each other as partners in discovery, whether the point of difference is plausible or can be challenged or reviewed.

The point of this process is to accept that both the agent and the health professional could reflect on their views and that they may experience moral growth by incorporating new insights into their thinking. They may even change their minds and come to a shared understanding or agreement.

- As partners consider, reflect and challenge both of your divergent ideas.
- Eliminate the differences that can be eliminated by testing and checking all divergent claims.
- Check the facts that you both base your views on. Could you update or review these facts?
- Check the assumptions that you both hold: are they warranted?
- Check the way you are both reasoning. Is your reasoning consistent? Are your arguments based on facts? Are your conclusions intuitively plausible?

Can either the agent or the health practitioner 'grow' or shift their view without compromising what they believe to be right? For example, does the agent hold an incorrect, outdated belief about the treatment? Does the health professional or another agent assume to know what is best for the patient? Can this assumption be tested/checked?

Are both positions reasonable/plausible/possible? Is it possible that Sally is right—that it would be good for Ayala to be able to hear and do well at school?  
Is it possible that the father is right that Ayala would like to marry well and that wearing a hearing aid might prevent this?

The answer to both these questions is Yes. We (or Sally), as the health professionals, don't really need any fact checking to see that both views are possibly true.

*Sally needs to reflect on her views—is hearing loss incompatible with a good life, or doing well at school in this situation?*

*Sally should also ask/encourage/assist Ayala’s father to reflect on his views. Sally could check how firmly Ayala’s father holds the view that marriage is what is best for Ayala. Would a visible hearing aid really make it so difficult to find a marriage partner? What does Ayala’s Father imagine his daughter’s life will be without the ability to hear? Does he know about the experiences of any families with children who wear hearing aids, or children with hearing loss?*

*We could ask Ayala what she wants, but this would undermine what Ayala’s father values and we accept that parents are entitled to decide what is best for children in lots of areas—choosing a school, a religion, deciding who they can see/whom they have relationships with/friends etc. It is not unusual for parents to think that it would be good for their children to marry well.*

*Sally (the practitioner) could ask the father how he would feel about asking Ayala what she thinks.*

4. **Negotiate** to accommodate both positions where both are reasonable/plausible/possible. Look for possibilities.

For each case where divergent views remain after analysis, give serious consideration to the possibilities that these raise for decision-making. Determine as partners in discovery, if there is an alternative that would protect what is divergent, but important, to both the agent and the health professional. The key feature of a moral partnership here is that both are involved and acknowledge the need to accommodate both divergent views.

The following questions will help you to come to a negotiated solution.

- Where there is ongoing disagreement about the best course of action, is there a possible action that is acceptable to both the agent and the health practitioner?
- Is there a possible action that would cause the least moral distress to both?

If both Sally and Ayala’s father’s views are possibly true, is there a middle position that would accommodate both?

Can we treat hearing loss without making Ayala less desirable to a good husband?

We could negotiate with the father, to proceed with a consultation with an audiologist to see what s/he recommends and to find out if a hearing aid is what is needed. If the audiologist recommends that a hearing aid is required, is there a hearing aid that cannot be seen? Is there an aid that she could wear only at certain times?

If it turns out that a hearing aid is indeed the recommended treatment, Sally could ask Ayala’s father to suggest a middle position.

- Is there a way to treat Ayala's hearing loss in a way that her father would find acceptable? Is there a way to hide a hearing aid (scarf, headband, or change of hair style)? Are there other ways of dealing with hearing impairment that he is comfortable with?

### **Conclusions**

A moral partnership approach might end up with either the father or Sally shifting their views or coming to a mutually agreed-upon decision.

On the other hand, it is possible that the differences between Sally and Ayala's father may not be resolved and Sally may feel bound by the rules of her profession or workplace.

However, if Sally makes her values explicit and is prepared to challenge and review them, and if she expects and allows the same of Ayala's father, it is at least possible that the two of them might come to a middle position that accommodates what they both value.

The advantage of this approach is that it accepts that reasonable moral agents can have different views about what constitutes the right action or a good life. It assumes that they will share fundamental ethical principles but might diverge on how these play out in different contexts. This approach respects different cultural contexts but requires that culturally based differences are reasoned through, not automatically accepted or rejected.

## Teacher Notes 5: ADSAN and Basilia

### Teacher notes for working through the Basilia case study using ADSAN

The aim of this exercise is to illustrate a case of divergent health values and to provide practice in arriving at a moral partnership through moral reflection, mutual challenge and through negotiating to a solution.

#### Case study

Basilia is a 75-year-old, active, diabetic Filipino woman. She requires amputation of her gangrenous right leg. Basilia's daughter, knowing that her mother will refuse surgery, gives consent, instructing the surgeon not to inform her mother.

The daughter argues that from the Filipino family's perspective, her obligation is to protect her mother's wellbeing. She explains that her mother needs to be protected from her refusal of treatment and that disregarding the individual's wishes in order to care for a sick family member is understandable and acceptable.

The daughter explains that Basilia may initially be angry after the surgery—but this will subside to relief and gratitude. She will realise that her daughter decided on a course of action out of concern for her mother's wellbeing and safety. The daughter believes that in the end, Basilia will accept the family's decision because this is what being part of a family entails adapted from Alora AT and Lumitao JM. *Beyond Western Bioethics: Voices from the Developing World*. 2001 Georgetown University Press).

#### **Process**

ADSAN: A Process for Ethical Decision-making as Moral Partners

1. Acknowledge the Difference/s
2. Identify Shared value/s
3. Analyse the point/s of difference
4. Negotiate

#### **1. Acknowledge, identify and analyse the point of difference.**

Identify, as partners in this discovery, where and how the health professional and the agent diverge in their thinking.

The following questions will help you to identify aspects of the context that are important to you and to the agent.

- How is the shared value/rule/principle understood in the particular context?
- What does the agent think that is different to what the health professional thinks is good or best? For example, do the health professional and the agent have different ideas about what constitutes good health or a good life or doing what is best? What do they think differently about?

*In the Basilia case, the point of difference is around the idea of what is good for Basilia and who decides what is good for the mother. Family? Doctor? Mother? The daughter believes*

*that she knows and should decide for her mother. The surgeon is not sure what the mother would want and believes that the mother should make this decision herself.*

## **2. Identify Shared value/s**

In each case, determine, as partners in this discovery, what is important or valuable to BOTH the health professional and the patient, family or agent involved.

Ask yourself and the agent each of the following *questions* to help you to articulate or name the principle that you share.

- What is the aim of the action?
- What is the ultimate goal that both the health professional and the agent are hoping to achieve?
- What do you both agree is a good thing? For example, doing what is best for the patient, better health, good quality of life, diminished pain, etc.

*In the Basilia case, all of the agents involved have in common the desire to protect the patient, to do what is good for the patient.*

*Note: the daughter is not arguing that she is overriding her mother's wishes, but that her mother would agree with family (in the end).*

## **3. Analyse the point of difference**

Think, reflect, challenge both positions. Check and challenge the facts, reasoning and assumptions underlying both positions. For each case, ask each other as partners in discovery, whether the point of difference is plausible or can be challenged or reviewed.

The point of this process is to allow that both the agent and the health professional could reflect on their views and that they may experience moral growth by incorporating new insights into their thinking. They may even change their minds and come to a shared understanding or agreement.

- As partners think about reflect and challenge both of your divergent ideas.
- Eliminate the differences that can be eliminated by testing and checking all divergent claims.
- Check the facts that you both base your views on. Could you update or review these facts?
- Check the assumptions that you both hold—are they warranted?
- Check the way you are both reasoning. Is your reasoning consistent? Are your arguments based on facts? Are your conclusions intuitively plausible?

Can either the agent or the health practitioner 'grow' or shift their view without compromising what they believe to be right? For example, does the agent hold an incorrect, out-dated belief about the treatment? Does the health professional or another agent assume to know what is best for agent? Can this assumption be tested/checked?

- Are both positions reasonable/plausible/possible?

*In the Basilia case, both the daughter and the surgeon's assumptions can be checked.*

*Is the doctor's claim reasonable? Is it possible that the mother's idea of what is good may not be the same as the daughter's idea of what is good for her?*

*Can the daughter accept this possibility?*

*Has the doctor considered the possibility that the mother and daughter/family accept this type of family decision-making? Are there prior examples of this?*

*We could ask Basilia what she wants, but this would undermine what the daughter/family values. We accept that families are often in the best position to know what their members would want. However, we also know that sometimes family members disagree with each other about important issues and that older people might be more vulnerable to having their wishes unheard or overridden.*

*We could check whether the mother has ever expressed any views about her medical care and decision-making. We could check the facts—is amputation the only effective treatment available?*

4. **Negotiate** to accommodate both positions where both are reasonable/plausible/possible—look for possibilities.

*For each case where divergent views remain after analysis, give serious consideration to the possibilities that these raise for decision-making. Determine as partners in discovery, if there is an alternative that would protect what is divergent, but important, to both the agent and the health professional. The key feature of a moral partnership here is that both are involved and acknowledge the need to accommodate both divergent views.*

The following questions will help you to come to a negotiated solution.

- Where there is ongoing disagreement about the best course of action, is there a possible action that is acceptable to both the agent and the health practitioner?
- Is there a possible action that would cause the least moral distress to both?

*Negotiation between these positions involves giving serious consideration to both and undertaking critical analysis of both possibilities. Are they both coherent and reasonable?*

*Possible alternative: is amputation the only effective treatment available, and if not, does this make a difference to the daughter's views? For example, would she feel better about informing the mother if the treatment were less invasive?*

*Would the daughter accept informing the mother and testing the idea that she would refuse treatment? If the daughter believes that, in the end, Basilia will accept the family's decision, would this then also be the case prior to making the treatment decision i.e. would the daughter contemplate talking further to her mother and getting her to accept treatment prior to the amputation?*

*Can we talk to the mother prior to any treatment about how she would like decisions about her care to be made i.e. with the family? If not, we could ask the daughter to have a three-way conversation on the grounds that between the two of them they cannot find a way forward that makes them both comfortable.*

An authentic moral partnership entails that the patient is as concerned with finding a mutually respectful solution as is the surgeon.

### **Conclusions**

A 'moral partnership' approach might end up with either the daughter or the doctor or the mother shifting in their views or coming to a mutually agreed-upon decision.

On the other hand, it is possible that the differences between their views about the right thing to do may not be resolved. The surgeon may feel bound by the rules/laws of her profession or workplace, and the daughter by the 'rules' of her family or cultural community.

However, if both the daughter and the surgeon makes their values explicit and are prepared to challenge and review these values, it is at least possible that the two of them might come to a middle position that accommodates what they both value.

The advantage of this approach is that it accepts that reasonable moral agents can have different views about what constitutes the right action or a good life. It assumes that they will share fundamental ethical principles, but might diverge on how these play out in different contexts. This approach respects different cultural contexts but requires that culturally based differences are reasoned through, not automatically accepted or rejected.

## Cross-cultural health ethics case studies

### Case study 1: Sally

Sally is an experienced general practitioner, born and trained in Melbourne, Australia. Her patient today is 13-year-old Ayala, brought in by her father after a school nurse identified a hearing loss. There is a letter from the school indicating that Ayala is struggling in the classroom this year, but had previously done well. Sally confirms the hearing loss, and refers them to an audiologist for hearing aids.

