12. Ethical Considerations for a Multicultural Clinical Workforce

Statement of the Subcommittee Charge

The ethical issues surrounding multiculturalism are most often approached from the perspective of patients' cultural diversity. The effects of a multicultural provider workforce on individuals' approaches to clinical practice have received much less attention. The cultural background of the provider may have a strong impact on the effectiveness and quality of patient care. For example, a provider's cultural background affects the way he or she communicates with patients. One's cultural perspective influences how a provider interprets linguistic nuances, responds to etiquette issues, and how he or she relates to the patient as an individual. Cultural perceptions also affect interactions in the workplace with other health care providers.

The way in which a provider's cultural perspective affects his or her professional judgment can support or undermine the patient's right to self-determination. For example, a provider's expectation about the patient's ability to process information may be based on how he/she views the patient's gender, race, or social class. This may influence the types of treatment offered and the quality of the informed consent obtained. When complex medical and ethical issues are involved, such as a decision to withhold or withdraw life-sustaining treatment, the patient's decision may often hinge on religious or other cultural values. When the patient and the provider have different values or beliefs, it may be difficult for the provider to understand and implement the patient's health care decisions. Different cultural perspectives can also

make it difficult for professional colleagues to agree on the best approach in a given clinical situation.

The subcommittee was asked to identify areas of clinical practice that may be significantly affected by providers' cultural diversity, to consider the ethical issues at stake, and to suggest strategies for addressing and/or resolving these concerns. This report focuses on how differences in cultural perspectives affect individual approaches to clinical practice. We examine the ethical issues that arise when culturally based conflicts occur in the health care setting. Finally, we suggest various ways to address and/or resolve some of the ethical concerns that are raised.

The mix of health care workers, professional staff, and patients that interface in the modern health care setting has become more diverse. Consequently, concern about how to accommodate cultural differences and maintain the quality and consistency of patient care has become more prevalent in medical ethics. When conflicts arise that stem from differences in culture or ethnicity, they affect the relationships of all parties involved in the delivery of health care. Numerous articles in the recent medical literature address the myriad issues raised when there is a conflict between the cultural values and beliefs of the patient and those of the provider. Many authors suggest that in order to become more attuned to the cultural perspectives of their patients, providers must first acknowledge and understand the impact their own cultural experience has on their approach to health care.

VA Demographics

The VA clinical workforce is culturally and ethnically diverse. (See Appendix A.) This is due, in part, to the extensive role the department plays in educating health care professionals. More than half the physicians in the United States receive some portion of their medical training with VA. Many VHA facilities are also affiliated with university medical centers, with which they share educational facilities and resources. Residents, fellows, interns, students, and faculty trained

in various professional disciplines (e.g., dental, medical, nursing, social work) from across the country and around the world rotate through VA health care facilities. VHA also employs a number of health care professionals, such as international medical graduates,[1] who received their initial medical training in countries other than the United States. All of these factors contribute to the mix of professional disciplines and different clinical approaches among VA health care providers. Thus, there are numerous instances where providers of different cultural backgrounds interact in the VA health care setting.

In recent years the VA patient population has also become more diverse. Although more veterans today come from different cultural and ethnic backgrounds, most also share many commonalties. VA patients are primarily male U.S. citizens who were educated and reached maturity in the United States.[2] Most speak a common language and all have a shared experience of military service.

Culture Defined

Culture is defined as "[t]he totality of socially transmitted behavior patterns, art, beliefs, institutions, and all other products of human work and thought characteristic of a community or population."[3] Another definition of culture is: the collective social experiences of a group; experiences that determine the importance group members place on particular elements of their lives. These experiences and values are not static, but evolve and develop over time, as the group migrates and members become exposed to different ideas, environments, and problems. Certain individuals in a group may retain their cultural integrity, while others become acculturated as they integrate into their new surroundings. Cultural experiences and values that have become dormant with time may re-emerge when particular situations, difficulties, or stresses strike a familiar, resonant chord deep within the group's psyche or the individual's subconscious. When this occurs, it may not be readily apparent what aspect of the individual's cultural experience may have caused him/her to react in a certain way.

Culture is reflective of, but is not limited to, nationality, citizenship, geographic location of birth, season or time of birth,

language, manner of dress and bodily adornment, food restrictions or preferences, rituals, etiquette, customs, music, dance, crafts, mythology, artistic expression, and religion. Culture defines the role and importance of subgroups within the society: women, men, children, elders, and those considered less fortunate, such as the sick, the disabled, and the poor. It also determines who in society, for example, the individual or the head of the family or the group, has the authority and responsibility to make decisions. Such diverse elements as the definition of success and the value of time, money, and respect, especially self-respect and "saving face", are important. Additionally, subgroups within the larger group or culture may be influenced by place of residence (urban vs. rural), site, source and level of education, occupation, socioeconomic status, caste, religious affiliation or sect, gender, sexual orientation, primary language or dialect, group self-esteem or ethnic pride, and level of group or individual accomplishment. Each individual then becomes a mosaic of these various forces or elements to which he or she has been exposed over time.[4]

As we examine the different ways in which culture informs and influences daily clinical activities, we may discover shared values, ideals, and virtues within our varied cultural traditions. Increased awareness and understanding of our own cultural perspectives can help renew our sense of professional vocation by calling to mind why we chose health care as a profession. It also creates an opportunity to reaffirm our commitment as providers to maintain the dignity and integrity of VA patients in a manner most appropriate and meaningful to them. As providers become more familiar with the ways in which culture and experience influence individual approaches to clinical practice, they may begin to appreciate more what can be learned from different cultural perspectives. This insight should also help providers become more cognizant of how their cultural perspectives or values may differ from those of their patients.

