

# Cross-cultural Considerations in Clinical Ethics Consultations

Robert D. Orr, MD; Patricia A. Marshall, PhD; Jamie Osborn, MD

**C**ross-cultural encounters between patients and physicians are now commonplace. Although increasing attention has been given to cultural issues in clinical medicine, there has been little discussion of cultural differences presenting as ethical dilemmas. We report four cases in which such differences led to requests for ethics consultations. In analyzing these cases, we identify four elements that are essential for successful resolution of such dilemmas: (1) an ability to communicate effectively with patients and their families; (2) a sufficient understanding of the patient's cultural background; (3) identification of culturally relevant value conflicts; and (4) a willingness to pursue discussion of the ethical dilemma until a compromise is reached or an otherwise satisfactory resolution of the problem is achieved. We conclude with several practical guidelines for clinicians facing ethical dilemmas in cross-cultural interactions with patients.

(*Arch Fam Med.* 1995;4:159-164)

In our pluralistic society, cross-cultural encounters between patients and physicians have become routine. In recent years, the number of physicians practicing medicine in ethnically diverse social settings has increased significantly.<sup>1</sup> In these interactions, patients or their physicians may represent ethnic minority groups, immigrants, or refugees. Moreover, such encounters occur not only in urban and metropolitan areas<sup>2,3</sup> but also in rural settings.<sup>4</sup>

Culture refers to the complex range of beliefs, values, and attitudes shared and perpetuated by members of a social group.<sup>5</sup> In the context of health care, an individual's cultural heritage provides an interpretive framework for perceptions of illness and wellness and the organization of treatment modalities. Patient groups of various ethnic backgrounds have been shown to vary in regard to pain response,<sup>6</sup> perception and interpretation of symptoms,<sup>7-9</sup> access to care and follow-up,<sup>10</sup> and compliance.<sup>11,12</sup>

Attention has been given recently to cultural diversity and ethical issues surrounding health care.<sup>13-16</sup> This small but growing literature has explored a number of issues, including the international application of research ethics,<sup>17-21</sup> disclosure of medical information,<sup>22-25</sup> informed consent,<sup>26,27</sup> the role of the family,<sup>28</sup> limitation of treatment,<sup>29,30</sup> and critical care.<sup>31</sup> Notably absent from the literature are discussions of the impact of cultural diversity on clinical ethics consultations.

During the past decade, ethics consultation services have become available in a wide range of health care settings.<sup>32-35</sup> An important goal of these services is to support collaboration between patients, families, and health care professionals in identifying, analyzing, and resolving moral dilemmas that arise at the bedside.<sup>36-40</sup> When the dilemma involves differences in cultural values, the consultant may act as a cultural interpreter or "translator," facilitating recognition of significant conflicts regarding cultural values.

In this article, we report four cases in which cross-cultural differences between the patient and practitioner led to a clinical ethics consultation. In these cases, physicians represent dominant Western culture and pa-

From Loma Linda (Calif) University Medical Center and the Department of Family Medicine, Loma Linda University (Dr Orr); Medical Humanities Program, Loyola University of Chicago Stritch School of Medicine, Maywood, Ill (Dr Marshall); and Travis Family Practice Residency Training Program, Travis Air Force Base, Calif (Dr Osborn).

tients represent non-Western traditions and values. We argue that four elements are essential in successfully resolving moral problems in cross-cultural patient care: (1) an ability to communicate effectively with patients and their families; (2) a sufficient understanding of the patient's cultural background; (3) identification of culturally relevant value conflicts; and (4) a willingness to pursue discussion of the ethical dilemma until a compromise is reached or an otherwise satisfactory resolution of the problem is achieved. The cases are analyzed along these dimensions. Finally, we offer practical guidelines for clinicians facing ethical dilemmas in cross-cultural interactions with patients.

## REPORT OF CASES

### CASE 1

A 31-year-old gypsy woman of Eastern European ancestry had surgery for a perforated appendix and subsequent surgery for abscess formation. Three weeks after surgery she experienced multisystem organ failure. When her relatives were told that she was dying, they insisted that the multiple surgical drains be removed. The surgeon was unwilling to do this because it would likely hasten her death. An ethics consultation was requested.