Ayala's father totally rejects the idea of hearing aids. If Ayala has them, it will be obvious that she has a disability. Then, within their community, it will not be possible for her to find a good husband. He explains that this is more important than Ayala doing well at school, because a good education will not help in relation to marriage. Ayala does not say anything. (With thanks to Lynn Gillam, University of Melbourne.)

### Case study 2: Raf

Raf is a resident doctor working in an emergency department. He grew up in Jordan, but did his medical training in the UK. A woman in her 40s presents to emergency in the English hospital in which Raf is working. She has a broken arm. She explains that her husband caused the injury when he found out that she had overspent their weekly budget. She is accompanied by her sister. Both seem to regard the husband's actions as quite reasonable: it is usual in their cultural community. (With thanks to Lynn Gillam, University of Melbourne.)

### Case Study 3: Florence

Florence is a resident doctor from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patients' decisions. On her clinical rounds, a family with similar cultural beliefs asked Florence to conceal the diagnosis of a terminal illness from their elderly father. (With thanks to Giuliana Fuscaldo, University of Melbourne.)

### Case Study 4: Dylan

Dylan studied medicine in Australia, and went to work in the Philippines as a registrar for 2 years. He has just diagnosed a man in his mid-40s with lung cancer. Dylan's next step is to outline the standard proposed treatment and an alternative treatment to the patient. Standard treatment includes many in-patient stays in the hospital over the next 12 months, and also numerous outpatient appointments for radiation therapy. Dylan is aware that the man is a father of 8 children. The family are poor farmers and live far from the hospital. So he wants to also offer an alternative—another, slightly less effective treatment that may not have the same degree of success, but would have fewer side effects and only involve the man being at the hospital once or twice over the 12-month period.

Dylan speaks to his consultant before talking to the patient. The consultant tells him that his planned approach is wrong. In the Philippines, it is the doctor's obligation to make the decision. Dylan should just tell the patient what the treatment is, and not mention alternatives or choice. In the circumstances, the less effective, but less burdensome, treatment is clearly best and Dylan should tell the patient that this will be his treatment. (With thanks to Lynn Gillam, University of Melbourne.)

#### Case Study 5: Maria

Samuel is a Kenyan man from Luo, now living in Melbourne, Australia. In Luo tradition, initiation into manhood involves the removal of six teeth from the lower jaw.

Samuel visits Maria, a local dentist near his home in Melbourne and requests that she perform this extraction. Maria is conflicted by this request and believes that the principles of good dentistry prohibit her from extracting healthy, functioning teeth. (With thanks to Thuy Nguyen, University of Melbourne.)

#### Case Study 6: Ivan

Ivan is a 26-year-old physiotherapist with a private practice in a small coastal town. His practice provides the only physiotherapy service in the district and Ivan sets aside a few hours each week to provide treatment to disabled children attending the local school. Over the past 3 years, the town has received an influx of migrants.

Waleed and his family moved to the school 2 years ago. The school asked Ivan to see Waleed, because he was often falling in the playground. Ivan contacted Waleed's parents, and found out that Waleed is 9-years-old and has been diagnosed with Duchene muscular dystrophy (DMD). He is still walking, although he falls often and is teased by other children because of this. Waleed's parents do not believe that their son has any medical condition, although they have had DMD explained to them. They say he is just clumsy, that he does not need any physiotherapy and should be treated "just like other children". They believe that it is important that boys must be and appear strong and that having treatment would undermine this.

Ivan thinks that Waleed's parents' beliefs are harming Waleed. He believes that Waleed should receive treatment because it will improve his quality of life, despite what his parents say. (With thanks to Clare Delany, University of Melbourne.)

#### Case Study 7: Basilia

Basilia is a 75-year-old, active, diabetic Filipino woman. She requires amputation of her gangrenous right leg. Basilia's daughter, knowing that her mother will refuse surgery, gives consent, instructing the surgeon not to inform her mother.

The daughter argues that from the Filipino family's perspective, her obligation is to protect her mother's well-being. She explains that her mother needs to be protected from her refusal of treatment and that disregarding the individual's wishes in order to care for a sick family member is understandable and acceptable.

The daughter explains that Basilia may initially be angry after the surgery, but this will subside to relief and gratitude. She will realize that her daughter decided on a course of action out of concern for her mother's wellbeing and safety. The daughter believes that, in the end, Basilia will accept the family's decision, because this is what being part of a family entails. (Adapted from Alora AT and Lumitao JM. *Beyond Western Bioethics: Voices from the Developing World*. 2001 Georgetown University Press.)

## Student exercise 1: "What is ethics?"

An exercise to illustrate the difference between ethics, law, cultural beliefs and religion.

### What is Ethics?

#### 1. How do you know what is right and what is wrong?

Even without any ethics training, when faced with a moral problem, most of us have ideas about the right or wrong course of action. Where do these ideas come from?

Go around the class and write a list of all the possible answers to this question: where do our moral ideas/beliefs come from?

#### 2. Some common views about ethics that you may have had on your list:

- *Ethics has to do with what our feelings tell us is right or wrong.*
  - *We learn about what is right or wrong through our cultural background.*
  - *Ethics is about what society will accept.*
  - *There are professional guidelines to tell us what is ethical.*
- a) Give an example of where someone might act according to how they feel, but you believe they did the wrong thing.
  - b) Can you think of an action that is part of a cultural practice but one that you think is morally wrong?
  - c) Give an example of a behavior or action that was accepted in particular societies in the past that we now think is unacceptable and morally wrong.

#### 3. Consider the following examples.

What do they suggest about ethics and how we know what is right and wrong. What do these examples suggest about the ideas on your list?

- a) Brenda Ann Spencer is an American convicted murderer who, at the age of 16, carried out a shooting spree from her home in San Diego, California, on January 29, 1979. During the shooting spree, she killed two people and injured nine others at Cleveland Elementary School, which was located across the street from her home. Spencer showed no remorse for her crime, and her full explanation for her actions was "I don't like Mondays; this livens up the day."

*Is Brenda's reason for the shooting acceptable? Why not?*

- b) The novel *Gone with the Wind* is set in the state of Georgia during the American Civil War (1861–1865). The story opens in April 1861 at the Tara plantation, which is owned by a wealthy Irish immigrant family, the O'Hara's. The O'Hara's use enslaved African people to carry out manual labor on their cotton plantations and as domestic servants in their homes.

*The O'Hara's did not think they were doing anything wrong; many of the households in Georgia at the time accepted slavery. Does the fact that a practice or behaviour is widely accepted make it morally permissible?*

- c) Socially and legally, women were regarded as inferior to men in the 19th century. In 1893, New Zealand became the first nation to extend the right to vote to all adult women. South Australian women achieved the same right in 1894, and became the first to obtain the right to stand (run) for Parliament (the Australian colonies federated in 1901, and women's suffrage was achieved nationwide from 1902).

*Before they achieved the right to vote, the role of women was both socially and legally accepted. What does this imply about where we should look for moral guidance?*

**4. Consider each of the following statements.**

- Being ethical is the same as following the law.
- Being ethical is doing what society accepts.
- Being ethical is about finding consensus.
- Being ethical requires following a religion.
- Moral standards differ from culture to culture.

For each statement:

- a) Assuming that the statement is correct, how would you find out what is right and wrong?

For example: If being ethical is the same as doing what is legal, where would we go to find out the right thing to do?

- b) Can you think of a counter example that contradicts each statements

For example, can you think of an example where being ethical is not the same as following the law?

**5. Give an example of each of the following:**

- a) An action that is illegal—but not immoral—in other words, an example of where someone breaks the law, but we do not think they are bad or unethical.
- b) An action that is morally wrong, but there is no law against it.

*What do these examples imply about ethical norms?*

## Student exercise 2: 'When in Rome'

An exercise to illustrate the implications of ethical relativism.

### Introduction

WHEN IN ROME, DO AS THE ROMANS DO. This famous proverb is attributed to Saint Ambrose (c.340-397), who gave the following advice to Saint Augustine: *Si fueris Romae, Romano vivito more; si fueris alibi, vivito sicut ibi* ('When you are in Rome, live in the Roman style; when you are elsewhere, live as they live elsewhere'). It is commonly understood to mean; "Don't set your own rules when you are someone's guest."<sup>1</sup>

The story behind this proverb is that when Saint Augustine arrived in Milan, he observed that the Church did not fast on Saturday as did the Church at Rome. He consulted Saint Ambrose, bishop of Milan, who replied: "*When I am at Rome, I fast on a Saturday; when I am at Milan, I do not. Follow the custom of the Church where you are.*" The comment eventually became known as "When in Rome, do as the Romans do."

**Ethical relativism** is a theory that claims that there are no universally valid moral principles. This theory is analogous to a 'when in Rome' approach to ethical decision-making. According to ethical relativism, the moral rightness or wrongness of actions varies from society to society and there are no universal moral standards that bind all people at all times; each culture establishes the basic values and principles that serve as the foundation for morality.

Clearly, human behaviour and ideas of right and wrong do vary from culture to culture and across historical periods. However, does it follow that because there is cultural diversity of moral standards that each set of standards is equally *right* or *justified* or that no universal standards exist? The following exercise will help you to reflect on these questions.

### Instructions:

Read the following article that appeared in *The Age* and other newspapers around the world in July 2012 and think about the implications of cultural relativism.

1. Does a 'when in Rome' approach to ethics make the execution of Najiba morally permissible?
2. Is the case of Najiba analogous to the example of St Augustine (summarised above)?
3. Read James Rachel's article, 'The Challenge of Cultural Relativism'<sup>2</sup>. How would

---

1. From "Random House Dictionary of Popular Proverbs and Sayings" by Gregory Y. Titelman (Random House, New York, 1996).

2. James Rachel and Stuart Rachel (2007). *The Elements of Moral Philosophy* 5th ed. McGraw-Hill, New York, N.Y Chapter 2 16-34.

Rachel answer Question 2 above?

4. On what basis did the British Foreign Secretary and the US Secretary of State condemn the execution of Najiba? What do their responses suggest about ethical norms and ethical relativism?

**'We cannot forgive her, God tells us to finish her': video shows public execution of woman, 22, in Afghanistan after adultery allegations.**

The public execution of a 22-year-old woman accused of adultery in Afghanistan has been condemned by the government as un-Islamic and inhuman.

A video shows her being shot repeatedly in the back in front of a crowd of men in Qol village in Parwan province just north of the capital, Kabul.

*Within one hour they decided that she was guilty and sentenced her to death.*

The woman, named as Najiba, was married to a member of a hardline Taliban militant group and was accused of adultery with a Taliban commander, Parwan provincial spokeswoman Roshna Khalid said on Sunday.

"Within one hour they decided that she was guilty and sentenced her to death. They shot her in front of villagers in her village, Qol," she said, adding that the execution took place late last month.

Following the shooting, a villager handed the video over to the provincial government and "the security forces are preparing a big operation to find the culprits", she said.