When Culture is a Source of Bias

When cultures meet in the health care setting, the potential for bias exists on either end of the provider-patient axis. Cultural bias can also intrude on interactions between professional colleagues and between different health care disciplines. This discussion focuses on ethical conflicts that may arise when the provider's cultural perspective differs from that of his or her patient, other providers, or VHA policy. It is important, however, to recognize that cultural diversity of providers also contributes in a positive way to the delivery of ethical care. Examples include cultural concepts such as strong respect for aged persons and for the role of families in care of the sick.

Ethical conflicts may arise when health care providers assume that if a particular approach works for them, it should be ethically acceptable for everyone else. As we alluded to in our previous discussion of culture, there are many factors that affect the delivery of health care. Some cultural practices and beliefs may conflict with concepts of patient autonomy and informed consent that are the ethical foundation for clinical practice in VHA. Problems can arise when a provider's clinical approach is offensive to the patient or contrary to VHA policy, for example, if a provider discourages participation by patients in decision-making.[5] Some VA providers may come from, or identify with, cultures in which:

1. The physician's judgment, decisions, or recommendations are never questioned or refused.
2. The physician or health professional is given the highest honor and respect in the community.
3. The provider is not expected or required to provide information to patients or families.
4. The provider expects to relate only to men, even if the patient is a girl or woman.
5. The accepted perceptions of the meaning of life, death, and illness differ significantly from those of VA patients.[6]

6. It is common practice to use alternative methods of treatment that are not part of the standard therapeutic armamentarium.
7. The provider does not expect to have to obtain the patient's consent to treatment or procedures.
8. The unique rituals or customs surrounding birth and death differ from those of VA patients.
9. Body language or other behavioral clues are more important than spoken or written communication, or certain language or gestures are considered taboo or insulting.
10. The family, group, or community is more important than the individual.

It would be unethical for a VA health care provider to allow cultural attitudes, such as the ones described above, to influence his/her clinical approach in a way that undermines patient autonomy. In addition, if a provider was to adopt a clinical approach that was inconsistent with departmental policy, the provider could be disciplined. Departing from accepted U.S. standards of practice could also increase the provider's risk of legal liability.

Respect for Culture and Cultural Relativism

In discussing how culture affects health care ethics, it is important to note that respect for other cultures, even cultures whose values appear to be at odds with one's own, is not the same as cultural ethical relativism. The approach to any culture, however different it may seem, is based on respect for others: just as all persons are worthy of respect, so are all groups of persons which make up distinct cultures. The value different cultures place on tradition, etiquette, dress, diet, arts and crafts, religion, and other similar domains may be of little moral import. Problems arise, however, when cultural values conflict over moral issues such as limits on individual freedom, treatment of vulnerable groups, responsibility for decision-making, the obligation to tell the truth, and justifications for allowing bodily mutilation or taking of a human life.

Cultural ethical relativism holds that moral norms are solely determined by cultural custom: whatever is the custom of a particular group is moral for the members of that group. The corollary is that there are no moral standards that apply universally to all persons of all cultures at all times. However admirable or repugnant one judges the behavior of persons of a particular cultural group, one outside that culture has no right to make a moral judgment vis-à-vis anyone within that cultural group. This position is contradictory, however, because while cultural relativism denies the existence of universal moral standards, it relies on a universal moral standard of tolerance for all cultural views.

The universal standard of tolerance, as an expression of respect for persons, is discussed in detail in philosophy and ethics literature. There are other universal moral standards as well. The ethical principles of beneficence, nonmaleficence, and justice are often referenced in discussions of clinical ethics. Beneficence refers to the provider's obligation to focus on the patient's welfare and best interest. Nonmaleficence requires the clinician to avoid causing harm. Justice imposes a moral obligation on the provider to treat patients fairly.

The application of the principle of autonomy to clinical ethics is premised on the assumption that an adult patient who has decisional capacity has the right to make his/her own health care decisions. This notion that patients have the right to make treatment decisions is fundamental to the provider-patient relationship in VHA. In order for the patient to freely exercise that right, the patient must understand the nature and consequences of his/her illness and the treatment alternatives, choose from among the available treatment options and communicate that choice to the physician. If the provider's cultural values or beliefs differ from those of the patient and that difference serves to frustrate or undermine patient self-determination, ethical problems occur. For example, if a clinician comes from a culture where only men are allowed to make decisions, the provider may discount the patient's treatment preference because she is a woman. Other commonly recognized moral concepts, such as truth telling, confidentiality, and promise-keeping may also be affected by the

provider's cultural perspective. However, the greatest impact appears to involve issues of autonomy. Accordingly, this paper focuses on how provider cultural diversity affects this aspect of clinical care.

Respect for Persons and Individual Freedom

The basic moral concept that serves as the foundation for much of clinical decision making is "do not deprive freedom"[7] or respect for self-determination or autonomy. The clinical application of this concept is most often perceived in terms of patients' rights. Adult patients who have decisional capacity have the right to accept or refuse any treatment or procedure presented by the provider for their consideration.[8] In the United States, patient participation in decision-making is a recognized part of the patient-physician relationship. Its importance is reflected in the informed consent process. The patient is free to choose, from among the available options, the treatment that is most compatible with his/her values, beliefs and health care goals. Cultural beliefs and values often provide the rationale for the patient's health care decision. This morally based understanding of the patient's right to choose is captured in VHA policy: "patients have the right to consent to and, equally, to decline any treatment, including the provision of life-sustaining treatment." [VA Manual M-2, Part I, Chapter 31, 31.03b.(l).]