Attending the ethics conference were the patient's surgeon and primary physician, the bedside nurse, and other members of the health care team, as well as members of the patient's family, the gypsy "tribal chieftain" (as he called himself), and the ethics consultant. The consultant learned that this gypsy tribe believed that if a person had unnatural holes in the body at the time of death, the soul could escape and be forced to wander without a place to reside. They further believed that this was a fate worse than death.

Once their concern was understood, it was possible to negotiate an agreement. Surgical instruments were kept by the bedside so that if and when she was pronounced dead, the drains could be removed immediately and the drain sites could be sutured. She lived for another 4 days with continued life-prolonging treat-

ment. When her heart did not respond to resuscitative attempts, her physicians immediately removed the drains and closed the sites. Members of the patient's extended family and tribe appeared to be satisfied with her care.

### CASE 2

An elderly Korean couple was injured in an automobile accident while visiting relatives in California. The woman recovered quickly, but her husband was hospitalized for several weeks with multiple injuries and respiratory failure. When it was clear to his care team that he was suffering from his protracted treatment and was not going to recover, they discussed with the patient's wife the possibility of withdrawing life support. She was unwilling to consent to this, and an ethics consultation was requested.

The ethics consultant held a meeting with the patient's wife, the primary nurse, and a Korean translator (a physician who was born in Korea but educated in the United States). The patient's wife appeared to understand his grave prognosis, but she was still unwilling to consent to any limitation of treatment.

Later, in talking with the pastor of the Korean church where the wife's relatives were members, the consultant learned that in Korean culture, women do not make medical decisions for their husbands. This is viewed as the duty of the oldest son.

The oldest son had visited his father in the hospital but had returned home to Korea. When reached by telephone, the son gave authority to his mother to make treatment decisions for his father, but insisted that she seek counsel from their pastor and follow his advice. Life support was continued for another 3 weeks on the pastor's recommendation, and the patient was given increased analgesia. Aggressive care was continued, but he died of further pulmonary complications that were untreatable.

### CASE 3

A 36-year-old Samoan agricultural worker (incorrectly identified in the medical chart as "Filipino") devel-

oped *Cryptococcus meningitidis* infection, with sudden blindness and obtundation. He responded slowly to intravenous administration of amphotericin B. Near the end of the 6-week course, however, he suffered a severe cerebrovascular accident, and his family requested discharge so they could use traditional therapies, including topical leaves and lotions and an oral herbal mixture. His physicians were reluctant to allow him to go home, recognizing that his only chance for survival was with the continued use of intravenous antibiotic therapy.

An ethics consultation was requested, and a meeting was held with family members, the health care team, and the ethics consultant. Discussion with the patient's family revealed their concern that they had failed in their obligation to use traditional treatment for his condition, rather trusting in Western medicine, which now appeared to be failing. A compromise was reached that was acceptable to everyone. The patient would stay in the hospital to receive conventional Western medication and his family would bring and apply their topical treatments, but they agreed to forgo their internal herbal therapy when the attending neurologist was very reluctant to authorize its use.

The patient showed alternating minimal improvement and significant deterioration during the next 3½ months, but never had significant neurological improvement. He died while plans were being completed for him to be discharged home, where he was to continue taking oral medications.

### CASE 4

A 76-year-old Mexican man had been receiving outpatient radiation and chemotherapy for 2 years for a lymphoma. Progression of his disease led to his first hospitalization during which he was under the care of a new team of physicians. His family told the admitting physician that the patient did not know his diagnosis or the seriousness of his illness, and they asked that this information be kept from him. The physician was uncomfortable with what he perceived to be a charade

that would deny the patient his "right to know," so he requested an ethics consultation.

The ethics consultant discussed the patient's right to know with the health care team. The point was made that disclosing the truth about serious illness to a patient is a relatively new concept in medicine that originated in the United States and Canada in the 1960s. Many cultures, including this patient's, retain a more paternalistic approach in which patients do not expect to be informed if their prognosis is grave. They expect to be cared for and protected from this bad news by their physician and family.

Based on this new understanding, the attending physician told the family that he would not tell the patient any more than he wished to know. The physician then asked the patient if he had any questions about his condition or his treatment. The patient had none.

#### COMMENT

The application of Western-based philosophical traditions to cross-cultural moral dilemmas in medical care presents unique challenges. While Pellegrino<sup>41</sup> and others argue that there is a *prima facie* obligation to respect cultural values, expressions of tolerance and deference to views that are culturally dissonant is especially difficult in biomedical settings in which professionals and patients are unequally matched in status, power, authority, and cultural expertise.

