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Please geben vôtre consentimiento! Informed Decision-Making in Intercultural Context

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Abstract

The present study places the well-discussed problem of reaching informed consent in medical treatments into an intercultural perspective. In doing so, it sheds light on some features of the term 'cultural context' in the twenty-first century, as it may be seen through the lenses of philosophical hermeneutics, interpretive anthropology, and intercultural discourses. These findings will be used to support the achievements of the anthropological turn in bioethics. The theoretical considerations will be followed by instances from empirical knowledge to highlight the cultural aspects of the already explored difficulties of attaining informed consent. Some of the value differences from Hofstede's cultural dimension theory, and the importance of the nativeness of the langue used in moral decision-making will be discussed.

Keywords

Informed consent; cultural context, moral decision-making, language; anthropological turn in bioethics; super-diversity.

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I. Introduction

This study focuses on the obstacles of gaining informed consent in an intercultural situation. The difficulties of achieving an informed decision are thoroughly disputed in medical literature, but most assume a monocultural context for the problem [1]. If not, the main emphasis is falls on the barriers of communication and understanding [2]. (This is obviously a considerable topic in monolingual situations as well, e.g.

problems of comprehension, psychological dispositions, mental disorders, socio-economic differences, etc.). The value differences amongst cultures and their impact on medical practices and bioethical principles represent an exciting topic, on which discussions have already begun, but are still far from reaching the end [3]. First, I will discuss the significance of 'cultural context' as such, as this is needed in order to establish an intercultural perspective, after which this topic will be addressed by using empirical knowledge. Cultural differences have been debated in relation to doctor – patient encounters, but up until recently, little attention has been paid in bioethical discussions as to how having different cultural identities affects the way we make moral decisions. [4] Additionally, the freshly-revealed relation between language and moral decision-making is offering a noteworthy consideration in better understanding the situation. With the help of these findings, the problem of giving autonomous informed consent in an intercultural context will be framed.

In doing so, this essay relies on both the achievements of the cultural critique of bioethics, or the so-called anthropological turn in bioethics [5-7], and on the results of recent psychological experiments on moral decision-making processes. Furthermore, I will use some insights of interpretive anthropology – mainly through the work of Clifford Geertz – and philosophical hermeneutics – as it was developed by Hans-Georg Gadamer, to support my claims.

II. The cultural context

Thinking and talking about culture has always been a rather complex and, at the same time, sensitive question. This difficulty also draws from the level of self-reflection it demands from the thinker in question, and from the inherent conceptual abstraction of culture. The leading 20th century German philosopher Martin Heidegger identified the notion of culture as being one of the epoch-making phenomenon of modernity [8] (p. 87-88). Culture in modern societies, in contrast to culture in traditional ones, implies that we no longer see our way of living and our interpretation of the world surrounding us as naturally preordained and unproblematic, but we rather perceive it as belonging to a certain culture, i.e. embedded in a continuation of a tradition established by our predecessors, therefore conceiving itself as *a* culture,

as *one* amongst many, for which being a culture has become a theme of reflection.

This density is clearly tangible in the book of Alfred Kroeber and Clyde Kluckhohn *Culture: critical review of concepts and definitions* [9], well-known in anthropological circles, which over half a century ago has collected nearly 300 definitions of culture – including all notes and citations see [9] (p. 149, 4a footnote) – of which they thematise 164 items which were in use in scientific discussions. Additionally, according to historical-semantic research, until the mid-19th century the notion of "culture" was only used in the singular [10], thus assuming the existence of only one possible culture that is *the* human culture. This might be another argument for the importance of moral circles as emphasised by Peter Singer [11]. This also allows us to better understand our self-centred attitude we may habitually (and almost automatically) hold, and what hinders us from perceiving the transcendental function of the notion. We, quite often, take terms and their conceptual framework as axiomatic, universally applicable even within the most reflective epistemic fields, such as philosophy or cultural anthropology. For instance, the concepts of morality, personality, or culture show a vast variety of meanings in different cultures across the globe, while "western" understandings of some of these concepts is nonexistent in certain cultures. "The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against its social and natural background, is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures" [12] (p. 31).

