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Cultural Conflict in Medicine: A Moral Debate between Paternalism and Patient Autonomy

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## Abstract

In today's society filled with globalization and mass movement of people and ideas, there is an ever present question of how each individual society fits into the overall culture of a diversified country such as the United States. The idea of the US as a melting pot has triggered the inability to create a "one size fits all" style of living. In terms of medicine, westernized practices are typically accepted in a majority of the world. However, conflicting traditional practices as well as religious beliefs are still present in some areas of the world as well as in the US itself. These minority cultures living in the US are faced with extreme turmoil and conflict when their personal beliefs do not match those held by those who are providing medical treatment.

Through the debate of consequentialist versus deontological schools of thought, paternalism versus individual autonomy and the concepts presented in ethics for medical professionals, this thesis will seek to establish a balance of all medical and cultural values in order to provide the highest level of care possible. An analysis of not only the ethical principles, but also their implications on the overall issue of multicultural tolerance in medicine beg the question to what extent can medical professionals be tolerant of minority views . The cases of Lia Lee, Robyn Twitchell, Mr. Begay and *Stamford Hospital vs. Vega* provide insight into how the medical system has dealt with these issues in the past. Meanwhile, explanations of multicultural communication theories and how they apply in the medical environment offer some solution to this moral dilemma.

Keywords: *cultural conflict, medicine, biomedical ethics, autonomy, paternalism*

### Cultural Conflict in Medicine: A Moral Debate between Paternalism and Patient Autonomy

The world is a host of globalized movement: movement of technology, movement of ideas, and movement of people. This rapid movement allows for increased interaction and integration of cultures. In the changing, modern society where globalization is becoming the norm, there is an ever-present question of how each individual and cultural faction fit into the mix. Moreover, this movement of individuals between cultures is making it so that there is an inability to create a “one size fits all” style of living. In terms of medicine, westernized practices are typically accepted in a majority of the world. However, traditional practices as well as religious beliefs still hold precedence in some areas of the world as well as in the United States itself.

Minority cultures living in the US are faced with extreme turmoil and conflict when their personal beliefs do not match those held by those who are providing medical treatment. The main conflict lies between what is accepted by the majority and what is accepted by those living within the majority as a minority religion, nationality or culture. There are a multitude of factors to consider in terms of how people should act within multicultural situations, whether to be assimilate into the majority belief system or hold onto one’s cultural beliefs. It is when the two factions fail to acknowledge, but not necessarily accept, the opposing view that cultural conflict occurs.

Modern medicine is highly driven by western ideas and concepts. There is a significant focus on science and what can be proven with limited influence of religious beliefs. Empirical data and scientific methodology are determined to be the overriding support as to what course of medicine is best, whereas most religious practices or cultural beliefs as to the cause of illness or treatment are viewed by scientists typically as “blind faith” or without having scientifically

proved evidence supporting it. In medicine there are tests to prove and disprove diagnoses, there are procedures and processes for everything from the moment of admission to discharge that rely heavily on fact and evidence. Contrastingly, cultural beliefs are rooted deep in tradition and to outsiders may seem to be without meaning or basis of support, but hold great significance to members of the culture itself.

As a result of this conflict between science and tradition, doctors, nurses and other health professionals are placed in an ethical bind as to fulfilling their duties to diagnose, treat and cure that at times may conflict with the respect for the cultural beliefs held by their patients. Through the debate of consequentialist versus deontological schools of thought, paternalism versus individual autonomy and the concepts presented in ethics for medical professionals, this thesis will seek to establish a balance of all medical and cultural values in order to provide the highest level of care possible.

Consequentialists postulate that the rightness of an action is based on consequences; more simply stated: if the result of an action is viewed as good, then it is morally right. This is typically accepted in schools of thought like Utilitarianism which aims to produce the most good for greatest number of people. Meanwhile, deontology states that the rightness of something is based on actions to reach that point, rather than the end itself. If steps taken to reach the desired result are not permissible, it does not matter what the result is, or even if it is positive. The most common deontological perspective is Kantian Ethics, which states that people must not be treated as merely means to an end (object), but must be treated as the end in and of itself (subject). Both perspectives have benefits and drawbacks to their ideology, oftentimes resulting in judgment on a case by case basis. As such, it is difficult to say that either ideology is absolute, resulting in a *prima facie* application of these concepts.