The cases reported reflect worldviews different from mainstream biomedical thinking. The family of the Eastern European gypsy had specific beliefs regarding an individual's "spirit" and the treatment of the dead body. The Samoan family held divergent cultural beliefs about appropriate healing practices. The question of who has decision-making authority arose in the Korean case, and the problem of telling the truth about an illness and disclosure was addressed in the case involving the Mexican family. Each case calls attention to difficulties associated with maintaining the delicate balance between professional integrity—doing what appears sci-

entifically to be in the patient's best interest—and respectful compromise in the face of differing cultural beliefs or values.

The practice of bioethics is a distinctly Western phenomenon, anchored in philosophical traditions emphasizing the principles of beneficence, nonmaleficence, autonomy, and justice.<sup>42-44</sup> In discussions of decision making in medicine, social and cultural issues have been relegated largely to the background.<sup>45,46</sup> However, recent dissatisfaction with the limitations of the principle-based approach to medical moral dilemmas has resulted in greater attention to the importance of community and interdependence.

Nevertheless, given the historical significance of individual rights and self-determination in the dominant US culture and in the microculture of bioethics, it is not surprising that in clinical ethics consultation, a strong emphasis is placed on patient autonomy.

We have identified four key elements for successful negotiation in cross-cultural situations.

#### EFFECTIVE COMMUNICATION

Good communication, essential for a strong patient-physician relationship, depends on the physician's capacity to be sensitive, attentive, and understanding. Effective communication is important in all clinical settings, but may take more effort and time and may be difficult to achieve when the relationship extends across cultural boundaries. In addition, miscommunication and misunderstandings regarding medical treatment are more likely to occur when patients and physicians speak different languages.

Many hospitals and clinics have lists of individuals available to assist with translation, especially with common foreign languages. While translators provide crucial assistance, they may not be conversant in particular dialects. For this reason and because of convenience, family members may be used as translators. Research on medical interpretation, however, has shown that there is a tendency for family

members to camouflage, exaggerate, or minimize information.<sup>47,48</sup> For example, a young bilingual girl dying of bone cancer often translated for her family who spoke only Spanish. The family were shocked when the young girl died; she had reassured her family that she would be going home.<sup>49</sup> A decision about whether to use family members as translators must be made on a case-by-case basis. Occasionally, the situation cannot be avoided. In general, however, nonfamily members should be used when possible.

A translator was necessary in only one of the cases reported. In this instance, a US-educated Korean physician assisted in the interpretation, not a member of the patient's family. Ironically, the translator was unable to identify the cause of the wife's distress about making treatment decisions for her husband. It was the family's pastor who provided important cultural information about decision making.

Language is only one dimension of effective communication. Beliefs about disclosure and telling the truth about an illness may vary in different cultural settings. This was the issue in the case involving the seriously ill Mexican patient. Although the patient's "right to know" has recently emerged as the norm in Western clinical settings, individuals from non-Western cultures may not share the proclivity to disclose uncomfortable or distressing medical news. For example, the study by Gordon<sup>50</sup> of cancer treatment in Italy demonstrates that, while attitudes are changing, the dominant practice is nondisclosure. In contrast, the analysis by Good<sup>51</sup> of the treatment of cancer in the United States suggests that oncologists view frank and open discussions as essential in forging partnerships with their patients. When patients expect to be told the truth, withholding information may be viewed as a betrayal of trust. Conversely, if patients expect family members and physicians to be circumspect, telling the truth about an illness might be experienced as an abandonment of the healing relationship between patient and physician and the protective relationship between family members.

Divergent beliefs between practitioners and patients about decision-making authority in medical care may also affect communication. When the patient's family is large, or when the community is close and involved, it may be helpful to identify one individual to be the spokesperson for the group. In the gypsy family described in case 1, it was the tribal chieftain who was clearly in charge of communication and decision making. In the Korean family discussed in case 2, the patient's son was the designated decision maker; it was the son who requested that his mother defer to the judgment of the pastor.

Identifying a proxy decision maker is important in caring for any seriously ill patient. It becomes especially important when the patient is from a culture in which the tradition about the locus of decisional authority differs significantly from our Western focus on individual rights. The majority of non-Western cultures have a more communitarian perspective on the issue of decision-making authority. In such situations, tribal or religious leaders may play a significant role in making major decisions. If it is determined that the patient or family seeks the wisdom of nonfamily members in making decisions, those individuals should be included in discussions.