The concept of autonomy or self-determination is not limited to patients, but applies to physicians and other health care providers as well. Providers exercise their right of self-determination in the health care setting in at least two fundamental ways: choosing their practice environment and making professional judgments.

Health care professionals have the freedom to choose where they will work. If a provider accepts a particular position at an institution then he/she has an obligation to abide by the institution's policies and fulfill the requirements of the position. In so doing, the health care provider is exercising his/her right of self-determination. Employers, however, may establish policies and procedures that limit or restrict the autonomy of health care providers in the health care setting. This is

similar to the responsibility patients have to comply with the basic rules of the medical facility where they are receiving care. For example, if the health care provider has agreed to practice in VA, he/she has an obligation to do so in accordance with VA rules and regulations. This restraint on absolute freedom does not unduly compromise the provider's autonomy because he/she voluntarily agreed to accept the terms of employment at a particular institution.

Second, within the framework of his/her position, the health care provider has the freedom to use professional judgment. When, for example, a physician determines what treatment options are medically appropriate given the patient's diagnosis and prognosis, he/she must rely primarily on professional training and expertise. A provider is not required to provide treatment that he/she considers medically or morally inappropriate. Most health care institutions, including VHA, allow providers to invoke the conscience clause when the provider is morally opposed to a particular treatment or procedure.[9] An example is a decision concerning life support. VHA policy specifically provides that "[a]ny health care provider may decline to participate in the withholding and withdrawing of life sustaining treatment." (VA Manual M-2, Part I, Chapter 31, 31.08a.) Thus, providers who object as a matter of conscience can refuse to perform certain treatments or procedures, even though the treatment at issue may be medically and ethically appropriate for the patient.

Although the provider's cultural perspective may legitimately influence certain clinical judgments, a provider may not impose his/her cultural values on the patient's treatment decision. Limiting the provider's freedom in this regard is justified because it avoids harm to the patient. Should a similar limitation be placed on providers with respect to cultural conflicts that occur between colleagues and other health care professionals? Can providers maintain their cultural integrity without compromising patients' rights? How does one determine when a provider's actions are culturally based? How should cross-cultural conflicts between the patient and the provider, provider and provider, and the provider and the institution be resolved? Finally, how does the existence of different cultural values, beliefs, and

attitudes among providers affect the overall quality of patient care? The following two case studies highlight these concerns. Although the cases are fictitious, the examples used were compiled from actual incidents that occurred in VA health care facilities.

Case 1

Dr. Mae Savannah is going on annual leave. She asks Dr. Charles E. Winchester III, a colleague in the VAMC medical service, to assume responsibility for the care of her patients while she is away. Dr. Winchester refuses, on the grounds that Dr. Savannah practices "inferior medicine" because she is a woman and is from a different ethnic group and social class. He also points out that she was educated at a second-rate school and has not completed a residency program. Dr. Savannah, whose parents immigrated to the United States from the Caribbean before she was born, received her medical degree from a state university where she was enrolled in a military program. Dr. Savannah completed one year of residency training while in the military. Upon completion of her military service, she accepted employment with VA.

Dr. Winchester contends that his professional standing would be compromised if he were forced to take over the care of Dr. Savannah's patients, to whom, he believes, she gives "second-rate" care. "I could not make up for the deficiency of her care," he says. He insists he should not be burdened with this responsibility, which would jeopardize his professional reputation. Dr. Winchester comes from an affluent community in up-state New York where class distinctions are marked. He was educated at a prestigious New England medical school and completed his neurology residency at a renowned West Coast hospital. The dispute has been brought to the attention of the facility's Ethics Advisory Committee (EAC) for advice and help in resolution.[10]

Ethical, Medical, and Other Issues Raised

1. **Professional Relations** – Dr. Winchester seems focused only on his own reputation. He does not mention the welfare, risks, safety, or best interests of the patients when he complains why he should not have to cover Dr. Savannah's patients. Even though they are

not "his" patients, Dr. Winchester's first concern should be the patients' well-being. Dr. Winchester appears unconcerned with his ethical obligation to act in the patient's best interest (beneficence), to avoid harm (nonmaleficence), and to treat patients fairly (justice).

2. **Courtesy and Respect** – In addition to being concerned about patient welfare, Dr. Winchester must also learn to respect and accept his professional peers. Although his bias against Dr. Savannah is culturally based, he should not be permitted to address a colleague in this fashion.

3. **Quality of Care** – If Dr. Winchester's concerns about the "quality of care" Dr. Savannah provides are genuine, why didn't he raise this issue with the chief of service or quality assurance office earlier? When Dr. Winchester thought that VA patients were at risk, he became professionally and morally obligated to protect them. Dr. Winchester may have been legitimately concerned that Dr. Savannah had only completed a year of residency training. However, the fact that Dr. Savannah is less experienced than he in this medical specialty does not negate Dr. Savannah's competence as a physician.

