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Article

Enhancing Cross-Cultural Understandings of Ethical Issues in Medical Education

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The four principles approach (principlism) is widely implemented in medical curricula. However, there is ongoing debate about the "universality" of this approach. A frequent criticism is that principlism reflects Western ideals such as the importance of individual rights. Some Asian scholars have argued that Asian bioethics is essentially different from Western approaches. This paper reports on a qualitative study investigating the impact of "Western-developed" medical ethics teaching on clinical experiences of 40 medical students in Malaysia. Our data suggest the possibility of shared understandings of ethical issues across different cultures. Our research also demonstrates that ethics education can be enhanced by tailoring the content to specific cultural contexts. The debate over the application of the four principles approach is frequently couched as a tension between the acceptance of either universal values or cultural norms. However, student responses suggest that it is possible to mediate between "the universal" and "the particular."

Keywords: bioethics curriculum development; cross-cultural bioethics; health ethics education; medical ethics curriculum; principlism

Medical ethics is a significant component of many medical curricula. Medical students are expected to be aware of, and have a commitment to, ethical practice. In addition, awareness of the ethical issues that arise in clinical practice can help to ameliorate the moral distress that is associated with difficult clinical decisions (Du Val 2004; Kalvemark et al. 2004).

Monash University offers programs of medicine in both Malaysia and Australia with compulsory medical ethics seminars and tutorials. The medical ethics curriculum in both programs is based on the "four principles" approach (principlism) popularised by American ethicists Beauchamp and Childress (1979). This approach is underpinned by four common, basic prima facie moral principles: respect for autonomy, beneficence, non-maleficence, and justice. According to Gillon (1994), principlism provides a simple, accessible, and culturally neutral approach to thinking about ethical issues in health care.

The four principles approach is widely implemented. However, there is ongoing debate about the "universality" of this approach. A frequent criticism is that principlism reflects American ideals such as the importance of individual rights and self-determination. Some scholars have argued that Asian bioethics is essentially different from American and European approaches. They propose a distinctive "*Asian ethos*" characterized by concern for holistic well-being and the welfare of groups and communities (Fan 1997; Sakamoto 1999; Qiu 2004). Some of these scholars argue that a moral framework based on Asian traditions is more suitable to the demands of Asian societies. According to Qiu, universalistic approaches to bioethics should be rejected. He has described the domination of bioethics by American approaches as a type of Western 'ethical imperialism' on developing countries (Qiu 2004).

Some European scholars have also criticized the emphasis that American bioethics places on patient autonomy as the central value. They argue that this is foreign to many European and non-European cultures and that alternative understandings of doctor–patient relationships based on notions of community and relationships are important (Justo and Villarreal 2003; Veatch 2000).

Conversely, some academics reject the notion of a distinctive European, Asian, or African bioethics (Nie 2000; 2005; de Castro 1999) and caution against dichotomy in cross-cultural studies (Nie 2008; Kim 2005; Hongladarom 2008). It is claimed that the widely accepted generalizations of Western-individualistic and Eastern-communitarian bioethics overly simplify or ignore the

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variation within cultures. Nie argues that neither Chinese nor American bioethics is a field with a single perspective. He points out that Chinese medical morality is neither static nor monolithic but a combination of Maoism–Marxism–Leninism, Confucianism, Taoism, and Buddhism. Nie (2000) also highlights that while principlism has dominated American bioethics, there is also a substantial following in communitarian perspectives.

In defense of the four principles approach, Gillon (2003) argues that this framework is neither an attempt at moral imperialism nor an attempt to impose a regimented method of doing ethics. He argues that this framework accommodates cultural difference and reflects common and shared prima facie values. To date, there has been little empirical work investigating this claim and the counterclaim—that the adaptation of principlism to guide clinical practice in Asian countries is problematic.

This paper explores the following question: How relevant and appropriate is the four principles approach as an ethical framework for clinical practice in non-Western countries?

We report on a qualitative study undertaken in 2007 investigating the impact of "Western-developed" medical ethics teaching on the clinical experiences of 40 Monash University medical students in Malaysia. The aim of this study was to examine the cultural relevance and appropriateness of the medical ethics curriculum.

Our project investigated whether the four principles approach taught in the Monash University medical ethics program helped students in Malaysia to reflect on, and deal with, ethical issues that they faced in their clinical placements. Of particular interest was whether the four principles framework was applicable in an Asian health care setting.