It is important to distinguish between at least two main considerations of culture in philosophical tradition: (1) culture as a social phenomenon; and (2) culture as a concept with transcendental function. The classical philosophies of culture (Die Kulturphilosophie) deal mainly with the first understanding, while epistemological research in philosophical hermeneutics and in phenomenology has placed the latter meaning into its focus. Although significant efforts were made to draw its inference [13], the "cultural turn" in philosophy has not yet been elaborated. As Gadamer argued: "…the world-constitutive

subjectivity, though it may be a manifold of such constitutive subjectivities, is a part of the world constituted by these subjectivities and therefore brings into play all the specific subjective relative characters of the personal horizon which distinguishes for example the negroes of the Congo or the Chinese farmers from Professor Husserl" [14] (p. 181).

Although this quote from Gadamer poses several problems by using sloppy examples from a social scientific point of view, it nevertheless convincingly shows the main concern here. Without further immersing into the relativism debate and accounting for it, it seems inevitable that the cultural context in general plays a much more important role in understanding human actions and thoughts than we used to presume.

A. Diversification of diversity

The problem of taking culture into account mainly emerges in two major fields of bioethics: (1) in relation to the so-called particular moral values and beliefs of a given group of people, and (2) concerning the traditional (local) understanding of (and relation to) health, illness, healing in general, or end-of-life issues, moral status of the foetus, genetic design, organ donation, etc. Fortunately, considerable important work has already been done in both fields, after several anthropologists and social scientists questioned the cross-cultural appropriateness of the "western" models of moral reasoning, which is grounded in rights-based liberal individualism [15, 16]. As for the second field mentioned above, complementary and alternative medicine (CAM) as part of traditional local systems of healing throughout the world is largely practised, although bioethical literature rarely discusses its ethical particularities [3]. Concerning moral differences – although anthropologists tend to remain in the field of medical anthropology or medical sociology, while bioethics was pushed farther mainly by philosophers, lawyers, theologians, and physicians – few qualitative researches have offered anthropological critiques of bioethics, and starting with the mid 1990s, the role of different cultural norms and ethnic differences in bioethics has been slowly acknowledged [5].

However, the pluralistic nature of our societies has been in a continuous changing state for the past decades. The main elements and conceptual schemes of multicultural discourse were shaped by experiences drawn mainly from the United States of America of the

1960s, where a relatively small number of minority groups – although each comprised of large numbers – represented cultural pluralism. Moving into the 21st century, this claim can no longer be maintained due to the massive changes in the structure of societies. As one of the most celebrated figures in the anthropology of migration, Steven Vertovec argued:

"Britain can now be characterised by 'super-diversity,' a notion intended to underline a level and kind of complexity surpassing anything the country has previously experienced. Such a condition is distinguished by a dynamic interplay of variables among an increased number of new, small and scattered, multiple-origin, transnationally connected, socio-economically differentiated and legally stratified immigrants who have arrived over the last decade" [17].

These conditions do not apply to the UK alone, but are applicable worldwide. (After coining the term, Vertovec witnessed its popularity skyrocket with newly-established research centres addressing the questions of super-diversity).

This leads to rethinking and re-evaluating the classical multicultural doctor-patient encounter, where the doctor – a member of culture A – engages in interaction with the patient from culture B. Along the discourse on interculturality, different cultural identities should also be highlighted here, with their instant correlation with each other and with their environment. Interculturality presumes interaction, process and change – in this regard, it can be used in a normative sense. Furthermore, culture should not be perceived as a closed and stable box of meanings, rather a frame of reference for the given personal identity which includes group affiliations and the sum of its beliefs, social roles, statuses, which makes a unique composition for the given situation – as we may position ourselves differently under different circumstances.

Due to this diversification and the massive changes we are facing, it is common that during the healing process, three different important actors can be identified: the institution of the service provider, the health care professional, and the patient – each of which possibly representing different cultural identities with different understandings of the meaning and importance of informed consent.

III. Achieving informed decisions and the related value differences

As one of the most significant topics of bioethics, the issue of informed consent is thoroughly disputed in related literature. After the so-called anthropological turn in bioethics, the underlying principle, i.e. 'respect of autonomy', was put into cross-cultural context: does it have the same importance and meaning in different communities? Although there still is an ongoing debate as to what extent culture represents a moral weight in ethics [18], most scholars would agree that there could be important values specific to a given community which affect moral decision-making – my arguments here tend to support these claims. The appearance and deliberation of African, Latin, or Islamic bioethics [7, 19, 20] in the millennial discourse also clearly shows the understanding of the emerging need to clarify these phenomena.