4. **Discrimination** – Dr. Winchester's refusal to cover for Dr. Savannah in her absence brought to the forefront his prejudice against Dr. Savannah based on her gender, race, and social class. Dr. Winchester cannot allow his cultural bias to interfere with his responsibilities as a VA physician. His first obligation is to ensure the quality of care provided VA patients. Dr. Winchester is also required to act in a respectful and appropriate manner toward his professional colleagues and other health care staff.

Suggested Solutions

The EAC reviewed the case and determined that the ethical issues raised were complicated by cultural conflict. The EAC observed that Dr. Winchester's behavior in this circumstance was inappropriate and unethical. Dr. Winchester should not have attempted to impose his

cultural perspective on his colleague. Furthermore, if he had concerns about Dr. Savannah's professional competence, he should have acted to protect patient welfare. The EAC offered two recommendations: 1) the administrative structure should seek appropriate methods to control or limit the behavior of Dr. Winchester; and (2) education should be developed to enhance cultural sensitivity and increase understanding of the ethical ramifications created by this type of cultural conflict.

Additionally, other appropriate solutions include the following:

1. The matter should be brought to the immediate attention of the chief of the service, who should assign a physician to assume care of Dr. Savannah's patients in her absence.
2. The chief may decide to assign this care to Dr. Winchester. Dr. Winchester cannot be excused under the "conscience clause." There is nothing to indicate that any of the patients have chosen (or refused) treatment that Dr. Winchester finds morally unacceptable. (The chief of service may want to supervise Dr. Winchester more closely to ensure that patients are not being neglected or otherwise jeopardized.)
3. If Dr. Winchester refuses to cover for Dr. Savannah in her absence, he should be counseled extensively—if he still refuses, dismissal may be considered.
4. The chief of service should meet with the rest of the staff to find out if Dr. Winchester's opinions have influenced them and to remedy any resulting misunderstandings.
5. Diversity training should be pursued on the service, with a special focus on ethical implications for patient care, as well as "team-building" exercises.
6. If Dr. Winchester has specific instances of substandard care by Dr. Savannah, the chief of service should appoint a quality assurance team to verify or disprove the allegations and take appropriate follow-up action.
7. Ethics education concerning multicultural issues might include

medical grand rounds sessions or other physician education forums, and facility-wide educational sessions on ethical issues in the multicultural workforce.

Case 2

Peter R. is a 60 year-old veteran, C7-quadriplegic, service connected. He had originally done well and was discharged to his home where he was cared for by his wife. She developed cancer of the pancreas and died within two months of diagnosis. Just before her death, Peter was re-hospitalized with recurrent urinary tract infection. He responded well to treatment, but while efforts were being made to find another caregiver, he developed recurrence. Peter is depressed about his wife's death and asks that no antibiotics be administered so that he can die.

Dr. Manu, Peter's physician, refuses to discuss the matter with him. Dr. Manu is a devout practitioner of his religion, which demands that every spark of life must be nourished and that treatment cannot be withheld even if there is only a remote chance that it might be successful. Dr. Manu is foreign-born and received his medical training outside the United States. He is not very comfortable speaking English or talking about his religious beliefs.

Peter solicits the aid of two nurses he has known for years and asks them to intercede with Dr. Manu on his behalf. Both nurses are from the Philippines and consider nursing a religious vocation. They are disturbed by Peter's refusal to take the antibiotics. They cannot understand why he is "giving up," when with treatment he could recover and be evidence of their excellent care. The nurses also consider Peter a friend and are worried about his state of mind. The nurses think Peter should be seen by a psychiatrist, but they are reluctant to discuss their views with Dr. Manu. In the past, Dr. Manu has become enraged when the nurses asked questions or expressed some concern about his patients. Instead, they contact the facility chaplain and ask him to talk with Peter about his situation. Peter, who is not particularly religious, is reluctant to discuss his concerns with a chaplain. The social worker becomes aware of the problem and asks the Ethics Advisory Committee (EAC) to consult.

Ethical, Medical, and Other Issues Raised

1. **Decisional Capacity** – If Peter is not competent to make health care decisions, then consent for treatment must be obtained from the patient's surrogate. Does the patient's situational depression interfere with his ability to make a valid decision in this case? Has this depression gone unrecognized and untreated by the physician? Would treatment of the depression cause the patient to change his mind about refusing antibiotics and wanting to die?

2. **Autonomy** – Adult patients who have decision-making capacity have the right to refuse recommended treatment, even at risk of death. If Peter is competent to make his own health care decision, then the health care staff should not try to circumvent his choice because they personally disagree with his decision.

3. **Communication** – Dr. Manu's refusal to talk to Peter about his decision to refuse treatment cannot be ethically justified. Dr. Manu does have the right to opt out for reasons of conscience. However, he must make arrangements for another physician to take over the patient's care.

4. **Courtesy and Respect** – Dr. Manu's apparent unwillingness to acknowledge or respond to the concerns of the nurses with respect to Peter's depression is problematic. Dr. Manu must be willing to listen to the concerns and observations of other members on the health care team.

5. **Professional Boundaries** – The nurses' response to Peter's situation indicates that the boundary between professional duty and personal friendship has blurred. How the nurses respond to Peter as a friend may not always be appropriate in the context of the provider-patient relationship. The nurses may be correct in their assessment that the patient's decision-making capacity has been compromised and should raise this concern with the chief nurse if Dr. Manu is not responsive.