The video opens with the woman, wrapped in a grey shawl, sitting at the edge of a ditch in a village surrounded by dozens of men, some perched on rooftops for a better view.

Watching ... this frame grab shows a gathering of people watching the execution by gunfire of a woman married to a member of a hardline Taliban militant group. *Photo: AFP/Parwan Provincial Government*



As she sits with her back to the crowd a bearded man is seen reading verses from the Koran condemning adultery, before saying: "We cannot forgive her, God tells us to finish her. Juma Khan, her husband, has the right to kill her."

The video then shows a man in white being handed an AK47 rifle. He approaches to within a couple of metres of the woman, says "Allahu akhbar" (God is greater), aims and fires twice, missing each time. The third shot hits her in the back, she flings her arms wide and collapses.

He then fires another six shots into her body as the crowd cheers wildly, shouting "Long live Islam", "Long live mujahideen (holy warriors)". The gunman then fires four more shots into her body.

The government issued a statement on Sunday saying it "strongly condemns this un-Islamic and inhuman action by those professional killers and has ordered the Parwan police to find the culprits and bring them to justice".

The Afghanistan Human Rights Commission also expressed outrage. Its executive director Mohammad Musa Mahmodi said: "We condemn any killings done without proper trial. It is un-Islamic and against any human rights values."

### **Hague shocked and disgusted**

British Foreign Secretary William Hague said on Sunday he was "shocked and disgusted" by reports that the Taliban had executed the woman.

The British government condemned the "deplorable" action and called upon Afghanistan's rulers to bring the perpetrators to justice.

"I am shocked and disgusted by [the] reports," Mr Hague said. "Such deplorable actions underline the vital need for better protection of the rights of women and girls in Afghanistan."

He explained that the British government was working with its Afghan counterparts, NGOs and international partners to improve the status of women in Afghanistan.

### **Clinton makes plea for women**

The killing came as US Secretary of State Hillary Clinton made a powerful plea on Sunday for the rights of women in Afghanistan, using a global forum to insist that they must be part of the country's future growth.

Mrs Clinton, who was addressing a world conference in Tokyo on Afghanistan's future, said: "The United States believes strongly that no nation can achieve peace, stability and economic growth if half the population is not empowered."

She said the way forward "must include fighting corruption, improving governance, strengthening the rule of law [and providing] access to economic opportunity for all Afghans, especially for women".

"All citizens need to have the chance to benefit from and contribute to Afghanistan's progress. The United States will continue to stand strongly by the women of Afghanistan," she added.

But the execution video could renew concerns that Kabul is not doing enough to protect women, particularly from so-called honour killings, which were common during the Taliban regime that ruled from 1996 to 2001.

The Taliban have since waged an insurgency against the government of President Hamid Karzai, which is supported by about 130,000 NATO troops.

According to figures provided by the US State Department, out of the 8 million students enrolled in schools today, nearly 40 per cent are girls. That contrasts sharply with 2002 when there were only 900,000 children in schools, virtually none of them girls.

The US says there are now 175,000 teachers in Afghanistan, about a third of them women, thanks to \$US316 million (\$310 million) spent on education initiatives.

US officials said Mrs Clinton had raised the issue of women's rights with Mr Karzai during her brief visit to Kabul on Saturday, warning that they were a litmus test for the country's progress.

The Tokyo talks have raised pledges of \$US16 billion in civilian aid for the conflict-torn nation over the next four years.

Representatives from more than 80 nations and international organisations gathering in the Japanese capital later adopted the "Tokyo Declaration", pledging support and cash for Kabul.

**AFP**

### Student exercise 3: “More same than different”

An exercise to illustrate universal or widely shared values and that culturally based differences in values are not incompatible with universal or overarching principles

In *The Challenge of Cultural Relativism*<sup>1</sup>, James Rachel argues that, while cultural relativism is useful in helping people keep an open mind to other cultural practices, it is based on unsound arguments and has implausible consequences.

Rachel argues very convincingly that there is much more similarity than difference between diverse cultures in their views about what is right and wrong. Rachel begins with stories about different cultural practices. In one story he compares one culture's practice of eating the recently deceased to another culture's practice of cremating the dead. Both cultures thought that their practices were correct and that the other's was appalling.

Rachel uses this story and many other examples to show that differences in cultural practices are not necessarily differences in moral values. Sometimes different cultures value the same things, but they have different belief systems. To use Rachel's example, two groups of people from different cultural backgrounds both believe that it is morally important to respect the dead. However, one culture believes that it is respectful to eat the dead, while the other culture believes that it is respectful to cremate the dead. They share the same values, but have different beliefs about how to uphold or act in accordance with these values.

#### **Task 1: Different beliefs, not different values.**

Here is a commonly accepted rule: Women should be protected.

Can you think of examples of how this rule or moral value might be interpreted differently by different cultural groups? What beliefs do diverse cultural groups have about how women can be protected?

- a)
- b)
- c)
- d)

#### **Task 2: Different options, not different values**

Rachel reminds us that sometimes people from different cultural backgrounds act in ways that seem ‘very different from what we do ‘ but this is often because life has forced them to

---

<sup>1</sup> James Rachel and Stuart Rachels (2007) *The Elements of Moral Philosophy*. 5<sup>th</sup> ed. McGraw-Hill, New York, N.Y Chapter 2 16-34,

make choices that we do not have to make, and not because they have different values . Can you give some examples of this idea for each of the following?

- a) Life and Death: different societies are forced to make different choices about who lives and who dies? Give examples.
- b) Resource allocation: Different societies are forced to make different choices about how resources are distributed.

Rachel reasons that there are some moral rules that all societies must have in common because without them society could not exist. He reasons that rules against murder and rules against lying are examples of rules that must be universal if society is to continue to function and exist. The rule that children should be looked after is another example of a value shared across all cultural groups. If this rule were not a universal rule, those societies that did not look after their children would soon cease to exist.

Rachel reasons that diverse cultural groups may agree on a moral value or rule, but disagree about what they accept as legitimate exceptions to that rule. For example all societies have some rules about killing people. But we have different beliefs about when this rule can be overridden.

### Task 3: Same rule, different exceptions to the rule

Complete the following exercise to think about the idea of cultural differences as shared rules and different exceptions to the rule.

	<b>'RULE' or moral value</b>	<b>Some culturally different 'Exceptions to the Rule '</b>
1	Don't kill people.	Except in self defence
		Except when.....
		Except
2	Children should be cared for by their parents.	Except
		Except
		Except
		Except
3	People should be free to make their own decisions.	Except
		Except
		Except
		Except
4	Doctors should not cause pain.	Except when causing pain improves long term health.
		Except

## Student exercise 4: “Ethical Thinking Map”

An exercise to introduce a ‘theoretical map’ to help students to identify different approaches to thinking about ethical issues.

### Introduction

Solomon Benatar has put forward a two-dimensional framework<sup>1</sup> that is useful for understanding disagreements about some of the ethical dilemmas that arise in cross-cultural encounters. This framework is illustrated below. We will refer to this framework as ‘Benatar’s boxes’ or an ‘Ethical Thinking Map’.

One dimension of Benatar’s approach stretches from a pole representing abstract universal principles to a contrasting pole, where local context (influenced by time, location, culture and other social factors) define moral norms.

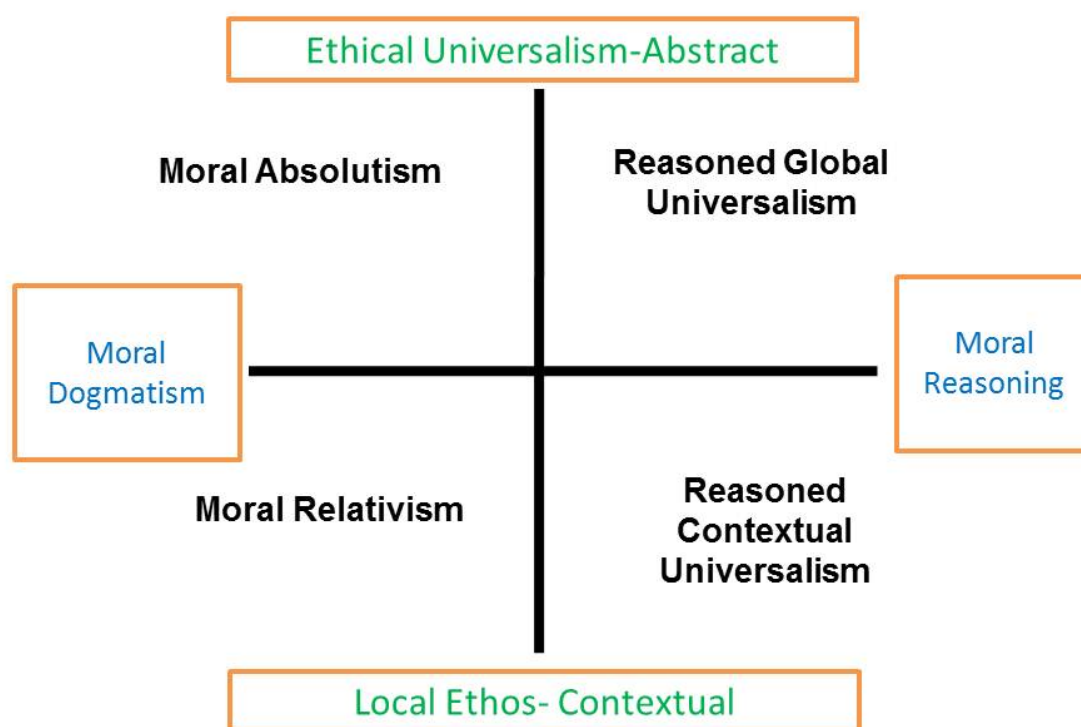
A second intersecting dimension stretches from a position that uses moral reasoning to positions of moral dogma.

---

<sup>1</sup> Solomon R. Benatar (2004). Towards Progress in Resolving Dilemmas in International Research Ethics. *The Journal of Law, Medicine & Ethics* 32: 4, pp 574–582.

Figure 1: Four perspectives on ethical dilemmas.

### Benatar's Four Perspectives on Ethical Dilemmas



Benatar, 2004

Benatar's approach distinguishes four broad moral positions:

- Moral absolutism describes a position where ethics is prescribed and immutable.
- Moral relativism contends that morality is entirely relative to time, place and culture.
- Reasoned global universalism is a position arrived at through the application of a set of abstract ethical principles that have been developed and justified through a reasoning process.
- Reasoned contextual universalism is reached by taking morally relevant local factors into account in applying reasoned global universalism.

#### Instructions

Read the following case study and use the 'Benatar Boxes' to help you complete the questions below:

#### Case study 1: Sally

Sally is an experienced general practitioner, born and trained in Melbourne, Australia. Her patient today is 13-year-old Ayala, brought in by her father after a school nurse identified a hearing loss. There is a letter from the school indicating that Ayala is struggling in the classroom this year, but had previously done well. Sally confirms the hearing loss, and refers them to an audiologist for hearing aids.

Ayala's father totally rejects the idea of hearing aids. If Ayala has them, it will be obvious that she has a disability. Then, within their community, it will not be possible for her to find

a good husband. He explains that this is more important than Ayala doing well at school, because a good education will not help in relation to marriage. Ayala does not say anything. (With thanks to Lynn Gillam, University of Melbourne.)