The renowned Dutch social psychologist Geert Hofstede has developed the alleged cultural dimensions theory [21], through which I will exemplify how value differences may affect informed decision making. Together with his research team, he defined six dimensions of national culture. The notion of 'national culture' might seem strange at first, but it is only used to when differentiating between countries rather than individuals. He asserts that the scores on those dimensions are relative and can only be used comparatively. He also believes that values are stable elements in culture (much more than practices), so a "comparative research on culture starts from the measurement of values" [22] (p. 28). Hofstede thus identified six dimensions: power distance index (PDI); individualism vs. collectivism (IDV); masculinity vs. femininity (MAS); uncertainty avoidance index (UAI); long-term vs. short-term normative orientation (LTO); indulgence vs. restraint (IND). I will use two of them to illustrate foreseeable difficulties in achieving informed consent. In doing so, I would like to support the already-existing knowledge and claims on these arguments. [23]

Power distance index is, in short, used to indicate how a given country is dealing with inequalities among people. Societies scoring high are likely to accept hierarchical order and large differences, while low PDI countries strive for equality and demand convincing justification when inequality occurs. Translating this into the health care scenario: how does this affect the doctor - patient power asymmetry in relation to providing the best possibility for informed decision making?

PDI seems to have a strong impact on various elements of the healing procedure: in large PDI cultures, doctor-patient consultations take less time and are more formalised with "less room for unexpected information exchange" [22] (p. 71). Blood transfusion practices have also shown differences with regards to PDI: countries with low scores have more blood donors and more blood is supplied to hospitals. Naturally, there are many more factors behind these differences, but the referring studies controlled them in a methodologically-appropriate way, making it possible to observe the significance of the correlations [24]. If evidence for these differences exist, one might claim that they pose a risk to securing informed decision making. Accepting authority and the feeling of dependence and large emotional distances are likely to appear when low and high score PDI country citizens are at the other side of the desk, e.g.: institutional policy may require strict obedience to its internal rules, while the doctor is assuming a high level of independence from the patient who draws different inferences by misunderstanding the behaviour of the doctor. *Ad hominem* kind of arguments may play another role in case of patients of low PDI countries, who take everything coming from the (superior) doctor as granted, because it was he/she who said that (therefore it must be right).

By presenting these ideas, I do not claim that these risks do not exist among members of the same community, especially as the differences in PDI also appear between classes, socio-economic statuses, occupations to some extent within the same country as well. Nevertheless, I do argue that these factors pose a significant threat to informed decision-making and, in most cases, are overlooked.

The insights identified in the individualism vs. collectivism (IVS) dimension represent well-known problems in the literature: the highly esteemed principle, the 'respect for autonomy' is clearly grounded in the ethos of individualistic liberal societies. But while this standard seems self-evident in the Euro-American culture, it has a different interpretation in many cultures across the globe: it is not the individual who ought to make decisions and bear responsibility alone. In Hofstede's model, this dimension refers to the preference towards loosely- or tightly-knit social frameworks: in the former, one is expected to take care of themselves and their close family, while in the latter, the community secures its members in exchange for obedient

loyalty. It might be difficult to understand shared responsibilities in cases of life-threatening decisions made by a community or a leader instead of the patient. The same applies in the case of medical interpreters or cultural mediators: the moral and legal responsibility of the mediating third party is more than dubious. Furthermore, speaking one's mind straightforward could be perceived differently, ranging from being honest to a rude violation of the interest of the community. Therefore, the appropriateness of truth-telling in a given moment requires proper cultural assumptions [25], and is not necessarily the right thing to do as moral intuitions would suggest.

The IVS dimension plainly shows value differences that may have a direct impact on the way moral decisions and informed consent can be made, insofar as it strongly relates to the different perception of autonomy.

IV. Moral decision-making and the question of language

The last, but probably the most vivid and less debated insight so far, concerns the role one's native or second language may play in moral decision-making. One might claim that answering questions in a moral dilemma should not depend on the language they were asked in as long as it is understood properly. Recent research however suggests the opposite [26, 27]: Albert Costa and his fellows refreshed the famous trolley problem by Philippa Foot [28] and have put it into a slightly different, but very new context. (This problem appeared in many different versions in the last half-century, independent of Foot's original purpose). They wanted to see what happens if two basic versions of the same problem would be presented in a language different from the subjects' native language. They first used the footbridge version (Fig. 1), where a man stands on a footbridge overlooking a train track. A trolley is coming and is about to kill five people. The only way to stop it would be to push a heavy man off the bridge in front of the trolley – thus killing the heavy man, but saving the five people. On a utilitarian basis, we would see this as sacrificing one to save five, but at the same time, also as violating the moral prohibition of killing. For methodological reasons, they repeated the experiment in another version of the dilemma (Fig. 2), where there is no footbridge, but an alternating track with a switch, so by pulling the

switch one can change the direction of the trolley to the track, thus only killing one man instead of five.