METHOD

This study was approved by Monash University's Human Research Ethics Committee. Participants' privacy has been protected by removing names and other identifying information.

All students who were enrolled in the third year of bachelor of medicine/bachelor of surgery curriculum at Monash University (Kuala Lumpur campus) were invited to complete an open-ended questionnaire. These students had undertaken their first-year medical ethics education in Australia. Their third-year clinical training was undertaken in Malaysia. Forty students described:

- What they found useful about first-year ethics tutorials.
- Any ethical issues that they might have encountered in their clinical placements in Malaysia.
- Any information from ethics tutorials that helped them to work through these ethical issues.
- Ideas for improving the medical ethics curriculum and making it more relevant to their clinical practice here in Malaysia.

Students were asked to comment on the following claim: "It is sometimes said that the way medical ethics is taught in Western countries is not culturally relevant or helpful in other cultures."

Thematic analysis was used to identify major themes in students' responses, which were then organized into categories and subcategories.

In the following discussion of the findings, texts in italics and quotation marks are direct quotes from a participant. These quotations have been selected to illustrate the main themes. The quotations are not intended to be representative of the sample, nor statistically generalizable.

FINDINGS

The findings from the questionnaire are presented in four sections:

1. Impact of ethics tutorials.
2. Cultural and systemic issues in clinical practice.
3. Cultural relevance of ethics tutorials.
4. Ideas for improving the curriculum.

Impact of Ethics Tutorials

When asked to describe what they found useful about their ethics seminars, all students were able to recall and describe useful learnings. Several students described the tutorials as raising awareness of basic ethical principles. They used formal terms to describe their clinical practice:

> *"[Ethics seminars] taught me to respect the privacy and confidentiality of the patient and to respect the autonomy of patients."*

Some described the seminars as providing a set of ideals, or a "*gold standard*," for clinical practice. Students also indicated that the seminars provided them with a framework for articulating their clinical experiences.

> *"They gave me an insight into how to treat patients with respect . . . It has changed my views on how to behave as a doctor and how patients have rights in the decisions that they make. In understanding this, I have been better able to build relationships with patients during my clinical year."*

Students indicated that they had reflected on the content of the ethics teaching during their clinical placements. Although students described the seminars as raising awareness of ethical issues, our data demonstrate a tension between what students were taught in their ethics seminars and what they experienced in their clinical practice. Students described the theory–practice gap as both cultural and systemic.

Cultural and Systemic Issues in Clinical Practice

Students described specific cultural practices and beliefs that make ethical theories difficult to implement in practice. Some of the conflicts that students described illustrated different cultural understandings of the concepts "confidentiality" and "autonomy." For example, students said that

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they commonly observed doctors disclosing information about patients to patients' relatives: *"Information is released to patients' relatives instead of patients themselves."*

Students also described the doctor–patient relationship in Malaysian hospitals as different from the ideal they had been taught in ethics tutorials. They described a cultural practice in which it is common for doctors to "*take charge of everything."* This paternalistic approach included cultural understandings of truth-telling such as *"concealing certain facts from patients."* Students also described a cultural context in which patients accept paternalism. Students observed that patients did not always make their own decisions about their treatment. They said that most patients accepted that doctors made all the decisions about their treatments: *"Most patients have the idea that doctors always know what the best is for them."* In addition, several students commented that because patients and doctors often spoke different languages, problems arose with communicating and sharing information.

Students also identified systemic issues in the clinical environment that compromised the ethical ideals that underpin the medical ethics curriculum. These issues included doctors' busy schedules resulting in a lack of time to spend discussing treatment options with patients. Another example was the design of wards in Malaysian hospitals using the "*Nightingale ward system*"—comprising a large number of beds in two rows. Although this environment may ensure economy of staff, students noted that it also limited patients' confidentiality and privacy.

Some students described ethics as a "*luxury*" item—they said that the difficulties in achieving ethical ideals were due to limited resources. They described the Malaysian health care system as not having the resources to practice in the way that they had been taught.

> *"A third world country might not have the luxury to have the standard of medical ethics practiced in a developed country."*

Students also described an organizational culture in which some clinical behaviors were entrenched. These behaviors were modeled on that of senior practitioners. According to some student, "*things were done the way they had always been done."*

Some students described patients as being "*surprised*" when medical students used processes that they had been taught during ethics seminars, such as to provide explanations to patients. They described patients as being reluctant to receive explanations. One student said that this encouraged "*skipping the processes*" that they had learnt in ethics seminars.