1. Identify your intuitive response: which of the four 'moral boxes' does your intuitive response fit into?
2. The following represent Sally's possible responses: which of the four moral boxes do they fit into?
  - a) Sally accepts that Ayala's father is responsible for Ayala and wants the best for her. Sally accepts that people from different backgrounds have different ideas about what is best for their children. Sally tells the father that it is up to him to decide for himself whether or not to take Ayala to the audiologist.
  - b) Sally accepts that Ayala's father is responsible for Ayala and wants the best for her. Sally points out that both the law and all ethical guidelines require that children are given every opportunity to realise their potential. She tells Ayala's father that these rules make it obligatory for him to seek medical assistance for Ayala and that if he fails to do so, this would amount to negligence and Sally would have to contact child protection agencies.
  - c) Sally accepts that Ayala's father is responsible for Ayala and wants the best for her. She reasons that doing nothing about hearing loss is harming Ayala, and she must balance her obligation not to harm the patient against accepting the father's wishes and the possible harm that he foresees. Sally reasons that, at 13, Ayala is at the stage where she will soon be able to decide for herself whether or not to wear a hearing aid, but, if she does not wear one now she would seriously limit her future autonomy. So Sally concludes that it is best to go ahead with this intervention and then later Ayala may decide differently. Sally explains all this reasoning to the father, but decides that she must act on accordingly by ensuring the proposed intervention.
3. Which of the four moral boxes does Ayala's father's response fit into?

## Student exercise 5: ADSAN

### ADSAN: Decision-Making in Health Ethics through a Moral Partnership

#### Introduction

As a health professional, you may encounter situations where your cultural background and ethical beliefs are in conflict with those that you were taught to respect, or those of your patients, your colleagues or your workplace. There are different approaches to sorting out these types of ethical problems and coming to a decision.

- i. Some scholars believe that right and wrong are culturally based and that cultural beliefs must always be respected. According to this view, a health professional would act according to the cultural norms of their patients or their workplace. This is sometimes referred to as the ‘when in Rome’ approach and implies that the right thing to do may be different according to the cultural norms of the community in which you practise.
- ii. Some scholars argue that there are many ethical principles that are universally right or wrong. It is, therefore, possible to list or name these principles and to apply them to every decision-making situation. Holding this view, a health professional would act according to a framework that lists or prioritises universal ethical principles irrespective of his or her patients’ cultural beliefs. This kind of approach is also often associated with appeals to human rights. This kind of approach is sometimes referred to as a ‘top-down’ method of applying a framework or set of rules.
- iii. In this session, you will practise a third approach—coming to a middle position. Many scholars believe that it is possible and morally consistent to come to a decision that respects both cultural norms and overarching, agreed-upon, universal principles. In this class you will practice a process for “**Decision-Making through a Moral Partnership**”. This approach assumes that all people share some fundamental moral values and that in health care situations where there is disagreement about what should be done, it is possible to negotiate and come to a decision that respects both cultural diversity and universal values.

The key features of a Moral Partnership are that:

- it is a process for sorting out an ethical problem;
- it assumes that it is possible to respect both universal principles and cultural norms;
- doing this requires negotiation and willingness to challenge, reflect on and revise one’s beliefs;
- the health professional and the patient s are in partnership in this process; and
- it does not guarantee an agreed-upon outcome but is respectful of ethically acceptable diversity.

Choose one of the case studies provided and discuss in your group. Use the following framework to come to a decision as moral partners. The scenarios illustrate the way in which culturally based differences in values can raise ethical issues in health care. In your discussions you might like to assign someone to take the roles of the patient and health professional. Use the framework below to help you to come to a negotiated decision as Moral Partners.

### **A Process for Ethical Decision-Making as Moral Partners (ADSAN)**

1. Acknowledge the Difference/s
2. Identify Shared value/s
3. Analyse the point/s of difference
4. Negotiate

#### **1. Acknowledge the Difference/s**

In each case, identify, as partners in this discovery, where and how the health professional and the agent diverge in their thinking. The following questions will help you to identify aspects of the context that are important to you and to the agent.

- How is the shared value/rule/principle understood in the particular context?
- What does the agent think is good or best in the situation?
- What does the health professional think is good or best in the situation?

For example, do the health professional and the agent have different ideas about what constitutes good health or a good life or doing what is best? What do they think differently about?

#### **2. Identify Shared value/s**

In each case, determine, as partners in this discovery, what is important or valuable to BOTH the health professional and the patient, family or agent involved.

Ask yourself and the agent each of the following to help you to articulate or name the principle that you share.

- What is the aim of the action?
- What is the ultimate goal that both the health professional and the agent are hoping to achieve?
- What do you both agree is a good thing?

For example, the agent and the health professional might both agree that what they should be doing is what is best for the patient—better health, good quality of life, diminished pain, etc.

### **3. Analyse the point of difference**

For each case, ask each other as partners in discovery, whether the point of difference is plausible or can be challenged or reviewed.

The point of this process is to allow:

- both the agent and the health professional to reflect on their views; and
- both to experience moral growth by incorporating new insights into their thinking. They may even change their minds and come to a shared understanding or agreement.

As partners, think about, reflect and challenge your divergent ideas.

Eliminate the differences that can be eliminated by testing and checking all divergent claims.

- Check the facts that you both base your views on. Could you update or review these facts?
- Check the assumptions that you both hold. Are they warranted?
- Check the way you are both reasoning. Is it coherent?
- Are the claims you put forward plausible or justifiable?
- Can either the agent or the health practitioner 'grow' or shift their view without compromising what they believe to be right?

For example, does the agent hold an incorrect, outdated belief about the treatment? Does the health professional or another person assume to know what is best for the patient? Can this assumption be tested/checked?

### **4. Negotiate**

For each case where divergent views remain after analysis, give serious consideration to the possibilities these raise for decision-making. Determine, as partners in discovery, if there is an alternative that would protect what is divergent, but important, to both the agent and the health professional. The key feature of a moral partnership here is that both agents are involved and acknowledge the need to accommodate divergent views.

The following questions will help you to come to a negotiated solution:

- Where there is ongoing disagreement about the best course of action, is there a possible action that is acceptable to both the agent and the health practitioner?
- Is there a possible action that would cause the least moral distress to both?

# Chapter 8 Project Dissemination

## Overview

The dissemination strategy for this project was twofold:

- It targeted health ethics educators specifically.
- It aimed to raise awareness of the project and share the project outcomes more broadly with educators across a range of health disciplines and teaching contexts through international meetings and collaborations.

The early stages of the project utilised and expanded the existing networks of health ethics educators with an interest in cross-cultural ethics teaching. In addition, our dissemination strategies ensured broad knowledge transfer. Members of the project team launched the curriculum and teaching materials at several international conferences (see Appendix for conference presentations). These launches will be followed up with articles about our innovative pedagogical framework and teaching materials in bioethics and health education peer-reviewed journals. We have provided, and will continue to provide, information about how to access the teaching materials and other project material through the project website.

As well, our work is being disseminated by inviting national and international colleagues to participate in the ongoing development of our teaching materials by providing relevant case studies, commentary on our case studies and teaching materials, and by participating in a blog about cross-cultural health ethics issues on our project website.

The following sections provide reports on our presentations and four international meetings.

### 8.1 World Bioethics Congress, Singapore, July 2010 Conference Workshop Report

Members of the project team conducted a workshop entitled Bioethics education for a globalised world at the 10th World Congress of Bioethics (International Association of Bioethics) in Singapore in July 2010.

#### **Aims**

The workshop aimed to address two questions:

- How should health ethics education negotiate between universalist and particularist frameworks?
- How can ethics teaching be made more relevant to culturally diverse students and mobile health care professionals?

These aims were developed in the context of the cultural relativism versus universalism debate, which has significant practical implications for health ethics educators in a world of increasing globalization and international travel for study and work, and the overall aim of the project to design a curriculum framework that helps students to identify the influence of 'culture' on health values and to negotiate culturally based differences in values.

They were also framed against the background of two hypotheses:

- that there is less incompatibility between western values and the values of other cultures, and between western ethics practices such as truth telling and the practices of other cultures; and
- that there can be differences between what people think their cultural values and practices are and what they actually are.

### **Outline**

The workshop was attended by approximately fifty participants.

In the first part of the workshop, four keynote speakers, world-recognized experts in the fields of intercultural ethics presented short papers. These speakers then formed an expert panel to address questions from the audience and from each other.

The second part of the workshop consisted of a number of scenarios that were presented to and discussed by the attendees. These scenarios illustrated questions faced by health ethics educators in the context of the debate between ethical universalism and cultural relativism.

Attendees were also invited to share their ideas (in a written feedback form) about addressing cultural diversity in their student groups and in their teaching.

### **Expert commentary**

The following messages were strongly conveyed in the expert talks:

- Westerners tend to stereotype non-western ethical traditions as different, whereas the relationships are far more complex and not clear-cut. Examples exist where health ethics differences are the reverse of common stereotypes.
- Ethical absolutism is not the same as ethical universalism, which admits specific interpretations, including cultural variations.
- High level (general) norms are shared by many cultures.
- A number of non-western cultural norms are interchangeable with the principles of western bioethics, particularly in response to perceptions of harm within an increasingly industrialised, urbanized and globalized world.

## Outcomes

Within both the subsequent general discussion and the discussion of case scenarios, there was a significant level of agreement with these ideas, and hence an alignment with the hypotheses mentioned above.

Comments from these discussions were recorded and, together with other information, some of it derived from other conference presentations, have informed the subsequent development of the theoretical framework for ethics teaching in this area.

This was a very valuable workshop for the project, as it gathered information from a wide and disparate audience, who face similar challenges in their ethics education of multicultural students, as well as world experts on the theoretical approaches to cultural relativism and universalism. As such, it was a good example of applied ethics in action.

## 8.2 11th World Bioethics Congress, Rotterdam, June 2012 Conference Workshop Report

Members of the research team conducted a symposium, Health ethics education for a globalised world, at the 11th World Congress of Bioethics, in Rotterdam.

This 90-minute symposium was presented by A/Professor Lynn Gillam. There were approximately 50 attendees, mostly ethics educators, from many regions, including: UK, US, Europe, Indian subcontinent, Middle East, Africa, South America, Australia/New Zealand and South East Asia.

The symposium included:

- a summary of findings of consultations with educators and students;
- presentation of the pedagogical framework and curriculum materials;
- small group discussions using the case studies and instructions included in the curriculum materials; and
- feedback from small groups and discussion of the curriculum materials.

The main themes in the feedback and discussion were:

- Most educators from non-western countries used principlism in their teaching.
- Most felt this was appropriate (to a greater or lesser extent), but that there was a mismatch sometimes between local practices, understandings and assumptions, and the general principles.
- The key concepts of our pedagogy, especially the idea of ‘moral partners’, were well received.
- Educators needed more guidance on how to work through the case studies—an example showing the process was needed, before they undertook it themselves.
- Some groups struggled to see that there was any ‘grey’ in the cases—it seemed obvious to them that the universal principles (as held by the health professional) should trump the local cultural practice or ideas.