Arguably the most important debate that pertains to healthcare in terms of conflict with cultural values is the conflict between autonomy and paternalism. Autonomy is the idea of self-governance and self-determination by someone who is deemed capable of doing so. Supporters of individual autonomy state that those who are autonomous should be allowed to exercise their ability to make their own decisions. Typically, autonomy is granted at the age of majority, or the age in which someone reaches adulthood. When a person is deemed to be autonomous he is viewed to possess all the decision making capabilities to make beneficial choices. In doing so, supporters believe that the overall result is most beneficial because it is in fulfillment of the desires of the individual.

A contrasting view is paternalism, which can be defined as the act of overriding an autonomous person's decision-making ability out of duty for beneficence. Oftentimes, paternalism is used in instances in which the individual in question is viewed to have questionable ability to make decisions regarding their life. Although the age of majority is granted at eighteen years old, good judgment is not something that is inherent in every person. Those in support of paternalism use the justification that experts have the greatest capability of making the proper decision in their field of expertise; thus doctors should be permitted to override an individual's decision in order to benefit that individual's overall health.

Somewhere in the middle of both sides is the concept of informed consent. Informed consent is based off of the idea that people should select their choice of medical treatment after being educated. Informed consent is a form of social contract in which the individual acknowledges both the benefits and risks of the elected course of action. In doing so, it is believed that the greatest balance will result between the patient's wellbeing and the physician's responsibility while in charge of the patient's care. Nevertheless, the ideal of informed consent

must also acknowledge that the individual has the right to choose in a manner that goes against the physician's recommended treatment.

Although informed consent is typically believed to be a mutual agreement, this is not always the case. The assertion is based on the assumption that the patient will agree with the physician on the course of treatment. In reality, various factors—the primary one in this case being cultural beliefs— may influence an individual to view the “best” act as something other than what the doctor deems the most beneficial choice. Some cultures views lead to differences in opinions on cause of disease, treatment, etc. In some cases, religion prohibits certain interventions; for example, Jehovah's Witnesses are against receiving blood transfusions while Christian Scientists believe in the power of prayer to heal (Vaughn, 2013, p. 74). Another disagreement on the grounds of religious beliefs is the cause of disease; Hmong people believe that illness is triggered by the loss of a person's soul, instead of a pathogenic process (Fadiman, 1997). Although these claims may seem unfounded, maybe even irrational to people of another culture, these are deeply seated beliefs held by these minority cultures that often are traced back to years of tradition.

Herein lies the conflict of medical professionals: whether to respect the cultural beliefs of their patients or to override these beliefs in order to give the patient the care that western medicine has taught them to be necessary to provide the patient with diagnosis and treatment. Fadiman (1997) perfectly depicts the conflict between western medicine and cultural beliefs in her sociological exploration of both the American medical system and the Laotian culture. Fadiman extensively interviewed the family of a young epileptic girl, Lia Lee, as well as the medical professionals who treated her. While Lia's doctors wished to use western conventions

to treat her, her parents maintained that it was necessary to use traditional Laotian methods to heal her.

Similarly, the case of Robyn Twitchell, the two year old son of Christian Scientists, portrays the conflict of traditional versus modern medicine. Robyn was admitted to the hospital in April of 1986 complaining of abdominal pain and vomiting. His condition failed to improve and his parents refused treatment on the grounds of their religious beliefs. The parents continued to rely on prayer as a manner of healing, and the child died after five days (Turoldo, 2010a, p. 177). His parents were later tried and convicted of involuntary manslaughter (Vaughn, 2013, p. 81). Although the court ruling was later reversed, the parents nonetheless were persecuted for acting upon religious beliefs that they held to be true.