#### SENSITIVITY TO CULTURAL BACKGROUND

In cross-cultural medical encounters, physicians, other health care professionals, and patients may not share the same belief in the tenets of Western biomedical science. Learning something about the patient's cultural heritage represents a first step toward increased awareness of the patient's health-related beliefs and values. However, hospital admission demographic information is only a starting point for identifying the ethnic heritage of inpatients. As demonstrated in the case of the Samoan patient incorrectly identified as Filipino, this information may be inaccurate.

In the process of exploring a patient's cultural heritage, it is vitally important not to rely on ethnic stereotypes. Expecting all persons of a

similar ethnic group to believe and act in the same and predictable fashion is inherently disrespectful and simplistic. Moreover, it is not a solution to the difficulties of cross-cultural interaction. For example, while Spanish-language speakers may be able to understand each other, individuals of Central American, South American, and Mexican-American backgrounds have very clear ethnic identities. One Latino culture does not exist, just as one Anglo or white culture does not exist. In addition, class, gender, age, and other social differences blur the distinctiveness of ethnic backgrounds.

No individual clinician can be familiar with the language, customs, and beliefs of the myriad cultures represented by patients. Instead, clinicians should learn as much as possible about the cultural beliefs and practices of groups of people who make up a significant minority (or majority) of their practice. Individuals from a patient's culture who have lived in the United States for some time may be sufficiently bilingual and bicultural to act as a resource for cultural information. In addition, it may be beneficial to identify one or two individuals from the patient's family or community who are willing to act as cultural informants. Consultation and collaboration between social scientists, physicians, and medical ethicists is valuable but may not be convenient or practical in many clinical settings. However, efforts should be made to find professional resources for culturally relevant information at local colleges or universities. Cooperation between professionals will facilitate workable solutions to the increasingly complicated moral realm of patient-physician relationships.

#### IDENTIFICATION OF CULTURAL VALUE CONFLICTS AND COURSES OF ACTION

Identifying culturally based value conflicts depends on successful exploration of relevant background information concerning the ethnic heritage of the patient. Discovering gypsy beliefs about death and the potential for an individual's spirit to es-

cape from bodily wounds enabled the consultant to clarify attitudes and values necessary for resolving the problem. In this case, the primary value conflict focused on Western and non-Western notions of appropriate care of the dead body to ensure a restful soul.

In the case of the Korean man, treatment decisions were stymied until it was learned who could make decisions about the patient's care. Here, the ethics consultant drew on information provided by the pastor to identify value conflicts surrounding the locus of authority for decision making. The Samoan case calls attention to the need for physicians and ethicists to explore patient beliefs about the cause of the disease and about patient views on suitable remedies for treating specific problems. Finally, in the Mexican case, value conflicts were found to be anchored in Western and non-Western views about telling the truth about an illness and disclosure of sensitive information.

#### A WILLINGNESS TO COMPROMISE

The courses of action recommended in these cases demonstrate the importance of intellectual flexibility and professional compromise to reach a satisfactory solution to a moral conflict involving different cultural perspectives. Maintaining an unyielding and intractable position may serve only to stalemate the process, alienate a perhaps already estranged patient or family, and obscure essential information concerning opportunities for compromise.

Acceptable compromises were reached in each case reported. The moral dilemmas illustrated in these four cases proved amenable to compromise between the courses of action desired by the patients and families and those preferred by the physicians involved. The values of biomedicine and the culturally diverse values represented in these cases were honored through successful negotiation of therapeutic choices. Thus, it appears that respect for Western and non-Western traditions was achieved.

But what if a compromise is not

feasible? What if cultural differences prove to be insurmountable in the context of achieving a resolution that is generally agreeable to the parties involved? For example, what if the Samoan family insisted on implementing the patient's oral intake of herbal preparations, an action disapproved by the physician? What if the physician was adamant about informing the Mexican patient of the seriousness of his condition? What if the gypsy tribe was unwilling to have the surgical drains left in place until the patient's death?