- There was strong endorsement that the processes of engagement and exploration in the moral partners approach was both ethically valuable and practically useful, though there was some doubt as to how able patients and families might be to engage in the way suggested. The terms on which the discussion between health and professional are envisaged might need to be re-framed.

Overall: The attendance was high; the audience was engaged and very interested in the problem being addressed; and the response to our proposed approach was very positive.

### 8.3 10th Interdisciplinary Conference, Communication, Medicine and Ethics (COMET), Trondheim, June 2012 Conference Workshop Report

Members of the research team conducted a workshop, Addressing cultural diversity in health ethics teaching, at the 10th Interdisciplinary Conference, Communication, Medicine and Ethics, Trondheim.

#### **Aims**

The workshop aimed to address one key question:

- What should health ethics educators teach?

These aims were developed in the context of:

- an increasingly culturally diverse and mobile health student population; and
- an expectation that health professionals are 'culturally competent' and 'culturally sensitive'.

The current education context was presented as providing a spectrum of approaches which tend to draw, to some degree, from a universalism versus a relativist approach.

Problems between extremes of these approaches were discussed.

Universalism can lead to:

- arrogance;
- lack of respect for others; and
- perceived cultural or moral imperialism.

Cultural relativism can lead to:

- stereotyping and dichotomising of cultures;
- moral distress;
- loss of integrity; and
- moral apathy (stepping away from taking responsibility).

### **Presentation of findings**

Key findings from consultation with health educators demonstrated:

- more agreement with principlism/universal values than was expected, but still concern about culturally-based difference in values;
- a perception that principlism had been 'imposed' without regard for cultural sensitivities. and is not always cross culturally applicable or appropriate;
- key findings from consultation with students highlighted general agreement with what they are taught;
- However, many saw principles as not applicable in other cultural settings; and
- many found it difficult to know what to do when there is a clash between principles and cultural norms.

### **Presentation of framework for teaching**

Four main steps were presented as a method for discussing ethical scenarios involving health decisions which included the potential for differing cultural values and perspectives to be held by the patients, families and health professionals. These steps are summarised and presented as an acronym, ADSAN:

- Acknowledge the Difference/s
- Identify Shared value/s
- Analyse the point/s of difference
- Negotiate

### **Outcomes**

This conference provided a valuable opportunity to discuss our project and to seek feedback on our approach. It also enabled us to form a relationship with a number of international health ethics educators, some of whom have been in touch with team members to request project materials and to discuss future developments.

We received generally positive comments about the presentation from the audience that our approach was useful for negotiating decisions in cross-cultural health ethics. There was mostly agreement that our approach was theoretically coherent, and the participants agreed that it could be easily applied and understood by students.

Other comments are summarised in the following chapter, which provides the formal evaluation for the framework and teaching materials that we have developed. These evaluations were completed by colleagues following presentations at the international conference.

## 8.4 UNESCO Chair in Bioethics: 8th International Conference on Bioethics Education Contents, Methods, Trends, Israel, September 2012 Conference Workshop Report

Members of the research team presented a conference paper, Health ethics education for a globalised world, summarising the findings from our consultations with students. We were also invited to present our insights about cross-cultural health ethics education to the UNESCO Chair in Bioethics Education Research Working Group.

### **Aims**

The presentation aimed to stimulate discussion of student experiences of health ethics education in the context of

- an increasingly culturally diverse and mobile health student population; and
- an expectation that health professionals are 'culturally competent' and 'culturally sensitive'.

The paper focused on the following questions:

- What should we teach?
- How can culturally-based differences in ethical values be addressed in health ethics education?
- Is principlism applicable/acceptable cross-culturally?

### **Presentation of findings**

Key findings from consultation with students of health professions demonstrated:

General agreement that health ethics education is useful and relevant:

- 'western' health ethics is not (always) cross-culturally applicable; and
- students from diverse culturally backgrounds might not agree with the values they are taught in health ethics.

Culturally based differences in values in health care can lead to:

- confusion and uncertainty;
- clashes between personal values, family values, what is taught in health ethics, and/or professional guidelines; and
- moral distress.

Students seek to respect both cultural values and overarching principles.

We concluded that:

- to be more effective health ethics education needs to provide students with a framework for negotiating cross-cultural differences in values; and
- while some approaches are dogmatic, reasoning that takes into account both universal values and cultural contexts can produce negotiated decisions that accommodate diverse cultural approaches without undermining universal values.

## **Outcomes**

Our paper was received very positively. We also had the opportunity to discuss the development of our pedagogical framework in both our conference presentation and our presentation to the education group. We received comments suggesting that our work was timely and particularly relevant to the aim of the UNESCO Chair in Bioethics to foster cultural understanding and promote ethics education more widely around the world. Additionally, a number of papers in the session we chaired focused on and critiqued the dominance of western approaches in bioethics. Responses to our presentations suggested that we had 'hit the nail on the head' and developed an approach that was seen to be more applicable and respectful of cultural diversity. Our report has been welcomed by the UNESCO Bioethics Education Group and Dr Fuscaldò has been invited to join this group's steering committee.

In summary, this conference provided a valuable opportunity to discuss our project and to seek feedback on our approach. It also enabled us to form a relationship with a number of international health ethics educators and with the UNESCO Bioethics Education Group, which will enable ongoing sharing of resources and insights and further dissemination and evaluation of our project.

# Chapter 9 Project Evaluation

We designed an evaluation tool to match the specific aims of our project. This tool assessed the two components of our project: the pedagogical framework and the teaching materials. The evaluation phase of the project is ongoing.

## 9.1 Pedagogical framework

We invited health ethics educators from around the world to review our pedagogical framework for its capacity to mediate between the claims of universal and culturally-specific values in ways that are meaningful in the context of health practice and education and able to be used in this context.

The framework has been evaluated for:

- a. consonance with participants' understandings and perspectives (i.e. for 'fit' with the data).

This has been achieved through 'member checking', where participants who attended the workshops at the International Bioethics Conferences were informed about the framework/model and invited to complete a semi-structured questionnaire (see Figure 9.1 below).

- b. Theoretical rigour and internal coherence, by structured discussion with colleagues and by successful publication as a peer-reviewed journal article.

## 9.2 Teaching materials

The teaching materials have been qualitatively evaluated for face-validity, user-friendliness and practicality for health ethics educators through workshop presentations and by inviting colleagues that attended these workshops to complete a semi-structured questionnaire (see Figure 9.1 below).

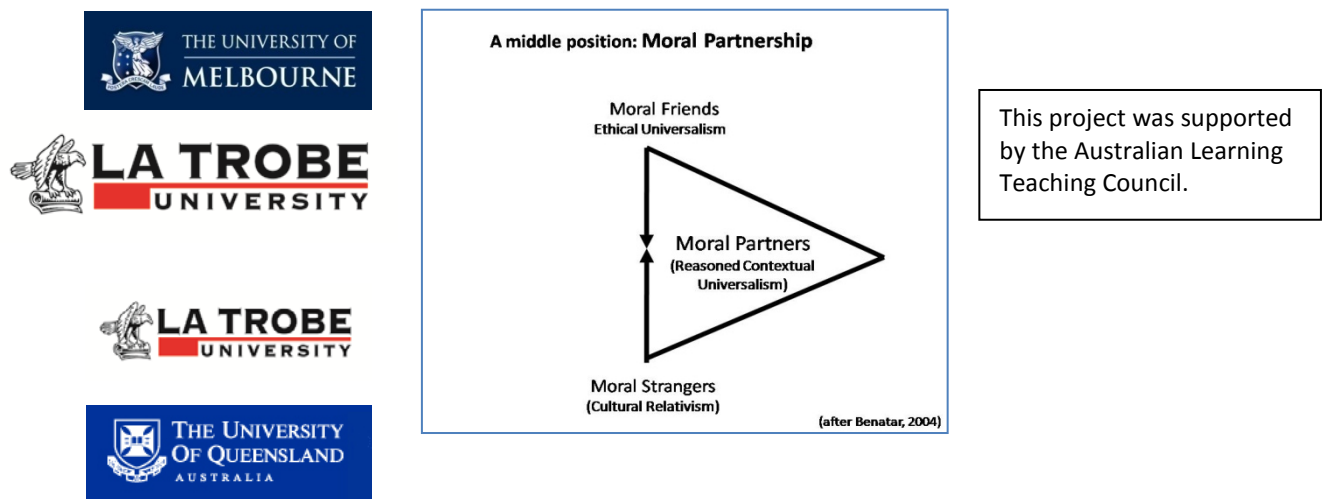
Evaluation of our project is also ongoing through commentary and discussion through the project website.

Evaluation of the acceptability and effectiveness of the teaching materials for students will be undertaken by piloting these materials with a sample of University of Melbourne, later year medical students to evaluate perceived relevance of ethics teaching to their situation and experiences and perceived conceptual consonance and dissonance.

In the next section (Figure 9.1), we present the evaluation tool that we developed and the results of peer evaluation of our pedagogical framework (summarised in Table 9.1).

## Figure 9.1 Project Evaluation Tool

Evaluation of MORAL PARTNERSHIP: an approach to cross-cultural health ethics



1. MORAL PARTNERSHIP is a useful approach for negotiating decisions in cross-cultural health ethics?

strongly disagree      disagree      agree      strongly agree

Please explain: what do you find useful or why do you think MORAL PARTNERSHIP is not a useful approach?

2. MORAL PARTNERSHIP is a theoretically coherent approach for addressing cross-cultural health ethics.

strongly disagree      disagree      agree      strongly agree

Please explain your thoughts about the theoretical aspects of Moral Partnership.

3. MORAL PARTNERSHIP is an approach that can easily be used to teach cross-cultural health ethics.

strongly disagree      disagree      agree      strongly agree

Please explain your thoughts about the ease with which Moral Partnership could be used in teaching.

4. MORAL PARTNERSHIP will be easy for students to understand.

strongly disagree      disagree      agree      strongly agree

Please explain your thoughts about how students might experience learning about Moral Partnership.

5. MORAL PARTNERSHIP is useful for making decisions in clinical situations.

strongly disagree      disagree      agree      strongly agree

Please explain your thoughts about the possible role of Moral Partnership in clinical situations.

6. I am interested in incorporating Moral Partnership into health ethics education or clinical practice.

strongly disagree      disagree      agree      strongly agree

Please explain what you would need to assist you to incorporate Moral Partnership into teaching or clinical practice.

7. The presentation on MORAL PARTNERSHIP and the student instructions made a difference to how I thought about, and came to a decision about, the case studies.

strongly disagree      disagree      agree      strongly agree

Please explain what difference Moral Partnership made to your thinking.

8. The process for how to use and teach moral partnership was adequately explained.

strongly disagree      disagree      agree      strongly agree

Please comment on anything that was not clear or any question you have about how to use or teach Moral Partnership.

9. If you would like further information about a teaching module that describes MORAL PARTNERSHIP or you would like to contribute case studies, reflections or comments to the teaching module please enter your EMAIL ADDRESS below.