A third case involves Mr. Begay, a 55 year old Navajo Indian who sought the medical advice of a doctor during a routine visit. After being diagnosed with hypertension, the physician suggested a low-sodium diet, restricted alcohol and to exercise regularly along with prescription medication (Turoldo, 2010a, p. 175). The physician completed his job as he had been educated to do, but did so in complete disregard for the patient's cultural beliefs. Erlen (1998) explains, "The Navajo believe that 'language does not merely describe reality, language shapes reality'. Thus, discussing a topic...may suggest to the Navajo that death is imminent" (Carrese & Rhodes as cited in Erlen, 1998, p. 80). This disregard of the Navajo tradition could be blamed for a negative outcome in the man's health that occurred following receiving negative news. In accordance with western medicine, physicians have the duty to inform their patients of their diagnosis and to educate them on prevention. As such, does this physician promote intolerance by not acknowledging the patient's beliefs?



Although the cases of Lia Lee and Robyn Twitchell deal with patients who are minors, for the sake of this argument, the parents will be assumed to be fit to possess parental proxy rights. Therefore, the debate will not be whether or not the parents have the rights to decide for their child, but rather if the parents have the autonomous right to refuse medical treatment on the grounds of cultural beliefs. There is undoubtedly, a moral argument to be made for or against the parents holding proxy rights, however it is another debate in and of itself and is beyond the scope of the arguments made here. The examples of intercultural conflict in medicine exemplified by the cases of Lia Lee, Robyn Twitchell and Mr. Begay beg the question as to how medical professionals ought to respond to the situation at hand. Are physicians morally obligated to respect cultural beliefs without question or are they justified in maintaining the role outlined in western medicine to diagnose, treat and prevent illness using commonly accepted practices?

It can be opined that it is the duty of physicians to respect beliefs of individuals and their right to choose. This argument states that it is not duty of a medical professional to force values or treatment, but rather to pay respect to the individual. In this way of thinking, there is a high value of autonomy. Deontologists would claim that even if the end result of treatment is being cured, if this treatment went against an individual's wishes it is not morally right because immoral actions (forced treatment) were used to achieve the result. Similarly, Kantian theory focuses on the idea that people must not be treated as objects but rather they must be treated as subjects. One could state that forced treatment regards the person as an object and not a subject by failing to respect the individual's desire to uphold their culture. Therefore, supporters of Kantian theory would maintain it is not right to force treatment.

The main foundation of this argument is simply respect for individuals and their culture. The First Tenet of Code of Nurses states that “nurses provide care that demonstrates respect for and recognizes the uniqueness of people” (Erlen, 1998, p. 79). This code encompasses the idea that medical professionals have a duty to uphold a person’s wishes because their aforementioned uniqueness is inclusive of their culture, traditions and beliefs. It is, therefore the duty of healthcare professionals to comply with an individual’s cultural beliefs out of respect for them. However, this respect is somewhat undermined when healthcare professionals refuse to perform a treatment for a patient that they deem to be unethical. Examples of this include what is known as female circumcision or the Chinese act of cupping (applying suction to the skin that they believe will promote healing). Although refusing to practice a therapy is typically deemed to be less offensive than when forcing a proposed treatment due to it being hands-off in nature, it is still refusing to recognize the uniqueness of the individual and their cultural beliefs and therefore could be deemed equally intolerant. Therefore, by this standard, physicians and other health professionals should accept the individual’s belief regardless of their views on the treatment.

Secondly, consent is deemed to be essential to western medicine in order to guarantee the ideal of autonomy that is held so dearly in the medical system. After the Nuremberg trials following the end of World War II and the human experiments carried out by Nazis, the Nuremberg Code was established stating that “the voluntary consent of human subjects is absolutely necessary” (Turoldo, 2010b, p. 543). This allows for the patient to be in control of his course of treatment so that it occurs in compliance with their cultural or religious beliefs. Consequentially, the act of promoting informed consent could also go against a person’s cultural values. In the example of Mr. Begay, educating the Navajo man about his condition was viewed by him as implying imminent death and could be viewed offensively by his culture. Also, in

cultures that place a great emphasis on family and elders, such as in Japan, it may be viewed as blasphemous to reveal a terminally ill patient's condition to the patient. In their culture, it is the family that should be informed and the "patient's autonomy is not considered the supreme value" (p. 545). This brings up the issue as to whether patient autonomy should be the ultimate principle in healthcare; while western medicine claims that it is, other cultures do not.