In some cases, concessions and compromise will not be possible. The physicians and other members of the health care team and the patient or family members may prove to be resolutely attached to pursuing a particular goal, one that is at odds with the goals of others involved. Ironically, as Crigger<sup>52</sup> astutely points out, clinicians and ethics consultants may rely on the normative principle of respecting a patient's (or surrogate's) right to self-determination to honor nonstandard requests for treatment or to justify withdrawal from a patient's care.

Engaging in the inevitable discomfort of articulating moral differences is always a demanding exercise. Deciding when the process of engagement is no longer productive requires careful and thoughtful consideration. Before abandoning the negotiations, every attempt should be made to keep all parties involved in resolving the conflict.

## RECOMMENDATIONS

In this article, we have focused on moral dilemmas that arise in encounters between physicians representing the dominant Western biomedical culture and patients with non-Western cultural backgrounds. Taking care of patients from cultures other than one's own can be challenging and time consuming. In cross-cultural professional encounters, however, the time spent in developing a trusting relationship that fosters clear communication and understanding may be more than recouped by the avoidance of conflicts or easier resolution of treatment dilemmas. In almost all situations, the extra time and effort will result in

more satisfied patients, families, and professionals.

The following are specific recommendations that may help physicians and other medical professionals facing ethical problems when caring for patients from other cultures:

1. Communicate effectively.
  - Allow more time for cross-cultural communication.
  - Make use of nonfamily translators when possible.
  - Never make assumptions about the patient's cultural and ethnic background and health care beliefs. Instead, ask questions of the patient and the patient's family and friends whenever possible.
2. Understand cultural differences.
  - Learn as much as possible about the cultural beliefs and practices of groups with whom you have frequent professional contact. Make sure the information about ethnic origin of the patient is correct. Country of origin or first language spoken is not necessarily synonymous with ethnic and/or cultural background.
  - Avoid stereotyping patients based on the color of their skin, the language they speak, or the clothes they wear.
  - Ask about the patient's and the family's understanding of the disease, their comprehension of what physicians have told them, their hypotheses of the cause of the disease, and what they think will solve the problem.
  - Consult with other health care practitioners from the same ethnic group as the patient. Consider developing a resource list of hospital employees by ethnic origin to include those who are willing to serve as cultural informants.
  - Realize that family integration is of greater importance than individual rights in many cultures.
  - Ask families and patients about their views on involving spiritual or religious advisors in medical care. Be willing to involve a patient's spiritual advisor and the hospital chaplain staff in the communication and decision-making process when appropriate.
  - Examine your own cultural and professional values and beliefs about the problem you are confronting. Be aware of your biases and prejudices.

• Be sensitive to the power you have to influence the decision-making process because of your status and prestige as a physician. In this situation, patients and their families are always vulnerable.

3. Identify cross-cultural conflicts.

• Find out who the patient considers to be the appropriate decision maker. The patient may expect someone else to make health-related decisions. Cultural maxims may dictate that the surrogate is someone other than the person Western physicians assume.

• Ask the patient, family members, and those who have been "appointed" to speak for the patient what they consider to be the primary ethical or moral problem the patient is facing. Explore these issues in detail.

4. Compromise.

• Show respect for beliefs that are different from your own.

• Be willing to compromise regarding treatment goals or modalities whenever possible.

In our culturally pluralistic society, encounters between patients and physicians from diverse cultural backgrounds are becoming everyday occurrences. In these situations, it is important to consider the validity of other belief systems. Claims of moral superiority on the basis of membership in the dominant white culture of the United States fall short of an ethical response to a medical dilemma. In the future, critical investigations are needed that examine the nature and scope of the influence of culture on the resolution of moral problems in health care delivery. The literature to date is meager and insufficient in addressing the complexity of these issues. Specifically, much more can be learned about how physicians and their patients define clinical ethical dilemmas, about the impact of the inevitable asymmetry of power that patients and physicians bring to the decision-making process, and about the nuances of negotiating and settling moral disputes in a cross-cultural context.

*Accepted for publication September 28, 1994.*

*The authors thank Lyn Behrens, MD, and David Pollock, MA,*

for their helpful comments on early drafts of the manuscript.

Reprint requests to Department of Family Medicine, Loma Linda University, 11340 Mountain View Ave, Suite C, Loma Linda, CA 92354 (Dr Orr).

