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Ethical Legal Feature

## Cultural Factors in Ethics Consultations

Guest Discussants: Désirée A. Lie, MD, MSED, Jack B. Fu, MD, Patrick Schmitt, DO,  
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### Feature Editor Introduction

As clinicians working in rehabilitation, we treat patients from various cultural, ethnic, linguistic, and religious backgrounds. Some of these cultural factors may impact the way that information is communicated, goals are negotiated, and medical decisions are made. The terms cultural competence, cultural humility, cultural sensitivity, cultural respect, and, more generally, diversity, often are used to discuss the aspects of practice that address cultural factors in health care delivery. Kleinman and Benson [1] have written eloquently in their article, "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It," that culture matters in the clinic, but addressing it cannot be reduced to a technical skill. They suggest a "revised cultural formulation" exploring ethnic identity, what is at stake, the illness narrative, psychosocial stresses, the influence of culture on clinical relationships, and the efficacy of a cultural competency approach. Addressing cultural factors requires thoughtful and complex notions of these factors, rooted in the specifics of the situation and case. What does this look like in ethics consultation in a rehabilitation setting?

In this column, we will explore a case that brings up issues of respect for autonomy, filial piety, truth-telling, prognosis disclosure, and family dynamics, among others. I sent the following writing prompt to the invited columnists:

The ethics consult service is called because an inpatient on the brain injury unit is asking if "he is going to die," and his family has asked that he not be told his prognosis. He has a glioblastoma, which recently was resected, and he has been admitted for inpatient rehabilitation to facilitate his ability to live in the community and gain strength for radiation and chemotherapy. Mr Zhang, (loosely based on a patient

we consulted on) is 68 years old, has a previous history of right hemisphere stroke, and believes he is in rehabilitation "just like the last time" to work on "walking and thinking." His primary language is Mandarin, although he understands limited English as he has lived in the United States for more than 30 years. He is married and has 2 adult children. His son is the primary spokesperson for the family and has requested that his father not be told about his diagnosis or prognosis or he will "lose hope" and "give up." He states that the oncologist and teams at other hospitals have been "fine" with this, as according to the patient's cultural beliefs, discussing death may hasten it. The patient's wife is in agreement; his daughter lives out of town and has only visited the rehabilitation hospital once. An Asian-American therapist calls the ethics consult—they are uncomfortable with the family's request and state that in the United States, every patient has the right to know their diagnosis and prognosis.

Who defines culturally sensitive or culturally competent care? What are the key aspects to consider as you are gathering information and approaching this case?

The first columnist, Desiree A. Lie, MD, MSED, is a Clinical Professor of Family Medicine at the Keck School of Medicine at the University of Southern California. She uses her expertise in cultural competency training to address the complexities of the case and offers communication strategies to dig deeper into the patient's question. The second columnist, Jack Fu, MD, is an Associate Professor in the Department of Palliative, Rehabilitation & Integrative Medicine at the University of Texas MD Anderson Cancer Center. He uses his expertise in cancer rehabilitation and brain injury medicine to explore the issues and concludes that the case fundamentally is about decisional capacity. The

third response is co-authored by Patrick Schmitt, DO, and Eric Kodish, MD, both from the Cleveland Clinic. Dr Schmitt is a Psychiatrist in the Department of Physical Medicine and Rehabilitation and has a joint appointment in the Department of Bioethics at Cleveland Clinic. Dr Kodish is a Professor of Pediatrics and Bioethics at the Lerner College of Medicine of Case Western Reserve University. Drs Schmitt and Kodish systematically address the ethics consultation by delineating the ethical questions and make recommendations.

## The Faces of Truth

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Culturally sensitive care requires skills that recognize the patient's values and nonmedical factors in the patient's decision-making process, as well as the role of the family and community. An approach that emphasizes cultural humility has been demonstrated to optimize physician–patient–family interactions. Models of cross-cultural communication share a common inclusive approach to patients, families, and communities, with negotiation as a key element [1] (see resources after the reference list).

The ethics team is being consulted because of a therapist's discomfort about perceived conflict between Mr Zhang's direct question about whether he is "going to die" (reflecting a desire for prognostic information) and his son's request that diagnostic and prognostic information be withheld from his father. The reason the son gives for withholding information is that the father would "lose hope and perhaps give up on rehabilitation." There is implied beneficence in that the son, in his filial piety, sees living a longer life as desirable for his father and does not wish to hasten death by discussing it. The son's (and family's) request also may reflect the principle rooted in Confucian philosophy [2] that the family's wishes take precedence over patient autonomy. Sometimes a proxy family member may make decisions even when the patient has decisional capacity. The son's request challenges contemporary Western bioethical practice in which patient autonomy—independence and self-determination—is the accepted basis of informed consent and truth-telling to the patient is considered a central moral and biomedical obligation [3]. So, how do we reconcile truth-telling in Western virtue-based ethics with the apparent obligation to hide the truth from the patient in the family-grounded communitarian bioethics of Confucius?

We can strive to protect the values of all parties (patient, family, and providers) to serve Mr Zhang's best interest. Open communication with clear understanding and acknowledgement of each party's well-meaning intent would respect the patient's decision-making

This set of responses underscores that there are various approaches to culturally responsive care and the ethical issues raised can be addressed in diverse ways. As always, I welcome ideas for the PM&R Ethics/Legal column at [dmukherjee@sralab.org](mailto:dmukherjee@sralab.org).

## Reference

1. Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Med* 2006;3:e294.

capacity and still enable him to prepare for immediate treatment and eventual palliative care [4] while validating the family's right to participation. As such, it reflects well on the team to acknowledge and respect the existing dynamic of the son being the primary spokesperson in the family.

Mr Zhang is aware of his previous diagnosis of stroke for which he received rehabilitation but appears to have limited awareness about the reason for his recent surgery. Given that he has received surgery, and chemotherapy and radiation are being considered, we need more information about what he already understands, how he wishes to receive further information, and what and how his family has communicated with him thus far. Assessing and responding to his health beliefs and literacy level will set the stage for effective communication.

I would recommend, as a first step, that we interview Mr Zhang through a qualified interpreter, independently from his family. The goal is to elicit how much he already is aware of his diagnosis and prognosis and to discern his desires and goals for future care. It's very likely that despite having limited English proficiency, Mr Zhang has gleaned that his current diagnosis is different from his previous stroke, especially as the treatment is different this time. Eliciting his understanding, values, desires, and goals in relation to his question—"Am I going to die?"—is central to providing care that respects his cultural, spiritual, and moral values.

In his culture, as indicated by his son, sharing a cancer or terminal diagnosis with a patient may be unacceptable and inappropriate. His family may hold a belief that this form of truth-telling would "invite death into the room" and cause an early demise. We need to balance the need to inform the patient and the patient's right to information with cultural expectations and the family's dynamic. Therefore, the clinicians might offer some options, for example, "How would you like us to share medical information? Would you prefer to discuss your condition alone with us, or with your family present, or would you prefer that we communicate first with your son and family?" They could then

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