However, the main defense in support of patient autonomy in terms of respect of their cultural beliefs when receiving treatment is that many conflicts can be resolved through education. These supporters maintain that it is possible to create a treatment plan that incorporates both the patient's and doctor's beliefs. The conflict in the case of Lia, as well as many others, was a result of the simple lack of understanding of one another and could be solved through mediation and education. Fadiman quoted the epidemiologist in charge of Lia's treatment as saying "western medicine saves lives" (Fadiman, 1992, p. 176). Although this belief is held very strongly by medical professionals as well as a majority of the western society, it is not universally true. The excerpt continues with the phrase "our view of reality is only a view, not reality itself" (p. 176). This succinctly sums up the overall viewpoint of those in support of upholding cultural beliefs in medicine: that although an opinion may seem true, the ideas of truth and reality are relative and that what is right for some is not right for all. Although it is impossible to respect every belief and request of the patient, it is possible to show a great level of respect through educating oneself on the patient's cultural beliefs.

A conflicting belief with the ideal of cultural tolerance is that it is permissible to disregard personal beliefs in order to ensure the best outcome for the patient. This viewpoint, maintains that it is duty of a medical professionals to provide treatment in order to ensure recovery. This school of thought emphasizes paternalism in as the medical professional is the expert and

therefore has the greatest capacity to make decisions about the care that an individual should receive. Through the consequentialist perspective it is the doctor's duty to treat a patient because it is morally right to cause good; therefore, by not proceeding with the necessary treatment the doctor is not doing what is right. Oftentimes associated with consequentialism is the core tenant of utilitarianism which, as mentioned earlier, emphasizes doing what benefits the most people and will create the most good overall.

Many would perceive this way of thinking as promoting cultural imperialism or insensitivity to the many cultural beliefs in the world, others calling it intolerant and insensitive. However, some theorists in support of medical paternalism maintain that they support this way of thinking because "there are no right answers in a conflict of cultures, merely different ways of looking at the world" and, as such, paternalism is justifiable because a mono-culture is necessary for the proper function of the medical system (Catherwood, 2000, p. 427). He writes that "respecting another person's opinions, or another culture's traditions, does not always mean allowing them to act in accordance with their views" (p. 430). This is the case with practices that physicians deem to be morally unethical due to a result causing more harm than good for the patient. However, as discussed earlier, what one culture deems as having highest value, another may disagree. Cultural relativity, in establishing certain values to hold greater weight, makes it nearly impossible to create this mono-culture Catherwood describes.

Catherwood states that society wants to achieve both a respect for the individual as well as principles with a "coherent universal constancy in application" which is simply impossible to achieve with the goal of tolerance (2000, p. 428). He gives the example of female circumcision being a medical treatment requested based on cultural grounds. In this case, beliefs held by some African cultures call for a procedure which most of the world would deem to be mutilation.

However, with the desire for universal principles, those who support cultural individualism would also be in support of western doctors performing such a procedure. Those who wish to support cultural individuality, Catherwood states, support a *prima facie* viewpoint of tolerance, one that applies a majority of the time but can be overridden.

Clearly, the example of female circumcision seems extreme, but Catherwood and other supporters of the establishment of universally applied principles in medicine maintain that by permitting one cultural belief to be upheld, one must permit all beliefs to be respected in order to create a consistent medical mono-culture. Although it is almost impossible to create a universal law that exists without exception, Catherwood and his supporters believe that universality is preferable to applying rules based on case-by-case basis as seen in act utilitarianism. The issue with act utilitarianism is that there can be justifiable reasoning for any decision made and, therefore, there is no clear answer of what should be accepted and what should not. He maintains that without firm guidelines, our medical system is not able to function at the level it is needed.