6. **Ethics of "Caring"** – This particular ethical approach focuses on what the patient needs given the unique circumstances of his or

her particular situation. Although not necessarily at odds with a patient's rights, for example to refuse treatment or make autonomous decisions, the ethics of "caring" goes beyond traditional notions of autonomy and beneficence and requires that the provider take affirmative steps to address the needs of vulnerable patients in special situations.[11] Peter is especially vulnerable because of his grief. The nurses think the best clinical approach is to help Peter deal with his feelings about his wife's death. This is exemplified by their effort to persuade Peter to meet with the chaplain.

Suggested Solutions

The EAC should talk with the patient, the nurses, the social worker, Dr. Manu, and any other appropriate member of the treatment team. The patient should be evaluated to determine whether he is capable of making health care decisions. If the patient has the capacity to make his own health care decisions, those decisions must be respected. If staff object, they may ask to be removed from the case.

1. Dr. Manu should discuss the consequences of non-treatment with his patient and determine whether a psychiatric consult is indicated. If Dr. Manu believes his religion prohibits him from even discussing non-treatment options with his patient, then he should ask to be excused for reasons of conscience and request that the service chief transfer the patient to the care of another physician.
2. If the patient agrees, the chaplain may be called to provide spiritual counsel and support.
3. Dr. Manu should be counseled to determine why he is reluctant to talk to patients about these issues and to the nurses about their concerns. (Does he consider the nurses "unequals" because of their gender or profession?) Perhaps special training in ethics may be valuable for him.
4. The nurses may need counseling about their decision to contact the chaplain before they were certain that Peter was in agreement. It would have been more appropriate to ask Peter if there was a clergy

member he would like them to contact. They should advise him that the facility chaplain and social work service are available and let Peter make his own decision.

5. The nurses' difficulty in trying to voice their concerns to Dr. Manu should be addressed through appropriate administrative channels—they should move up the chain of command to the chief nurse—who can then contact Dr. Manu's chief of service.

6. All staff on this service might benefit from a workshop or similar training program in ethics and patients' rights and team-building.

Recommendations

As noted earlier, the emphasis in current literature has been to make providers more aware of and sensitive to their patients' cultural beliefs. Providers are encouraged to recognize that their patients' beliefs, values, and health care goals may differ from their own and to avoid imposing their personal perspective on the patient's health care decision. Many of the techniques that have been suggested and applied to guide health care providers in their efforts to care for a culturally diverse patient population can be extrapolated to be relevant in a multicultural provider context. Thus, with slight modification or adaptation, programs developed within the VHA to deal with these ethical issues with respect to patients may serve as a model for our effort to address these concerns from the viewpoint of the provider.

In order to deal effectively with some of the ethical issues they might expect to confront in a multicultural clinical workforce, providers must prepare as follows:

1. Recognize how one's own culture affects behavior and attitudes toward colleagues, other health care staff, patients, and their families.

2. Acknowledge the various ways in which cultural differences can enhance or disrupt the delivery of effective health care.

3. Avoid making generalizations based on limited experience with or exposure to a patient or colleague who comes from a particular cultural group.[12]

4. Learn to listen and observe with an open mind. Providers must also be willing to adapt their skills and be attentive, sensitive, patient, and understanding toward those who have a different cultural perspective.
5. Know how and when to solicit feedback, especially from other members of the treatment team.
6. Be willing to concede power and control to a patient or colleague when the clinical situation demands it.

These recommendations relate in great part to the manner in which the provider is exposed to, trained, or indoctrinated into the nuances of medical care in the United States. The learning activities found in Appendix B can be adapted to meet the needs of different VHA facilities. These activities describe different strategies that may be useful to help providers become more familiar with their own cultural perspectives; recognize how culture can influence the delivery of health care; and develop skills that help them to avoid or resolve ethical concerns posed by cross-cultural conflicts in the health care setting. Employers can support the efforts of individual providers by creating a work environment that is tolerant of cultural differences. Institutional policies should clearly delineate procedures for resolving conflicts that occur. Providers should be encouraged to participate in educational programs designed to help clinicians recognize and respond to ethical dilemmas related to the multicultural workforce. They should also assist in the development of research protocols designed to amass empirical data on the clinical effect of the multicultural workforce on patient care, decision-making, and professional relations.

Conclusion

Providers, like patients, bring their own set of cultural beliefs and values to the health care setting. Each provider's personal cultural experience has some bearing on his or her clinical approach, in much the same way that a patient's beliefs and values influence his/her treatment decisions. Nonetheless, a provider's exercise of freedom and cultural integrity in a clinical setting may legitimately be limited to

protect patients' rights and to ensure compliance with institutional policies. When providers with different cultural backgrounds interact in a health care setting, a number of ethical considerations may emerge. The discussion of these ethical issues in this paper is not exhaustive. The focus is limited to those areas of clinical practice that would most likely be impacted by cultural nuances, such as communications with patients and interactions with other health care providers. This report does not address every potential conflict that might occur in the context of a multicultural provider workforce. The case studies we examined depict plausible conflicts that might occur when providers from different cultural backgrounds interact in a clinical setting. Our intent was to focus on the various ways in which a provider's cultural perspective can influence the delivery of health care and how it can support or undermine patient self-determination. As the VA clinical workforce and patient population become more diverse, it becomes increasingly important for providers to recognize how their own cultural experience, and those of their patients and colleagues, influences the delivery of VA health care.