## REFERENCES

1. Barker JC. Cultural diversity—changing the context of medical practice. *West J Med.* 1992;157:248-254.
2. US Dept of Commerce, Bureau of the Census, Economic and Statistics Administration. *Census Bureau Complete Distribution of 1990 Redistributing Populations to States.* Washington, DC: US Bureau of the Census; March 1991. Press releases on 1990 census data, CB-91-100.
3. US Dept of Commerce, Bureau of the Census, Economic and Statistics Administration. *Census Bureau Releases 1990 Census Counts on Specific Racial Groups.* Washington, DC: US Bureau of the Census; June 1991. Press releases on 1990 census data, CB-91-215.
4. *Estimates of Refugees in California Counties and the State, 1989—Report SR89-1.* Sacramento, Calif: Dept of Finance, Population Research Unit; January 1991.
5. Geertz C. *Interpretation of Cultures.* New York, NY: Basic Books Inc Publishers; 1973.
6. Zborowski M. *People in Pain.* San Francisco, Calif: Jossey-Bass Inc Publishers; 1969.
7. Zola IK. Culture and symptoms: an analysis of patients' presenting complaints. *Am Sociol Rev.* 1966;31:615-630.
8. Good B, Good MDV. The meaning of symptoms: a cultural hermeneutic model for clinical practice. In: Eisenberg L, Kleinman A, eds. *The Relevance of Social Science for Medicine.* Dordrecht, the Netherlands: D Reidel Publishing Co; 1981:165-196.
9. Kleinman A. *Patients and Healers in the Context of Culture.* Berkeley: University of California Press; 1980.
10. Kerr EA, Siu AL. Follow-up after hospital discharge: does insurance make a difference? *J Health Care Poor Underserved.* 1993;4:133-142.
11. Perez-Stable EJ, Sabogal F, Otero-Sabogal R, Hiatt RA, McPhee SJ. Misconceptions about cancer among Latinos and Anglos. *JAMA.* 1992;268:3219-3223.
12. Anderson BG, Toledo JR, Hazam N. An approach to the resolution of Mexican-American resistance to diagnostic and remedial pediatric heart care. In: Chrisman NJ, Marezki TW, eds. *Clinically Applied Anthropology.* Dordrecht, the Netherlands: D Reidel Publishing Co; 1982:325-350.
13. Pellegrino E, Mazzarella P, Corsi Pietro, eds. *Transcultural Dimensions in Medical Ethics.* Frederick, Md: University Publishing Group Inc; 1992.
14. Pellegrino ED, Flack HE. *African-American Perspectives on Biomedical Ethics.* Washington, DC: Georgetown University Press; 1992.
15. Connor SS, Fuenzalida-Puelma H, eds. *Bioethics: Issues and Perspectives.* Washington, DC: Pan American Health Organization; 1990.
16. Veatch RM. *Cross Cultural Perspectives in Medical Ethics: Readings.* Boston, Mass: Jones & Bartlett Publishers Inc; 1989.
17. Angell M. Ethical imperialism? ethics in international collaborative clinical research. *N Engl J Med.* 1988;319:1081-1083.
18. Jsselmuiden CB, Faden RR. Research and informed consent in Africa—another look. *N Engl J Med.* 1992;326:830-833.
19. Christakis NA. Ethics are local: engaging cross-cultural variation in the ethics for clinical research. *Soc Sci Med.* 1992;35:1079-1091.
20. Marshall P. Research ethics in applied anthropology. *IRB.* 1992;14:1-5.
21. Lane SD. Research bioethics in Egypt. In: Gillon R, ed. *Principles of Health Care Ethics.* New York, NY: John Wiley & Sons Inc; 1993:885-894.
22. Surbone A. Truth telling to the patient. *JAMA.* 1992;268:1661-1662.
23. Pellegrino ED. Is truth telling to the patient a cultural artifact? *JAMA.* 1992;268:1734-1735.
24. Beyene Y. Medical disclosure and refugees: telling bad news to Ethiopian patients. *West J Med.* 1992;157(special issue):328-332.
25. Akabayashi A, Fetters MD. Truth-telling of the cancer diagnosis in contemporary Japan: a discussion and analysis for the 1990's. *Arch Found Thanatol.* In press.
26. Levine RJ. Informed consent: some challenges to the universal validity of the Western model. *Law Med Health Care.* 1991;19:207-213.