### 9.3 Peer evaluation

We asked a number of our peers in health ethics education to review our work by completing an anonymous questionnaire with both Lickert scale and open-ended questions. These colleagues were given an explanation of the framework we developed and a demonstration of the teaching materials in the Rotterdam and Trondheim international workshops

The results of this peer evaluation are summarised below in Table 9.1 and give a generally positive evaluation of our project. All 20 reviewers agreed or strongly agreed that our framework was useful for negotiating cross-cultural differences in health ethics. Nearly all of the reviewers also agreed that our framework was theoretically coherent, easy to understand and to teach, and useful in clinical situations. The responses also show that nearly all of the reviewers had some interest in incorporating our framework into their teaching and that our approach made a difference to their thinking and decision-making in situations such as the case studies we presented.

*... it encourages people to understand the values/context for the other person—more*

*informed decisions or outcome, might make student/HP feel more comfortable when going against patient/family wishes. (17)*

*... very useful, should be introduced into the medical curriculum at earliest opportunity. (13)*

*... easy to grasp, transferable to other clinical scenarios. (7)*

Additional comments suggest that our approach requires some time to teach and practise and time to develop skills. Two reviewers suggested that the presentations did not allow enough time to fully appreciate how the framework could be applied.

*Needs enough time and good teaching. (8)*

*Needs to be supplemented with other approaches ... the students need to think through their own and other theories. (10)*

*Needed more time and real-life scenarios to see how it works. (14)*

We conclude from these evaluations that our peers in health ethics education found our framework for negotiating issues in cross-cultural health ethics theoretically coherent and practically useful. However, attention needs to be paid to the way in which we present our framework and the way in which it is taught. The use of real clinical examples to illustrate how it can be used is clearly an important teaching strategy.

In response to these evaluations, we now provide a number of worked examples in our teaching material and 'start-up' exercises to help educators and students think about their own ethical beliefs and how to categorise their views prior to embarking upon attempts to negotiate. These are included in the teaching materials provided in earlier chapters.

**Table 9.1 Peer Evaluation**

<b>Question</b>	<b>strongly disagree</b>	<b>disagree</b>	<b>agree</b>	<b>strongly agree</b>
1. MORAL PARTNERSHIP is a useful approach for negotiating decisions in cross-cultural health ethics. (N=20)	0	0	11 55%	9 45%
2. MORAL PARTENRSHIP is a theoretically coherent approach for addressing cross-cultural health ethics. (N=18)	0	1 5.6%	12 66.7%	5 27.8%
3. MORAL PARTNERSHIP is an approach that can easily be used to teach cross-cultural health ethics. (N=17)	0	0	8 47.1%	9 52.9%
4. MORAL PARTNERSHIP is an approach that will be easy for students to understand. (N=15)	0	1 6.7%	9 60%	5 33.3%
5. MORAL PARTNERSHIP is useful for making decisions in clinical situations. (N=19)	0	1 5.3%	12 63.2%	6 31.6%
6. I am interested in incorporating Moral Partnership into health ethics education or clinical practice. N=16)	0	0	10 62.5%	6 37.5%
7. The presentation on MORAL PARTNERSHIP and the student instructions made a difference to how I thought about and came to a decision about the case studies. (N=19)	1 5.3%	3 15.8%	10 52.6%	5 26.3%
8. The process for how to use and teach moral partnership was adequately explained. (N=20)	0	5 25%	9 45%	6 40%

## Chapter 10 The Project Continues

One of the significant findings from this project has been that there is a lack of cross-cultural dialogue in health ethics education and that the experiences of colleagues from outside the 'west' are largely absent from education initiatives and teaching materials. Our recent invitation to contribute to the UNESCO Chair in Bioethics Education Unit is timely and provides an opportunity to both share our project outcomes and invite increased participation in ethics education through this body.

We invite ongoing development of our work through the project website and through discussion of our forthcoming publications.

We believe that the project has provided a valuable contribution to ethics education, however, if health ethics education is to be both relevant and applicable to successive student cohorts, it is important to initiate strategies for regular cross-cultural dialogue and review. We will continue to disseminate the project and to invite ongoing dialogue, review and development.

In the spirit of moral growth through moral partnership, the project is ongoing.

## References

- Beauchamp and Childress JF (1997). *Principles of Biomedical Ethics*. New York/Oxford, Oxford University Press.
- Benatar S (2004) Towards Progress in Resolving Dilemmas in International Research Ethics. *The Journal of Law, Medicine & Ethics* 32: 4, p574–582
- DuVal G, Clarridge B Gensler G and Danis M (2004).A National Survey of U.S. Internists' Experiences with Ethical Dilemmas and Ethics Consultation. *Journal of General Internal Medicine* 19: 251–258.
- Edwards I and Delany C 2008 Ethical reasoning In: Higgs J, Jones M, Loftus S and Christensen, N (eds) *Clinical Reasoning in the Health Professions* 3rd edn. Elsevier, Boston, p 279-289.
- Engelhardt T (1996), Jr. *The Foundations of Bioethics*, 2nd ed. (New York: Oxford University Press.
- Fan R (1997). Self-determination vs. Family-determination: Two Incommensurable Principles of Autonomy. *Bioethics* 11: 309-322.
- Fuscaldo G, Russell S and Delany C (2010). Enhancing cross-cultural understandings of ethical issues in medical education. *American Journal of Bioethics Primary Research* 1: 1, 28-33
- Gillon R (2003) Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals". *Journal of Medical Ethics* 29:307-312.
- Goldie J 2000 Review of ethics curricula in undergraduate medical education. *Medical Education* 34: 108-119.
- Hongladarom S (2008) Universalism and Particularism Debate in "Asian Bioethics". *Asian Bioethics Review*, 1:1-14
- Justo L and Villarreal J (2003) Autonomy as a Universal Expectation: A Review and a Research Proposal. *Eubios Journal of Asian and International Bioethics* 13 53-7.
- Kim SH (2005).Confucian bioethics and cross-cultural considerations in health care decision-making. *Journal of Nursing Law*, 10: 161-166.
- Macklin R (1999). *Against Relativism. Cultural Diversity and the Search for Ethical Universals in Medicine*. New York/Oxford: Oxford University Press.
- National Health and Medical Research Council (2005). *Cultural Competency in Health: A guide for policy, partnerships and participation*.  
[http://www.nhmrc.gov.au/publications/synopses/\\_files/hp19.pdf](http://www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf)

- Nie JB (2000). The Plurality of Chinese and American Medical Moralities: Toward an Interpretive Cross-Cultural Bioethics. *Kennedy Institute of Ethics Journal* 10: 2239-260.
- Nie JB (2005) Cultural values embodying universal norms: a critique of a popular assumption about cultures and human rights *Developing World Bioethics* 5: 251-257.
- Nie JB (2007) The specious idea of an Asian bioethics: beyond dichotomizing east and west. In: Ashcroft RE, Dawson A, Draper H, McMillan J, (ed.) *Principles of health care ethics*. 2nd ed. Chichester: John Wiley and Sons, p. 143–9.
- Nie JB (2011) *Medical Ethics in China*. Routledge. London.
- Paasche-Orlow M (2004) The Ethics of Cultural Competence. *Academic Medicine*, 79:347-350
- Qiu RZ (2004) Introduction: Bioethics and Asian Culture - a Quest for Moral Diversity, in Qiu RZ (ed.), *Bioethics: Asian Perspectives. A Quest for Moral Diversity*. Dordrecht: Kluwer, pp. 1-9.
- Rachel J and Rachel S (2007) *The Elements of Moral Philosophy*. 5th ed. McGraw-Hill, New York, N.Y
- Sakamoto H (1999). Towards a New 'Global Bioethics'. *Bioethics* 13: 191-197.
- Tsai DFC (2005) The bioethical principles and Confucius' moral philosophy. *The Journal of Medical Ethics*; 31:159-163
- Tong R (1997) A Feminist Interpretation of Engelhardt's Bioethics *Reason Papers A Journal of Interdisciplinary Normative Studies*. Issues 22 Fall 1997
- Veatch RM (2000) *Cross-Cultural Perspectives in Medical Ethics*. Boston: Jones and Bartlett.
- Westra A, Willems D and Smit B (2009) Communicating with Muslim parents: "the four principles: are not as culturally neutral as suggested European *Journal of Pediatrics* March 21

# Appendix

Presentations for 11th World Bioethics Congress, Rotterdam, June 2012 and 10th Interdisciplinary Conference, Communication, Medicine and Ethics (COMET), Trondheim, June 2012

**Fuscaldo G**, Gillam L, Delany C, (2012) *Addressing cultural diversity in health ethics teaching*. 11th World Congress of Bioethics, Rotterdam and Tenth Interdisciplinary Conference Communication, Medicine & Ethics (COMET)



**Addressing cultural diversity in health ethics teaching**

**Giuliana Fuscaldo  
Lynn Gillam  
Clare Delany**

**University of Melbourne**

 THE UNIVERSITY OF MELBOURNE  LA TROBE UNIVERSITY  THE UNIVERSITY OF QUEENSLAND AUSTRALIA

This project was supported by the Australian Learning Teaching Council



## Acknowledgments

- This project was supported by the Australian Learning Teaching Council
- **The Research Team**
  - G Fuscaldo, University of Melbourne and The Victoria Institute
  - L Gillam, University of Melbourne
  - C Delany, University of Melbourne
  - M Guillemin, University of Melbourne
  - M Parker, University of Queensland
  - G Murphy, La Trobe University
  - P Stewart, University of Melbourne
  - S Russell, Research Matters
  - G Hall, University of Melbourne



## Symposium Outline

- Introduction and background 10 min
- Selected research Findings 15 min
- Teaching Framework 15 min
- Working through teaching materials 30 min
- Feedback and discussion 20 min
- Concluding remarks and finish





## Introduction

Context for teaching health ethics:

- student population is increasingly culturally diverse
- Increasingly mobile health workforce
- Health professionals expected to be “culturally competent”, “culturally sensitive”

What should health ethics educators teach?



## The problem for Health Ethics Educators

Respect for and sensitivity to cultural norms and health values may challenge and compete with notions of fundamental ethical principles- (eg truth telling, informed consent, confidentiality, respect for autonomy)

- In background ongoing debate, *Universalism versus cultural relativism*





## What universalism implies for health ethics education

- Same set of values/principles should apply in all settings, across all cultures
- Health professionals should act in accord with universal values (eg B+C principles, human rights), even when local values or practices are different (whilst also being sensitive and respectful to cultural difference)

Even allowing room for how the universal values are specified in a particular situation, this will sometimes mean going against local values and practices



## Arguments against universalism in health ethics

- **Universalist frameworks** (eg 4 principles approach ) reflect **Western values**
- Asian, European, African bioethics essentially different to American
- **West individual focus: East community, family**
- domination by American approaches = **Western ‘ethical imperialism’** (Qui, Justo,





## What cultural relativism implies for health ethics education


- The values which health professionals hold or are taught do not apply in different cultural contexts
- When the HP's values clash with those of patient/family/community, there are no grounds for judging whose values are more correct/ethical
- So HPs should fit in, act according to the local values and practices, even if these go against their own.