Another argument against permitting cultural practices in the western medical setting is supported by the complexity behind what defines a “culture” and also how to differentiate a cultural belief from an individual belief. According to Erlen, a culture is defined as the “expression of the customs, habits, beliefs and values shared by a collective group of people” (1998, p. 79). However, what defines a “collective”? This loose definition as to what defines a culture, and in turn what can be defined as a cultural belief, makes it difficult to recognize the validity of refusing treatment on grounds of cultural belief. Catherwood (2000) also states that “A group of people may have in common a strong opinion...but it is not clear that this is enough to show that they have a separate cultural identity (p. 430). Because it is difficult to distinguish

what is a cultural belief, those in support of a paternalistic approach to medical treatment maintain that it is justifiable in order to protect the health of their patient.

Another defense of paternalistic medicine is that of relative autonomy, that is to say that autonomy is something people are not born with, nor are guaranteed to achieve (Turolto, 2010b, p. 544). Children are often recognized as not having autonomy and, as such, their parents, guardians or doctors are allowed to make decisions for them. However, there is no set definition of how autonomy “looks,” even in adults. Without definitive autonomy, there is no clear ability to discern who is capable of making sound decisions and who is not. Skeptics of this view would state that although autonomy is not guaranteed, those who are deemed to be autonomous should be granted the right to choose for themselves.

However, it is here where the line between normative ethics, what ought to be done, and descriptive ethics, what actually occurs, comes into play. Theoretically, autonomous individuals should always be granted this privilege, but it rarely happens in such a way. In the cases of Lia Lee and Robyn Twitchell, the parents were granted autonomy over their child’s treatment but as a result, Lia fell into an irreversible coma at the age of four until her death 26 years later, while Robyn died after only five days (Fadiman, 1997; Turolto, 2010a, p. 176-177). While some may believe these tragedies happened as a result of ignorance on the part of the parents, others argue that the physicians were simply respecting the family’s autonomy. In the case of Mr. Begay, the Navajo Indian, the physician believed he was respecting the man’s autonomy, but ignored Mr. Begay’s personal beliefs and went ahead with informing the patient of his illness. It is for this reason that Turolto states that although autonomy is something that one can strive for, it is not guaranteed.

There is an obvious conflict between the apparent solution to the problem and what seems to occur in reality. This clash, explained earlier as the conflict of normative and descriptive ethics, is explained further by Catherwood. He states that our medical system has become one where the practitioner's moral judgments and autonomy are "not as important of the patient, and that the patient's opinion has this overwhelming weight because of the cultural background that forms the opinion" (2000, p. 427). In this, he maintains that our medical system is one that typically focuses on the patient's choice, but when that choice is made out of a duty to uphold one's culture, it becomes almost untouchable, and difficult for a medical professional who believes it should be overridden. He later states that it is often argued that "all opinions should carry equal weight, and should be equally respected" (p. 429). However, it is impossible for each opinion to carry equal weight in all situations because there must be a standard practice that is upheld. Today's medical system is faced with the difficult task of attempting to balance all values in order to create an overall good for both the patient and practitioner in what seems to be an impossible battle.

People are taught to promote tolerance and acceptance or face being labeled a bigot, racist, etc. The freedom of religion is one of the inalienable rights granted to Americans. Therefore, under the protection of this amendment, Jehovah's Witnesses and Christian Scientists are free to believe what they choose; however there is also a difference between believing and acting. Under examination of court rulings in cases such as that of Robyn Twitchell, it appears that this distinction between believing and acting holds true (Turoldo, 2010a, 176-177; Vaughn, 2013, p. 74). In the Twitchell case, his parents were later persecuted as criminals for upholding their religious beliefs and refusing treatment for their child and were initially convicted of involuntary manslaughter. However, in the Supreme Court case of *Stamford Hospital vs. Vega*, a Jehovah's

Witness woman's rights to refuse a blood transfusion was upheld after a physician ruled to override her determination to refuse blood products stating that "A healthcare facility cannot presume to substitute its own judgment for that of the patient" (Blood transfusion: Court, 1996, p. 4). This clear lack of uniformity in rulings by the court, in regards to whether the freedom to believe what one chooses also encompasses the freedom to do as they see fit, upholds Catherwood's assertion that rulings should be universal in terms of the permissibility of cultural tolerance versus intolerance in the medical setting. However, there is something unsettling about a "one size fits all" system when human rights are at stake.