Appendix A

The following demographic information was extracted from a nationwide survey of full-time and part-time permanent clinical staff at VA health care facilities, VA Workforce Profile by OCC/Levels COIN-PAI 173: 9/30/95. This example is limited to VA nurses and physicians. Information concerning other clinical professions may be obtained from the VA Office of Human Resources Management, Personnel Reports Section (052C1). (Please note that the percentages have been rounded out to the nearest whole number and, therefore, do not reflect the presence of minorities in the workforce where their representation is less than 0.5 percent.)

A nationwide survey of VA health care facilities indicates the following breakdown of racial and ethnic groups among the VA nurse and physician staff.

VA Workforce Profile (Nationwide)

Nurses	Male	Female
White	10%	62%
African American	1%	13%
Hispanic	1%	4%
Asian/Pacific	1%	8%
Native American	0%	0%

Physicians	Male	Female
White	61%	14%
African American	2%	1%
Hispanic	4%	2%
Asian/Pacific	11%	5%
Native American	0%	0%

A survey of the nursing and physician staff at a large West Coast VA medical center reflects a somewhat different mix.

VA Workforce Profile (VAMC Long Beach, CA)

Nurses	Male	Female
White	5%	40%
African American	0%	10%
Hispanic	0%	6%
Asian/Pacific	2%	37%
Native American	0%	0%

Physicians	Male	Female
White	62%	9%
African American	3%	2%
Hispanic	0%	0%
Asian/Pacific	16%	8%
Native American	0%	0%

A survey of the clinical workforce at a hospital located near a large urban center on the East coast shows a different distribution of minorities and women among the nurse and physician staff.

VA Workforce Profile (VAMC New York, NY)

Nurses	**Male**	**Female**
White	4%	30%
African American	1%	18%
Hispanic	3%	12%
Asian/Pacific	2%	29%
Native American	0%	1%

Physicians	**Male**	**Female**
White	59%	20%
African American	3%	2%
Hispanic	3%	2%
Asian/Pacific	9%	2%
Native American	0%	0%

There are essentially no minority nurses or physicians on staff at this rural VA medical center located in the upper Northeast region of the country.

VA Workforce Profile (VAMC White River Junction, VT)

Nurses	**Male**	**Female**
White	13%	86%
African American	0%	0%
Hispanic	0%	0%
Asian/Pacific	1%	0%
Native American	0%	0%

Physicians	Male	Female
White	77%	23%
African American	0%	0%
Hispanic	0%	0%
Asian/Pacific	0%	0%
Native American	0%	0%

Appendix B

Cultural Values and Attitudes of Clinicians

Facilitating Learning Activities

When we reflect on what we think about ourselves and all the communities—family, work, civic, geographic—in which we live, we can appreciate that the way we think, what we think, and what we do is the result of our cumulative experiences in those communities. From these experiences come our cultural perspectives. In the health care setting, as elsewhere, a good understanding and awareness of one's cultural perspective is essential to establishing and maintaining sound relationships—clinician-clinician—as well as clinician-patient. The learning exercises in this section are designed to give clinicians an opportunity to examine their own cultural values and how those values affect their working relationship with other staff and with patients.

Culture is fundamental to the very being of each individual. Thus, it is essential that exploration of cultural issues always take place in a supportive learning environment: one of respect and understanding for each person's cultural perspective. This is the starting-point for preventing or resolving problematic issues.

The exercises in this section are designed to help clinicians:

- appreciate what culture means;
- discuss sensitive cultural issues in a constructive way;

- assess how our individual cultural makeup determines our attitudes and actions toward our fellow clinicians and our patients, particularly our ethical values; and
- use a heightened awareness and understanding of cultural values to prevent or resolve culturally based ethical problems.

Space permits only these brief guidelines to help facilitators plan and carry out the learning activities. More detailed help is available from facility education offices and libraries.

These exercises were adapted from the VA HIV/AIDS National Training Program and are based on accepted principles of adult learning.[1] They are designed to be led by experienced facilitators. Those who are not yet skilled in facilitating adult learning activities should seek the assistance of more experienced colleagues before conducting the suggested exercises.

Every learning activity should begin with a planning session. The first step is for the facilitator and other planners to have a clear idea of why the learning exercise is being presented. The target audience, purpose, objectives, and outcome should be developed for each session, as well as a means of evaluating the extent to which objectives are achieved.

Answers to the following questions should be written down by the planners:

- What specific issue generated the need for this session?
- Who is expected to participate, and for what purpose?
- What are the specific objectives that participants should accomplish in this session?
- How will participants' achievement of the objectives be evaluated?

Facilitators should develop objectives for each learning exercise similar to those that follow. Keep in mind the factors listed immediately above.

Upon completion of these activities, participants should be able to:

- list the main factors that determine culture;
- demonstrate an understanding of how cultural perspectives affect individual health care providers and those with whom they interact in their professional environment;
- recognize the psychosocial implications of coming from a group other than the dominant cultural group in a given professional environment; and
- identify ethical problems that may arise as a result of misunderstanding or ignorance of the cultural backgrounds of staff members who work together.

Culture: What It Is and How It Works

Facilitated Audience Discussion – Large And Small Groups

- **Description** – This exercise gives participants the opportunity to learn what each of them believes are the factors that make up culture, and to work together to articulate a useful definition of culture.
- **Learning Activities** – Large group discussion, then small group discussions of issues raised in large group, ending with a return to the large group. The initial large group activity can stand alone, if time is limited.
- **Materials Needed** – Flip chart, markers, and masking tape preferred; blackboard will suffice.