## Arguments against cultural relativism

- no substantively distinctive European, Asian or African bioethics - many shared values
- Accepted generalisations\* over-simplify, ignore variation within cultures  
(\*Western-individualistic and Eastern-communitarian)
- cultural values neither static nor monolithic  
(Nie, Macklin, Kim)





## Problems for both approaches in teaching health professional student

Universalism can lead to

- arrogance
- lack of respect for others
- perceived cultural or moral imperialism;

Cultural relativism can lead to:

- Stereotyping and dichotomising of cultures
- moral distress,
- loss of integrity,
- moral apathy (stepping away from taking responsibility)



## SELECTED FINDINGS FROM OUR RESEARCH INVESTIGATING THIS ISSUE



## Overall aim:

### to develop health ethics pedagogy that

- provides students with a framework for making ethical decisions in the context of diverse culturally-based values
- is relevant and applicable in a variety of cultural settings

## Methods

- Surveys of health ethics educators and students
- Ethical and pedagogical analysis, based on existing theory



# 1. Selected findings from international survey of health ethics educators

- Anonymous on-line survey
- Closed questions (likert scale) and free text responses
- n = 108





## Results 1. Health educators

		n	%
Discipline	Medicine	68	70.8
	Nursing	24	25.0
	Physiotherapy, Dentistry	14	14.6
Country	Europe	10	13.3
	USA	10	13.3
	UK	5	6.7
	Australasia	23	30.7
	Asia	17	22.7
	Other	10	13.3
	(South America, Africa, Israel)		



## Health educators: perceived diversity of student population

- 80% agreed that their student population was culturally diverse.
- described this diversity as
  - local v international students
  - diversity of religion
  - indigenous students
  - Migrants
  - gender diversity
  - socio-economic diversity.





## Health ethics educators: Ethical framework(s) underpinning curriculum

FRAMEWORK	n	%
Principlism	68	91%
Feminism	21	28%
Confucianism	4	5%
Communitarianism	24	32%
Other	39	52%



## Health ethics educators: Reasons for using principlism:

- Simple and useful (and familiar) and straightforward, systematic framework for students

*“Principlism seems to be an appropriate generic platform ... Our students tend to be unsophisticated in this area (science graduates) and respond well to the structured approach provided by an introduction to bioethics and ethical decision-making”.*





- Set of tools for thinking, articulating
- Internationally recognized and commonly used

*“The principles are generally accepted within the medical community in which I work, and when I discuss them in the wider community, I haven't encountered much dissent.”*



## Health ethics educators: Reasons for not using principlism:

- Not culturally appropriate

*“Bioethics comes from Anglo-Saxon cultures where for instance autonomy is the main principle while in our country the social view is prevalent.”*





## Other key points from the survey

Educators agree it is important that health ethics education addresses cultural diversity because

- Cultural values impact on health practice and health outcomes
  - Understanding cultural diversity promotes reflection, analysis, moral growth
- Educators are addressing cultural diversity in health ethics currently ad-hoc – have no standard approach or theoretical framework, feel uncertain how to proceed



## 2. Selected findings from survey of health professional students

Australian students

Anonymous survey, completed on paper on on-line

Closed questions (likert scale) and free text responses

n = 183





## Results 1. Students in health professions

Discipline	Number	%
Medicine	56	30.5
Nursing	76	42
Physiotherapy	17	9
Dentistry	15	8
Other	19	10.5



## Self identified cultural backgrounds

Aboriginal, Afghan, African  
American, Asian, Australian  
Anglo- Saxon; Bangladeshi, Canadian, Chinese,  
English European, Ghanaian, Greek. Indian,  
Indonesian, Islamic, Iranian, Irish, Japanese,  
Latin, Latvian, Malaysian, Mauritian,  
Middle East, Pacific Islander, Polish,  
Pakistani, Vietnamese

and combinations, or none





## Student surveys: key questions

- a. Was health ethics education relevant and applicable to your training as a health professional?
- b. Do you agree with the values that you were taught to respect?
- c. is the way health ethics is taught in western countries culturally relevant or helpful in other cultures?
- d. Cross cultural Hypothetical



## Student surveys: results

- a. Was health ethics education relevant and applicable to your training as a health professional?  
n = 124

Yes N= 107

No N= 6

Unsure N= 11

- Preparation for clinical practice
- Skills in decision-making
- Patient care
- Teaching what we should do
- Guidelines for practice





## Student surveys:

- b. Do you agree with the values that you were taught to respect?

n = 122

Yes 114 No 0 Unsure 8

*Yes agree with values because they are universal*

*Yes they are values which everyone should agree with.*

*Yes, can be applied to all patient interactions and direct nursing care delivery.*

*Yes any reasonable person would.*



## Student surveys: results 3

c. is the way health ethics is taught in western countries culturally relevant or helpful in other cultures?

n = 108

No, not relevant to other cultures: 50%

Yes, are relevant to other cultures: 28%

Unsure: 22%





## Some examples of “No” responses

- Not for Asian cultures. Rightness and wrongness also lie in the viewer perspective. The western culture is more focus on individual and the Asians more focus on family and culture.
- no because they have different cultural background and many decision making are different based on cultural background.
- Every culture has their own values and we must try to respect all cultures and abide by their decisions.



## More examples of “No” responses

- No, I believe if I go back to my home country, there might be a clash in ideas/opinions and beliefs especially in medical field
- I went to Vietnam to do my clinical elective. family is much more involved in decision making and although I didn't agree with the lack of autonomy, I had to adapt to the cultural difference.





## Some examples of “yes” responses

- ethics concepts translates across all boundaries, that has been my experience
- I think it applies to everyone, the principles are very considerate of individual rights.
- I think that there are ethical problems that arise in other countries more frequently than western countries due to lack of resources etc (e.g. justice/allocation of resources) but the principles still remain



## Experience of cultural value conflict

Have you experienced this type of conflict, (i.e. where your own cultural beliefs clash with what is expected of you in your profession?)

Yes: 23 / 79, 29% of those who answered the question





## Some examples of comments re cultural value conflict

"In my culture it is not acceptable to tell the patient that he/she will die soon. Doctor asked me to tell the patient...but I didn't...I told the patient that the hospital can't offer more. Patient understands."

"Kept quiet and complied with the rules."

• I've been involved in many situations like this. Generally, in a surgical setting, what the surgeon says, goes but I am ethically troubled by this

• "I have stepped up and complied with Australian culture."



## Overall observations on Educator and Student Surveys

- Consultations with health educators reveal more agreement with principlism/universal values than we expected, but still concern about culturally-based difference in values
  - Sense that principlism had been 'imposed' without regard for cultural sensitivities. Not always applicable
- Consultation with students reveal general agreement with what they are taught but
  - Many see principles as not applicable in other cultural settings
  - they find it very difficult to know what to do when there is a clash between principles and cultural norms





## Implications of survey data for our aim of developing a cross-cultural ethics pedagogy

- The need to address cultural diversity in ethics education is endorsed
- There is wide acceptance of some degree/type of universality of some ethical principles
- There is also drive to acknowledge and respect different culturally based values



## A FRAMEWORK FOR TEACHING





## What seems to be needed for effective cross-cultural ethics education

- Respect culturally based differences in values
- Respect shared values (universal principles)
- Negotiate between universal and particular rather than impose set of principles

Provide educators with sound ethical and pedagogical foundation for an approach to teaching

Provide students with a framework or approach for doing this negotiation between different value positions



## A Process for Ethical Decision Making as Moral Partners ADSAN

1. Acknowledge the Difference/s
2. Identify Shared value/s
3. Analyse the point/s of difference
4. Negotiate





## 2. Identify shared value/s

- There is obviously something we disagree about, but what is there that we agree on?
- Look for values that both parties share, by asking
  - what is each person trying to achieve?
  - What are their aims?
  - WHY do they hold the view that they do?
    - Look for increasing levels of generality in the reasons, to identify common moral ground
  - Can each party see something of value in the other party's reasons?



## 3. Analyse point/s of difference

Identify, as equal partners in this discovery, where and how the health professional and the patient/family diverge in their thinking.

- What does the patient/family think that is different to what the health professional thinks?
- Is there a shared value/rule/principle that is being understood differently by the two parties in the particular context?
- Do the health professional and the agent have different ideas about what constitutes good health or a good life or doing what is best?





## 4. Negotiate

Think through possibilities that will promote shared values

- Find a mutually acceptable solution by incorporating new reasoning, new insights
  - Middle ground
  - compromise
- If no agreement, then respectful disagreement
  - but health professional will not automatically cede to wishes of patient/family, because moral integrity of HP matters.



Foundations in  
ethical theory

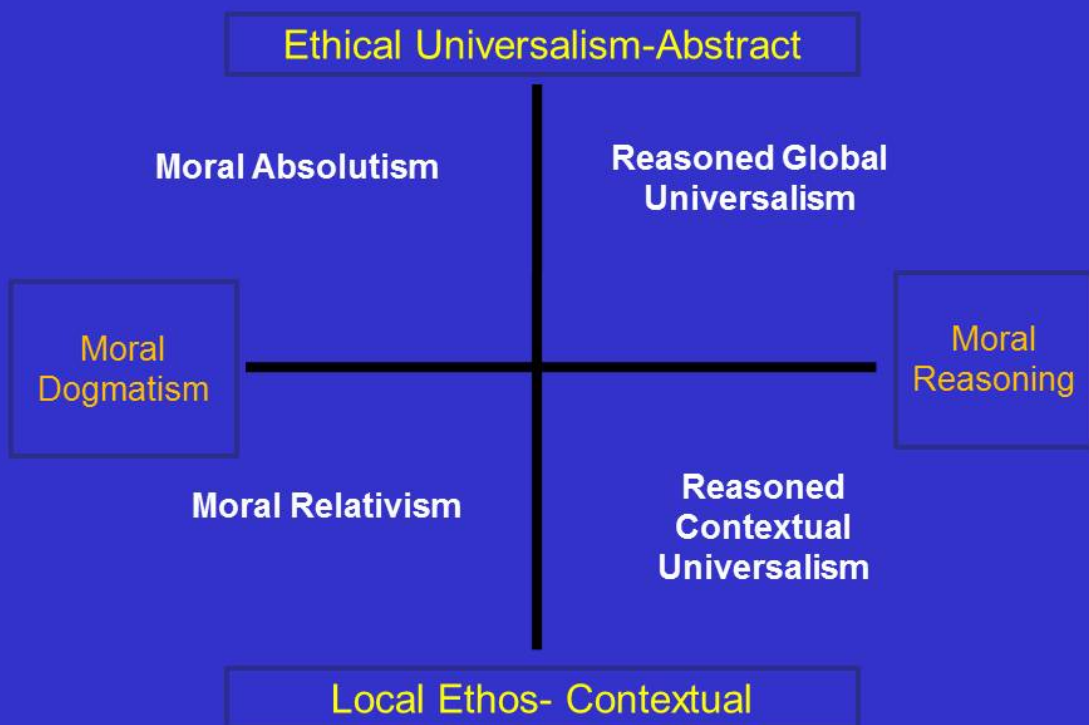


- Drawing on Macklin, Jing Bao Nie, Benatar  
Principlism/universal values *not incompatible*  
with culturally specific norms/practices,  
**it is possible to find a middle position**