Intercultural conflicts like those experienced in the cases of Lia Lee, Robyn Twitchell, Mr. Begay and *Stamford Hospital vs. Vega* occur rarely, maybe even only once, in a physician's career, so are often overlooked. Cultural awareness and sensitivity are rarely taught to health care professionals, yet they are crucial in resolving conflicts of traditional versus modern beliefs in medicine. There will never be a universally accepted answer for any solution as to what doctors should do when confronted with difficult conflicts such as the cases stated above. As such, education and awareness is really the closest thing that anyone can do to resolve the conflicts in any sort of respectable manner.

Intercultural communications theorists suggest that there are multiple degrees in which an immigrant may interact with the majority culture ranging between assimilation, integration, marginalization, separation or any combination of the four main stages. Assimilation occurs when the person devalues his own (minority) culture and adopts the host (majority) culture fully, while integration is the value of both the original culture and the host culture. Contrastingly, marginalization is rejecting not only one's own culture, but also the host culture and separation is the value of their own culture, with the devaluation of the host culture (Martin & Nakayama,



2010, p. 315). Although it is not necessary for a medical professionals to be able to recognize what stage of interaction a patient is in, it is important for them to at least acknowledge that there are varying degrees of interaction that will affect how patients will view their role in the greater, overall culture and consequentially how they will interact with people from the majority culture.

One of the most significant, yet most easily remedied, sources of intercultural conflict is the language barrier. Hallenbeck & Goldstein (1999) state “language barriers or hearing impairment may hinder communication” making resolution seemingly impossible (p. 26). When doctors cannot communicate with their patients, there is an enormously greater potential for miscommunication, therefore generating conflict. Martin and Nakayama (2010) define conflict as “the interference between two or more interdependent individuals or groups of people who perceive incompatible goals, values, or expectations in attaining those ends” (431). The key part of this conflict is the incompatibility of expectations, because the patient may expect the doctor to be able to help, but in the end this is not possible if there is no way to communicate. As such, the easiest remedy is to seek out a translator who is competent in both languages to act as a mediator.

Erlen (1998) also states that it is important for healthcare professionals to avoid generalizations. Although in some cases generalizations may present the truth, they also “may not be true; they may be based on inaccurate assumptions” (p. 81). As such, it is important for medical professionals to research information about the culture thoroughly and not base their perceptions on claims made by someone who may have only interacted with a single individual from the primary cultural group. Researching interactions and values of the other culture allows a doctor to get an idea for whether they value autonomy versus paternalism, or a direct versus

indirect approach to the situation. As mentioned earlier, Navajo Indians value indirect language in which negative subjects are not discussed out of the belief that language shapes reality.

The most crucial concept to keep in mind when faced with cultural conflict in medicine is that conflict is not always negative. Conflict can be used to educate individuals and promote awareness of other opinions that challenge the traditional belief system. As a result, doctors and other professionals may be “encouraged to think of creative, and even far-reaching, solutions to conflict. Furthermore, the most desirable response to conflict is to recognize it and work through it in an open, productive way” (Martin & Nakayama, 2010, p. 432). If physicians can act in a professional manner while addressing intercultural conflict, they have the ability to grow immensely not only as physicians, but as individuals by being able to acknowledge their own biases and views of the situation

Neither complete compliance with an individual’s cultural beliefs nor absolute intolerance appear to be suitable options for resolution to intercultural conflict within the medical system. A somewhat moderate belief is outlined in Turoldo’s “Ethics of Responsibility” (2010a, p. 178-180). This system focuses on four responsibilities of medical professionals in the workplace that permit the greatest amount of cooperation to reach a common goal. The responsibilities are “the recognition and acknowledgement of others (responding to someone)”, “responsibility as taking charge (responding for someone)”, “responsibility as the ability to assess actions” based on intentions as well as consequences and “responsibility as a professional commitment made towards others” (p. 178). In accordance with these four values, the greatest amount of good can be done with the least harm.