> *"Patients become very surprised by the way I approach them in the wards or other clinical situations. It's a difficult issue to deal with because patients generally respond by being very reluctant to go through all my explanations in the beginning of each interview—they are used to the paternalistic way of things in Malaysia."*

Some students described this 'theory-practice' gap as stressful.

> *"Knowing what's ethically acceptable (and what is not) seems to only place pressure on us students."*

Cultural Relevance of Ethics Tutorials

Students were asked to comment on the following statement: "It is sometimes said that the way medical ethics is taught in Western countries is not culturally relevant or helpful in other cultures."

Some students agreed with the claim. They described being taught ethical ideals that could not be achieved in Malaysia. For some, these ideals were unattainable in the Malaysian context because of different understandings of the role of the family versus the individual. They described the Malaysian culture as "*family oriented*." As such, decisions about treatment are often made as a family rather than made by individuals.

> *"Medical ethics in the Western cultures tends to focus more on the individual patients. It's hard to apply that especially in Asian countries because here, patients and their families are one unit, treating them means 'treating' that whole group of people."*

Some students said that Asian cultures are underpinned by different ethical frameworks.

> *"What is ethical in the East may not be so in the West, mainly due to the religious, cultural and racial backgrounds."*

Interestingly, most students indicated that they believed that many principles in medical ethics are shared across cultures. They said that the values taught in the ethics tutorial were universal and relevant across all cultures.

> *"I don't think this [statement] is true because no matter where we are practicing, we are still dealing with human patients with the same human rights and feelings. The way we treat them should not be any different. The respect and care we show them should not be determined by race or culture. However, with that said, there are of course additional cultural issues to be considered while the main principles remain the same."*

One student strongly rejected the notion of culturally specific values as a justification for less than ideal medical practice.

> *"I think the claim [that western ethics is not culturally relevant] can be used as an excuse to ignore some important ethical standards in this country. However, I believe the ethical views should be tailored to be relevant to Malaysia, taking into account barriers of language, socio economy, status, etc."*

Some students described the principles as "*roughly universal that can be applied regardless of location*," though the application of these principles was different.

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"The four main ethical principles need to apply to all patients; there should not be double standards. Nevertheless, the way it is practiced differs from country to country."

This suggests that the medical ethics curriculum needs to assist students to interpret the four principles for their particular contexts.

Ideas for Improving the Curriculum

Students were asked for their ideas for improving the medical ethics curriculum and making it more relevant to their clinical practice in Malaysia. Some students stated that the scenarios used in the tutorials were not always culturally relevant.

"Some of the issues with regard to religions and cultural issues (e.g. organ donation) are quite vague since these issues are handled completely differently in Malaysia."

Several students suggested that the scenarios would be more culturally relevant if they were based on local case studies. One student suggested that the clinical scenarios used to illustrate ethical issues need to be tailored to their "*real-life experiences.*"

"Using examples in scenarios that actually happened in Malaysia. This would make the scenarios more real."

Several students also suggested that the tutors could spend some time with students on the wards. They suggested using "*real scenarios*" that are relevant and applicable to the Malaysian context.

"Have classes in hospital with real scenarios. This will make it easier to discuss the issues."

One student suggested focusing more on conflicts between religious beliefs and medical practice.

"Religion plays a big role here. So perhaps the curriculum should look at the conflicts between religious beliefs and medical practice."

DISCUSSION

It has been argued that cultural differences between East and West make the adoption of Western ethical principles in Asia problematic (Tai and Lin 2001). Our findings suggest that students found the four principles approach useful as a framework for guiding their actions, identifying ethical issues, and reflecting on clinical experiences. While students identified specific cultural traditions in Malaysia that differ from those in the West, many students rejected the notion that these differences in traditions entail differences in ethical values.

Many students stated that the ethical values that the west prescribes for doctor-patient relationships are also appropriate in Malaysia. However, they identified difficulties in applying the four principles in an Asian context. Our data reveal the three types of difficulties in putting theory into practice. The first two issues are commonly experienced by medical students in all settings, and have previously been described. The third, however, illustrates issues specific to medical students in Malaysia that created a theory–practice gap.