Fig. 1. Footbridge version of the trolley problem
Source: https://kevinbinz.com/tag/footbridge-dilemma/

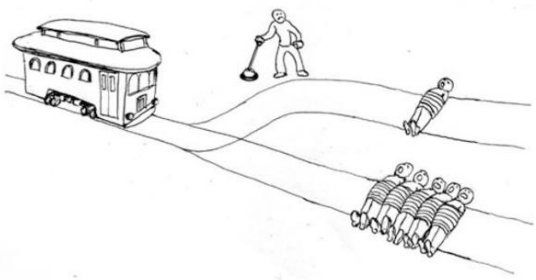

Fig. 2. Switch version of the trolley problem
Source: https://kevinbinz.com/tag/footbridge-dilemma/

The main difference between the cases is the level of emotional involvement: while the former requires physical contact and action to kill/save people, the latter is less emotionally aversive. The hypothesis was grounded on a moral psychological model, where "moral judgment is driven by a complex interaction of at least two forces: intuitive 'automatic' processes prompted by the emotional content of a given dilemma, and rational, effortful, controlled processes driven by the conscious evaluation of the potential outcomes" [25] (p. 1]. In this model, the first intuitive processes supports decisions based on the

shared basic values and norms of the community, so deontological judgements, while the rationally-controlled process favours judgements for the sake of the greater good: the utilitarian decisions. They thus hypothesise that listening to these dilemmas thinking about them in a foreign language will increase utilitarian decisions, because the usage of foreign language stimulates less intense emotional reactions compared to a native language. As shown in the charts below (Fig. 3), the switch version with less emotional involvement resulted in fairly similar (~80%) utilitarian choices in native and foreign languages, while the emotionally demanding footbridge version resulted in more than twice as many utilitarian decisions in a foreign language than in the native language. The experiment was carefully designed with control over many different factors which can play any role, but, along with the results of the few other studies [27, 29, 30] on this topic, they conclude that people's moral decisions depend on the nativeness of the language in which the question or problem is presented.

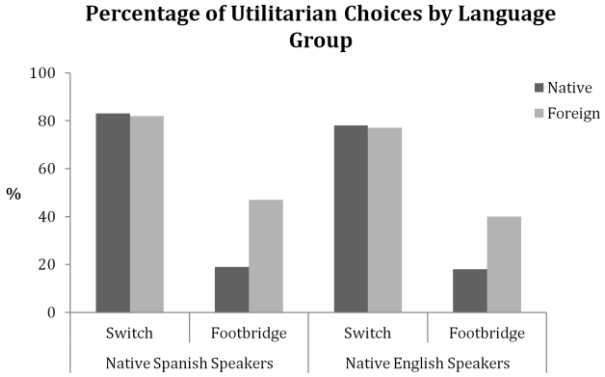

Fig. 3. Percentage of utilitarian decisions by language group. Source: [Costa] (p. 5)

Considering that in our globalised world there are hundreds of millions of people who speak and manage their businesses in a foreign language every day, including making moral decisions, this result also represents a significant finding in relation to achieving informed consent.

V. Summary

Receiving informed consent from the patient has been a central concern in the bioethical dialogue since its very beginning. Fortunately, a vast amount of research explores the difficulties of making informed decisions. Following the anthropological turn in bioethics, an increasing number of studies on cultural differences, local moralities, and culturally-affected cognitive processes were carried out, resulting in a shift in evaluating the role of culture as a context for bioethical issues. This study would like to support these efforts by giving an alternative understanding of the cultural context using insights from philosophical hermeneutics, interpretive anthropology, and intercultural discourses. Further to the theoretical findings, a few instances from empirical knowledge have been used to highlight culturally-driven difficulties in achieving informed consent, such as the different value dimensions of different societies and the hidden impact of using a foreign language during moral decision-making.

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