The first aspect discussed by Turoldo is that of recognizing and acknowledging others. As he explains, this is the responsibility of responding to someone by not only listening to the

differences, but also going further than simply tolerating another person's cultural value (Turolido, 2010a, p. 178). The premise of responding to individuals goes past the idea of only listening to their beliefs, but also to understand why they hold their belief at the personal level. Turolido writes "if we acknowledged value of the culture itself, before the individual who embodies it, we would risk allowing cultural minorities to impose a specific identity on their single members" (p. 179). This statement nullifies the argument that those in favor of intolerance use: postulating that a culture is not clearly defined and therefore it is difficult to discern between what is a cultural versus an individual belief. Going along with the ideal that generalizations of a culture should be limited, Turolido's belief that ethics should be based on response to an individual implies that a belief is valuable solely based on the fact that the individual believes it. Therefore, through understanding the individual, a doctor should be able to better understand what the patient wants.

The next responsibility in Turolido's model is the responsibility of taking charge (2010a, 178). Although this ideal also pertains to the concept of interpersonal interaction, it relates more heavily to responding to individuals who are incapable of understanding or expressing their beliefs, also known as those who lack autonomy. Turolido states that in these instances "it is no longer a matter of responding to, but of responding for" (p. 179). This concept of advocacy, however, should not exist solely when dealing with non-autonomous individuals. It is the duty of a physician to act in accordance with the best interest of patients, including upholding their cultural or religious beliefs. In acting for the patient instead of acting on the patient's inferred goal to get better, the physician shows a greater respect for the patient as a person instead of a set of symptoms.

The third aspect of the ethics of responsibility as explained by Turolto (2010a) is the responsibility to assess the consequences in regards to an action. In this value, it is explained that every action has rewards and consequences and it is the duty of the doctor to examine and weigh both. He writes “someone who has good intentions but ignores the consequences of his actions is irresponsible” (p. 180). In the example of the court case of *Stamford Hospital vs. Vega*, the physician who ordered a blood transfusion for the woman against her wishes could be deemed irresponsible because he/she failed to recognize the Jehovah’s Witness’ motives against receiving blood products (Blood transfusion: Court, 1996, p. 4). Although one is not obligated to agree with a person’s beliefs, the failure to recognize the personal ramifications that individual may face as a direct result of a physician’s actions is a clear disrespect for the individual.

The final aspect of Turolto’s ethics of responsibility is the responsibility to the ethics of a professional vocation (2010a, p 180). All health professionals, doctors, nurses, physicians assistants, etc. are bound by a professional code which outlines the ethical standards to which they are held. Whether it be the Hippocratic Oath or the First Tenet of Code of Nurses, or some other ethical commitment, this is a promise taken by healthcare professionals that they vow to uphold in their profession. One of the promises given under the Hippocratic Oath is “I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being” (Lasagna, n.d.). The most powerful part of this statement is to acknowledge of people being treated as a human beings: individuals, unique and in their own right to their bodies. As such, no judgment can be made upon the person in accordance of their beliefs on behalf of the doctor.

No situation in medicine is ever simply black and white; there will always be other factors to consider when making medical decisions. Although it is an admirable goal to be able to come up with a universally applicable set of rules and guidelines as to how a medical

professional should act in the case of intercultural conflict, there will never be a clear answer.

However, the main consideration to keep in mind is that people are human beings and deserve the respect of those around them, even if those around them disagree with their cultural beliefs.

Primarily, the physician has a duty to respond to and for their patients and to advocate for them in their medical care. Also, a physician must weigh heavily all options as well as the consequences and benefits of each. Although medically one option may far outweigh the alternative, the cultural views of that individual must also be taken into consideration. Finally, it is important for medical professionals to act in accordance with their oath taken in their profession; although they may wish to respect a patient's cultural beliefs, one cannot do so if by acting upon their patient's beliefs they will in turn violate their own obligation to society.

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