Our teaching framework based on what Benatar refers to as Reasoned Contextual Universalism (“moral partnership”)

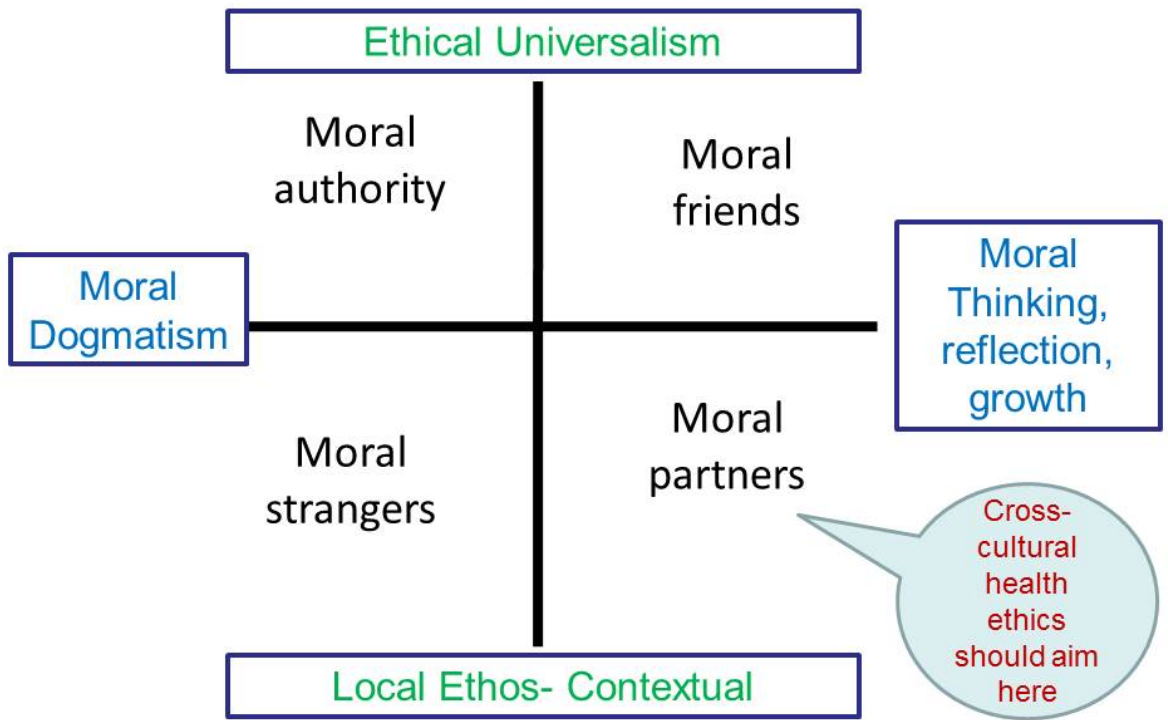


### Benatar's Four Perspectives on Ethical Dilemmas



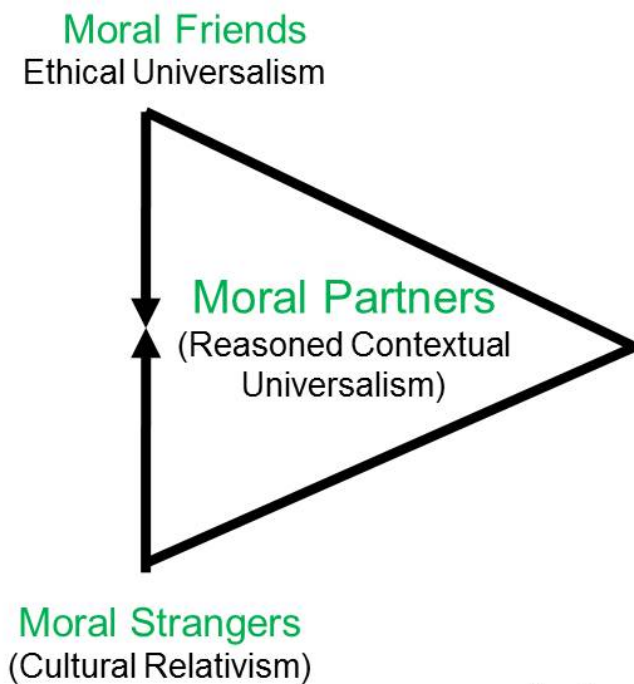
Benatar, 2004

## Four Perspectives on Ethical dilemmas



Adapted from Benaetar, 2004

## A middle position: Moral Partnership



after Benatar, 2004



## “Moral partners” – a key concept

- Moral partners seek to identify shared moral values, starting from a position of equality (neither assumes their values are better or more correct).
- Based on the view that there are some universal values (even if at very general level).
- Our approach to teaching involves teaching health practitioners to
  - identify and reflect on their values and those of their patients
  - negotiate from a position that assumes shared values are possible



## Pedagogy of our approach





## Locating our pedagogy within standard approaches to ethics education

1. Ethics as decision-making for action
  - Reasoning skills
  - Applying general principles to particular situations
2. Ethics as character and attitude
  - Commitment to values, and to acting on them
  - Interpersonal and communication skills
  - integrity



### 3. Ethics as advocacy

### 4. Ethics as moral agency

Awareness of self as a moral agent, having moral values  
Integrity and moral responsibility

### 5. Ethics as professional identity

Delany, C., R. McDougall, L. Gillam. (2009). Ethics in Clinical Education. In C. Delany and L. Molloy (eds) *Clinical education in the Health Professions.*, Elsevier



## Pedagogical strategy

- Deliberate perturbation of students' existing moral frameworks.
- Use cases involving culturally-based value difference to create '*disorientating dilemmas* or '*moral disequilibrium*'.
- “**Transformative learning**” involves a process of:
  - critically challenging existing perspectives
  - articulating the reasons for their limitations
  - apprehending new or revised perspective(s) which can better account for the phenomenon at hand.

Mazeno, J. Transformative dimensions of adult learning. San Francisco: Jossey-Bass;



## Teaching Strategies

1. Make ethics knowledge visible to students
  - Teach ethics frameworks from a meta ethics approach.
    - What are ethics frameworks?
    - What is their epistemological bases?
    - How do the frameworks relate to each other
2. Teach ethical reflection and analysis as a collaborative rather than an individual (theoretical) endeavour
3. Promote and practice being curious, open and non-judgmental in communication and negotiation





# TRYING OUT TEACHING MATERIALS



## Using case studies to teach ADSAN approach

Step 1 (to get started) – What do you think the health practitioner should do?

Step 2 (ADSAN – a new way of thinking about this situation)

Students as “observer” – work through ADSAN, asking what health practitioner and patient *could* say or think

Step 3 – role play the ADSAN approach, with students taking role of health professional and patient, working through the conversation



## For group discussion today 1

### Starter question:

“What should the health professional do?”  
What answers would your students give to this question?

### ADSAN questions:

2. “What values and goals could the health professional and patient/family have in common?”
- What is each party trying to achieve?
  - What are their reasons?
  - Could they understand and agree with each other’s reasons at some level of generality ?
- How would your students answer these questions?



## For group discussion today - 2

### 4. Negotiation

- Can you see a possible middle ground or mutually acceptable solution be seen? (what is it?)
- If no mutually acceptable solution, what should the health professional do/say?





## Case 1

Basilia is a 75 year old, active diabetic Filipino woman. She requires amputation of her gangrenous right leg. Basilia's daughter, knowing that her mother will refuse surgery, gives consent, instructing the surgeon not to inform her mother.

The daughter argues that from the Filipino family's perspective, her obligation is to protect her mother's well being. She explains that her mother needs to be protected from her refusal of treatment and that disregarding the individual wishes to care for a sick family member is understandable and acceptable.

The daughter explains that Basilia may initially be angry after the surgery- but this will subside to relief and gratitude. She will realize that her daughter decided on a course of action out of concern for her mother's well being and safety. In the end Basilia will accept the family's decision because this is what being part of a family entails.

(adapted from Alora AT and Lumitao JM. Beyond Western Bioethics: Voices from the Developing World. 2001 Georgetown Uni Press)



## Case 2

Florence is a resident doctor working in Australia. She grew up in Malaysia, and moved to Australia to do medical training. She is from a cultural background where it is customary for a patient's family to make decisions about medical treatment. However, in her ethics classes in Australia, she was taught that it is important to respect individual patients' decisions.

On her clinical rounds one morning, a family who shares her cultural background, asked her to conceal the diagnosis of a terminal illness from their elderly father. The father has just been diagnosed with a malignant brain tumour, which is causing his symptoms of confusion, dizziness and fainting. He has not yet been told this by the neurologist.

(with thanks to Lynn Gillam, University of Melbourne)





## Case 3.

Samuel is a Kenyan man from Luo, now living in Melbourne Australia. In Luo tradition, initiation into manhood involves the removal of six teeth from the lower jaw.

Samuel visits Maria, a local dentist near his home in Melbourne and requests that she perform this extraction. Maria is conflicted by this request and believes that the principles of good dentistry prohibit her from extracting healthy functioning teeth.

(With thanks to Thuy Nguyen, University of Melbourne)



## Case 4.

Ivan is a 26 year old physiotherapist with a private practice in a small coastal town,. His practice provides the only physiotherapy service in the district and Ivan sets aside a few hours each week to provide treatment to disabled children attending the local school.

Over the past 3 years, the town has received an influx of migrants. Waleed and his family moved to the school 2 years ago. The school asked Ivan to see Waleed, because he was falling often in the playground. Ivan contacted Waleed's parents, and found out that Waleed is 9 years old and has been diagnosed with Duchene muscular dystrophy. He is still walking, although he falls often and is teased by other children because of this.





## Case 4 (cont)


Waleed's parents do not believe that their son has any medical condition, although they have had DMD explained to them. They say he is just clumsy, does not need any physiotherapy and should be treated 'just like other children'. They believe that it is important that boys must be and appear strong and that having treatment would undermine this.

Ivan thinks that Waleed's parents beliefs are harming Waleed. He believes that Waleed should receive treatment because it will improve his quality of life, despite what his parents say.



# DISCUSSION

## Evaluating the ADSAN approach

- What do you think of this approach?
  - Would students be able to use this approach?
  - Would the ADSAN approach encourage them to think differently (more productively) about situations where there are culturally-based value differences?
- 



# CONCLUDING REMARKS



## Challenges for ADSAN approach

Requires skill in identifying, articulating ethical values

- Can health professionals do this well enough?
- Can they enable/assist patients and families to do this as well, so that there is real moral partnership?

Requires moral courage and openness to moral growth  
incorporating new insights = may need to change mind

Some people hold intractable positions

Some values may be non-negotiable (conscientious objections)



## Student Surveys: What should Florence do?

- Discuss further N=55,
- with bioethicists N=2, family N=24, patient N=14 colleagues N=10 senior clinician N=5
  
- Tell patient N= 30
- Follow professional guidelines/law of country working in N=25
- Respect cultural background/ family's wishes N=20
- Do what the patient asks you to do N= 7
- Do as taught N=3
- Do what is best for the patient N=2
- Follow her own personal ethics N= 1
- Pass case to another clinician N=3
- Unsure N= 4