27. Kaufert JM, O'Neil JD. Biomedical rituals and informed consent: native Canadians and the negotiation of clinical trust. In: Weisz G, ed. *Social Science Perspectives on Medical Ethics.* Philadelphia: University of Pennsylvania Press; 1990:41-64.
28. Muller JH, Desmond B. Ethical dilemmas in a cross-cultural context: a Chinese example. *West J Med.* 1992;157(special issue):323-327.
29. Klessig J. The effect of values and culture on life-support decisions. *West J Med.* 1992;157(special issue):316-322.
30. Caralis PV, Davis B, Wright K, Marcial E. The influence of ethnicity and race on attitudes toward advance directives, life-prolonging directives, life-prolonging treatments and euthanasia. *J Clin Ethics.* 1993;4:155-165.
31. Veatch RM. The ethics of critical care in cross-cultural perspective. In: Moskop JC, Kopelman L, eds. *Ethics and Critical Care Medicine.* Dordrecht, the Netherlands: D Reidel Publishing Co; 1985:191-206.
32. Fletcher JC, Quist N, Jonsen AR. *Ethics Consultation in Health Care.* Ann Arbor, Mich: Health Administration Press; 1989.
33. Siegler M, Pellegrino ED, Singer PA. Clinical medical ethics. *J Clin Ethics.* 1990;1:5-9.
34. Fry-Revere S. *The Accountability of Bioethics Committees and Consultants.* Frederick, Md: University Publishing Group Inc; 1992:iii-v.
35. LaPuma J, Schiedermayer D. *Ethics Consultation: A Practical Guide.* Boston, Mass: Jones & Bartlett Publishers Inc; 1994:xi-xii.
36. LaPuma J, Schiedermayer DL. Ethics consultation: skills, roles, and training. *Ann Intern Med.* 1991;114:155-160.
37. Self DJ, Skeel JD. A study of the foundations of ethical decision making of clinical medical ethicists. *Theor Med.* 1991;12:117-127.
38. Frader J. Political and interpersonal aspects of ethics consultation. *Theor Med.* 1992;13:31-44.
39. Zaner RM. Voices and time: the venture of clinical ethics. *J Med Philos.* 1993;18:9-31.
40. Scofield GR. Ethics consultation: the least dangerous profession. *Camb Q Healthc Ethics.* 1993;2:417-426.
41. Pellegrino ED. Intersections of Western biomedical ethics and world culture. In: Pellegrino E, Mazzarella P, Corsi P, eds. *Transcultural Dimensions in Medical Ethics.* Frederick, Md: University Publishing Group Inc; 1992:15.
42. Pellegrino ED. The metamorphosis of medical ethics: a 30-year retrospective. *JAMA.* 1993;269:1158-1162.
43. Fox RC. The evolution of American bioethics: a sociological perspective. In: Weisz G, ed. *Social Science Perspectives on Medical Ethics.* Philadelphia: University of Pennsylvania Press; 1990:201-220.
44. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 3rd ed. New York, NY: Oxford University Press; 1989:7, 47-55.
45. Marshall PA. Anthropology and bioethics. *Med Anthropol Q.* 1992;6:49-73.
46. Weisz G, ed. *Social Science Perspectives on Medical Ethics.* Philadelphia: University of Pennsylvania Press; 1990.
47. Diaz-Duque OF. Advice from an interpreter: overcoming the language barrier. *Am J Nurs.* 1982;82:1380-1382.
48. Putsch RW III. Cross-cultural communication: the special case of interpreters in health care. *JAMA.* 1985;254:3344-3348.
49. Marshall P. Children in medical settings. In: Garbarino J, Stott F, eds. *What Children Can Tell Us.* San Francisco, Calif: Jossey-Bass Inc Publishers; 1989:282-288.
50. Gordon DR. Culture, cancer, and communication in Italy. In: Pfleiderer B, Bibeau G, eds. *Anthropologies of Medicine.* Heidelberg, Germany: Vieweg Bertelsmann Publishing; 1991:137-156.
51. Good MJD. The practice of biomedicine and the discourse of hope: a preliminary investigation into the culture of American oncology. In: Pfleiderer B, Bibeau G, eds. *Anthropologies of Medicine.* Heidelberg, Germany: Vieweg Bertelsmann Publishing; 1991:121-136.
52. Crigger B. Negotiating the moral order: paradoxes of clinical ethics consultation. Presented at the Annual Meeting of the Society for Health and Human Values; November 6, 1993; Washington, DC.