Large Group Discussion (60 minutes)

Introduce the Session (5 Minutes)

If this is the first time the group has been together, the facilitator should introduce him or herself and give the participants the opportunity to introduce themselves.[2] Use the introductions to establish an informal environment that will support open discussion.

Tell the group that you would like to guide them through an exploration of what we mean by culture, how culture affects our professional and personal lives, and how cultural values influence our clinical behavior. Highlight comments on ethical issues.

As a basis for the discussion that follows, ask those in the group to reflect on their family, community, and school experiences, as well as their professional experience.

What is culture? (15 minutes)

- Ask the group, "What are the elements that make up culture?" You are asking for factors—not a definition—that comes later. Encourage spontaneous responses—avoid leading individuals to think that they have to "second guess" what you are looking for—you want the group to go on to work with a list generated by its own members.
- List individual responses on the flip chart—do not discuss them yet. If responses are slow in coming, stimulate responses with questions. Have someone tape the flip chart pages to the wall as you fill them up with cultural factors. Stop soliciting responses after four or five minutes.
- Ask if everyone agrees that the factors listed are all part of what we mean when we say "culture." If there is agreement or disagreement, ask why. Try to guide the group to discover if the members can work toward a consensus, but do not force it—discussion can bring up important nuances in perceptions of culture.
- Ask various individuals in the group if they can use what has been discussed so far to come up with a working definition of culture. Continue to use the flip chart. Complete this part of the activity by coming up with a working definition that is useful for everyone in the group.
- Briefly restate what the group has defined as culture. Ask each person to reflect on what his or her culture is and how it may affect their outlook and behavior.

What is the culture of your professional environment? (10 minutes)

- Now that the group agrees on the overall concept of what culture is, next ask individuals to describe the cultures represented in their professional environment. A good starting point is to spend a few minutes asking what participants feel makes up their professional environment; we are talking about the clinical staff as well as the patient demographics of the medical center or outpatient clinic. The group may bring up other factors not previously considered.

Are there factors in your cultural background that make you comfortable or otherwise help you when working with the staff and patients in the professional environment? (10 minutes)

- List the factors on a flip chart. Ask how they help, how they are viewed as strengths. If some in the group bring up factors that you feel are outside the realm of culture, ask for additional details.
- Summarize. Are there commonalties? What can we learn from these factors?

Are there factors in your cultural background that make you uncomfortable or otherwise hinder your work with the staff in your professional environment? (10 minutes)

- List the factors on a flip chart. Ask how they hinder, if they are viewed as weaknesses. If some in the group bring up factors that you feel are outside the realm of culture, ask for additional details.
- Avoid having an individual or the group belabor a negative issue, which is always easy to do.
- Summarize. Are there commonalties? What can we learn from these factors?

Among the cultural factors that we have listed, which are the ones that most affect the ethical aspects of our practice? (10 minutes)

- Focus attention on the cultural values that determine our attitudes toward issues like respect for colleagues and for patients,

autonomous patient decision-making, power and vulnerability, and gender issues.

Summarize the Session (5 minutes)

- Briefly restate what the group tried to accomplish. Summarize what the group did accomplish, stressing the connection between cultural values and the ethics of clinical encounters. If there is unfinished business, discuss what the group can do to take care of it.
- If this was a stand-alone large group session, it ends with the facilitator's summary. If this session will be followed by small group sessions, give the group directions on what to do.

Small Group Discussion (25 minutes)

- **Preparation** – The facilitator may use some random method of assigning participants to groups, such as counting off by the number of groups desired (with all the participants that are "1" going to one group, "2" going to the second group, and so on), or by random placement of colored dots on handout materials or name badges given to participants (participants having the same color going together). The facilitator should be aware that there may be reluctance on the part of some or all of the participants to join small groups and to make this process as comfortable as possible.
- **Materials** – Flip chart, markers, and masking tape preferred; notepads will suffice.

Ask each group to select someone to briefly report in the concluding large group session.

From the cultural factors identified during the large group discussion, direct the small groups to select one or two that they feel have most strongly influenced their ethical judgments in clinical encounters.

- Have they found these factors to be a help or a hindrance?
- How do they deal with the cultural factors that they believe hinder their professional relationships?

- How can they help other clinicians to appreciate and understand how these factors may affect professional behavior?

Large Group Discussion (15-30 minutes)

- In the large group, each small group reporter will share one cultural factor that the group found to be ethically problematic and strategies that members of the group have identified that can help to resolve issues surrounding this factor. Each reporter should deal with only one factor that has not been mentioned by previous reporters: this avoids redundant reports and allows each group to bring up a fresh issue. The facilitator should try to keep reports focused and concise. Total time for the reports depends on the time available and the number of groups reporting.
- The facilitator asks if there are any issues on which anyone would like to comment before closing, and then makes a brief summary comment on what the group was attempting to do in this exercise, and how well it was done.

Cultural Perspectives of Others

Panel Presentation and Discussion[3]

- **Description** – Participants have the opportunity to hear, firsthand, how the culture of clinicians affects how they relate to their colleagues and patients, and how the dominant cultures in their health care environment affect them.
- **Learning Activities** – Panel discussion led by a moderator, with questions and comments from the audience, followed by large or small group discussions.
- **Materials Needed** – Table and chairs in front of the room for the panel, microphones and speakers, depending on size of room and number in audience; flip chart and markers may be useful in reinforcing main issues and in focusing discussion; areas for small group discussion activities, if included.