Systemic Issues

Students identified lack of time and lack of resources as factors that undermined their capacity to practice the ethical ideals that they were taught. Institutional constraints have previously been identified as factors contributing to a theory–practice gap and as a cause of moral distress among health care professionals (Kälvemark et al. 2003; Maben et al. 2006; West and Tait 2007).

Professional Hierarchies

Students identified issues related to institutional hierarchies. They observed a disparity between the ideals and values taught, and those exemplified in every day practice by their role models and senior colleagues. Students described feeling disempowered to question their seniors about less than ideal practice, or to alter entrenched practices. This finding is consistent with earlier studies (Hefferman et al. 1999; Engel et al. 2006) and is an example of what Hafferty and Franks (1994) have described as the "hidden curriculum" (861). According to Hafferty and Frank, the hidden curriculum is a set of peer-sanctioned values, attitudes, and behaviors that may contrast with the content of the formal ethics curriculum. Hafferty and Frank describe the way in which students' clinical role models can have a powerful influence on students' ethical outlook through informal clinical processes.

Issues Specific to Cultural Context

Students identified some cultural practices and beliefs that created a tension between the framework that they had been taught and clinical practice in Malaysia. These included cultural understandings of truth telling, involvement of family in decision making, and the idea that the doctor knows best.

Students acknowledged that the ethical principles they were taught in Australia were appropriate to their clinical experiences in Malaysia. However, they suggested that in order to usefully apply these principles, the medical ethics curriculum needs to be more sensitive to the cultural context. They made a number of suggestions to improve the applicability of the curriculum.

Many of the students' responses indicated their attempts to negotiate between universal values and cultural traditions. This supports Macklin's approach to the "East–West" debate, and her claim that it is possible to mediate between "the universal" and "the particular" (1999).

The debate over the application of the four principles approach is frequently couched as a tension between the acceptance of either universal values or cultural norms (reviewed in Hongladarom 2008). However, some scholars suggest that cultural norms do in fact embody universal

values. Nie (2005) cites Confucianism and Daosim as examples of universal prescriptions intended for all people, both Chinese and non-Chinese. Similarly, Tsai (1999) argues that Western values are not at odds with Asian norms. Tsai explored the cross-cultural plausibility of the four principles and showed that these values are clearly identifiable in ancient Chinese medical ethics dating back to literature from 581 AD.

Macklin (1999) argues that it is a common mistake of both critics of principlism and defenders of cultural relativism to presume that principlism is insensitive to social context. While the four principles have a universal domain of applicability, they are broad and require interpretation (Macklin 1999). Our research findings, in particular students' suggestions for improving the medical ethics curriculum, support Macklin's claim that principlism can be sensitive to social context.

According to Macklin (1999), there is no opposition between universal principles and cultural particulars but rather a complementary function: "To apply any 'abstract' ethical principle, it is first necessary to look at the social context, to take account of who stands to be affected and in what ways, and to factor in a large array of particular circumstances" (48).

Similarly, Nie (2000; 2005) argues that simply applying ethical principles developed in a particular moral tradition to other cultural settings, or merely respecting cultural differences in local settings, is both practically dangerous and theoretically impossible. Like Macklin, Nie suggests that bioethics must find a way to address both what really matters locally and the universal moral values we share. He argues that "interpretative cross-cultural bioethics promotes a richer dialogue than generally occurs among different medical moral traditions" (Nie 2000, 256). Our research illustrates the beginning of such a "dialogue."

The aim of this study was to examine the cultural relevance of implementing an Australian medical ethics curriculum in Malaysia. Our findings suggest that this curriculum, based on the four principles approach, is both relevant and appropriate to medical students in Malaysia. However, our data illustrate some of the difficulties that the students experienced in the application of their ethical education. The main finding was the gap that students experienced between "universal" ethical theories and some of the cultural values and practices that they encountered in the clinical environment.

To close this theory–practice gap, medical ethics education needs to take into account students' cultural contexts. According to Macklin, "the ways of understanding and implementing general principles are numerous and can take different forms in different contexts, countries or cultures" (1999, 48). Our project demonstrates that the implementation of the four principles approach would benefit from culturally specific scenarios to elucidate the broad principles. Improving the cultural relevance of teaching materials may foster ethics education that is more applicable to Malaysian clinical practice. ■

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