- **Preparation** – Panelists should be chosen for their willingness to be self-disclosing to a moderate degree and should be able to express themselves clearly. They need not be experienced presenters, since the moderator will guide them. A panel of three of four persons is optimal. The suggested times may be altered to suit the total time available, the number of panelists, and the interests of the participants.

  Prior to the session, the moderator should spend some time with the panelists to clarify the focus of the panel, review the type of questions they are likely to be asked, and to alert them as to how the moderator will guide the session.

  "Ground rules" should be agreed to before the session and should be restated to the audience as the panel begins:

  - Panelists or members of the audience will not violate the confidence of patients or colleagues in recounting their experiences;
  - Those in the audience are asked to be sensitive to the feelings of panelists and others in the audience when asking questions of the panelists;
  - Those in the audience may ask any reasonable question and panelists may decline to respond to any question;
  - The moderator will maintain the focus of the discussion and may defer questions to a later time.

Panel Presentation (30 minutes)

The moderator introduces him or herself, states the purpose of the session with its focus on culture and ethics, and states the ground rules. The ground rules may be posted on a flip chart as well. Next the moderator briefly introduces the panel—each of the panelists should add to the introduction as he or she begins his or her comments.

Large or Small Group Discussion (25 minutes)

Following the panelists' comments, the moderator may ask participants to respond to the following, or similar questions. If the audience is large, more productive discussions are likely in groups of four to six persons—the moderator can circulate among the groups and each of the panelists can be invited to join a group, if they wish.

1. What feelings did you experience while listening to the panel?
2. What issue affected you the most?
3. What are your concerns about relating in a constructive way with co-workers of different cultures?
4. What are your concerns about respecting your own cultural values and perspectives in your health care environment?
5. What approaches can you take if clinicians holding different cultural values appear to be in conflict with each other or with patients over factors such as race, gender, professional status or social class?

The moderator may close the session by asking the small groups to reassemble, soliciting a few brief comments on what the participants thought of the activity, and making a brief closing comment.

Notes

[1] Some international medical graduates are foreign-born. Others are U.S. citizens who are graduates of foreign medical schools.

[2] Nelson WA, Law DH. "Clinical Ethics Education in the Department of Veterans Affairs." *Cambridge Quarterly of Healthcare Ethics* 1994;3:143-148.

[3] *The American Heritage Dictionary of the English Language*, New College Edition. Boston: Houghton Mifflin, 1976.

[4] Fejos describes culture as "the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey, or hand down to the next; in other

words, the non-physically inherited traits we possess." Another way of understanding the concept of culture is to picture it as the luggage that each of us carries around for our lifetime. It is the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals, and so forth that we have learned from our families during the years of socialization. In turn, we transmit cultural luggage to our own children. The society in which we live—and other forces, political, economic, and social—tend to alter the way in which some aspects of a particular culture are transmitted and maintained. Spector, RE. *Cultural Diversity in Health and Illness*. 2nd ed. Norwalk, CT: Appleton-Century-Crofts, 1985:60-61.

5 See, VHA Handbook 1004.1, "Informed Consent."

6 These are subject areas where differences in cultural values and beliefs can have a tremendous impact on patient care. The question of how a provider's attitudes concerning life, death, and illness, for example, influence the treatment options offered to patients should be examined more fully in a separate paper.

7 Gert B. *Morality: A New Justification of the Moral Rules*. New York: Oxford University Press, 1988.

8 If a patient does not have the capacity to make health care decisions, consent must be obtained from the patient's surrogate.

9 This concept is based on the premise that a provider should not be forced to provide treatments or procedures to which he or she is morally opposed. Questions have been raised about the use and scope of the conscience clause, for example, in circumstances where the patient's access to other health care providers is limited. The committee maintains that the practice of allowing providers to opt out for reasons of conscience is justifiable and should be continued.

10 Cross-cultural problems that occur in the health care setting may be presented to an ethics advisory committee for consideration. However, in some situations it may be more appropriate to address the matter through administrative, supervisory, or personnel channels.

[11] Davis AJ. "Are There Limits to Caring?: Conflict Between Autonomy and Beneficence," in *Ethical and Moral Dimensions of Care*, Leininger M., ed. Detroit: Wayne State University Press, 1990:25-32.

[12] Providers must resist the temptation to stereotype based on skin color, surname, gender, age, accent, or style of dress. No one physician, for example, is an exact cultural match with every other physician from the same cultural group.

Appendix Notes

[B-1] The effect such educational programs might have on the resolution of culturally based conflicts that occur in the health care setting has not been studied. Nonetheless, we are confident that efforts that encourage providers to openly discuss their cultural differences and how they enhance or disrupt the delivery of health care will prove beneficial.

[B-2] Facilitation or training guides may be consulted for ideas on effective ways to conduct introductions.

[B-3] If a panel discussion is not feasible, case studies or role-playing scenarios that depict culturally related ethical problems can be used to stimulate discussion. Facilitators can adapt the ground rules and discussion questions to fit these formats. The cases described in this paper can be read by participants or can serve as the foundation for role plays.

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Writers

Angela Prudhomme, J.D. - Chairperson

J. Richard Durnan, D.D.S.

Paul R. Jensen, M.D.

William A. Nelson, Ph.D.

Dorothy Rasinski-Gregory, M.D., J.D.