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### Ethics in medical decision making: an intercultural outlook

*La ética en la toma de decisiones médicas: una perspectiva intercultural*

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#### ABSTRACT

In the climate of globalization, the choice dilemma is complicated by ethical conflicts that exist in multicultural contexts. This article investigates the capacity criteria across cultures and the boundaries of delegating responsibility for the patient's health to other people. The attitude towards euthanasia was taken as a marker to trace differences. Statistical analysis of euthanasia acceptability in 2017 involved Western civilizations, according to Huntington. The analysis showed a high prevalence of euthanasia in the Netherlands (48%) and the lowest prevalence in the United States (2%) and Canada (2%). Religious beliefs have a direct effect on ethics in decision making.

**Keywords:** Ethical Decisions, Euthanasia, Globalization, Prevalence.

#### RESUMEN

En el clima de globalización, el dilema de elección se complica por los conflictos éticos que existen en contextos multiculturales. Este artículo investiga los criterios de capacidad entre culturas y los límites de delegar la responsabilidad de la salud del paciente a otras personas. La actitud hacia la eutanasia se tomó como un marcador para rastrear las diferencias. El análisis estadístico de la aceptabilidad de la eutanasia en 2017 involucró a las civilizaciones occidentales según Huntington. El análisis mostró una alta prevalencia de eutanasia en los Países Bajos (48%) y la prevalencia más baja en los Estados Unidos (2%) y Canadá (2%). Las creencias religiosas tienen un efecto directo sobre la ética en la toma de decisiones.

**Palabras clave:** Decisiones éticas, Eutanasia, Globalización, Prevalencia.

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## INTRODUCTION

Culture has a profound influence on how ethical decisions are made in critical situations in medicine. What is considered as right or wrong in the healthcare setting may depend on the socio-cultural context (Chattopadhyay & Simon: 2008). As a source of exchange, innovation and creativity, cultural diversity is as necessary for humankind. In this sense, it is the common heritage of humanity but it cannot be used as a pretext for infringing on human rights and fundamental freedoms.

The fast-growing multicultural world requires physicians and physiotherapists to understand different cultures in order to make right ethical decisions and work effectively with people possessing different values, beliefs and ideas about health, care, illness, death and disability. There are at least 2500 cultures and subcultures on Earth (Leininger & McFarland: 2006). Ethical principles for decision making in healthcare settings are to preserve and protect human life and health in the perinatal and postnatal periods, to prevent diseases, to restore health, and to reduce suffering from incurable diseases, at birth and death (Goloff & Moore:2019). There is a direct relationship between the level of competence of medical workers and their ability to provide culturally sensitive medical services (Minkoff:2014). Health professionals must have the skills to resolve ethical dilemmas. Primarily, they must be able to effectively communicate and understand the unique cultural values and beliefs of each client/patient, to respect cultural differences, and to make decisions that will meet the needs of each client/patient thoughtfully and effectively.

A common ethical dilemma arises when respect for autonomy and cultural sensitivity collide (Donate-Bartfield & Lausten: 2002). Bioethics is one the areas of applied ethics that aims at reflecting, discussing and resolving moral dilemmas in medicine (Johnstone: 2019). Traditionally, the following practices are distinguished as those raising questions about the moral and ethical background of decision making:

- Abortion (the induced ending of pregnancy);
- Euthanasia (the practice of ending the life of a person who is experiencing unbearable suffering from an incurable disease, at his/her request);
- Homotransplantation (lifetime organ removal);
- Allotransplantation (the use of organs from dead people);
- Surrogate motherhood (gestation and childbirth, including premature birth, under a contract between a gestational carrier and potential parents, whose sex cells were used for fertilisation) (Drabiak et al.: 2007; Mautner: 2009).

The moral meaning and assessments of good and harm are deeply influenced by culture; examples include general acceptance of euthanasia in the Netherlands and Belgium, African practices of female circumcision, the prohibition of sex-selection in India (Chattopadhyay & De Vries: 2012).

Making ethical decisions to resolve ethical dilemmas is a hard process for health professionals to deal with. Decision-making depends on many factors, such as ethical principles, morality, values, beliefs, standards, legal issues, personal and professional experience (Coward & Ratanakul: 2006). In other words, decision-making depends on the cultural context.

A decision maker should follow a sequence of logical steps to guide and support all participants in medical practice (Louw: 2016). The growing number of elderly people poses many economic and ethical problems for modern society, among which euthanasia is the most debatable and burning (Brogden: 2001). The question of whether euthanasia should be legal is one of the hotly debated issues that revolve around decisions.

The contradictions of euthanasia are, in fact, the contradictions of ethics and morality. In theory, there are two types of euthanasia: passive (the deliberate cessation of patient's maintenance therapy by a physician) and active (administration of drugs or other means of producing death). The physician-assisted suicide is often referred to as active euthanasia with medical assistance (administration of lethal drugs at patient's request)

(Jha et al.: 2015; Nikolaeva et al.:2018). Factors that have a great influence on people's attitudes toward euthanasia include cultural and religious beliefs, age and gender (Ramabele: 2004).

The most relevant research on issues related to euthanasia was conducted mainly in the United States and Europe, since these countries began to discuss government policy on its legalisation (Wasserman et al.:2015). Another work targeted various end-of-life issues, including euthanasia. Relatively recent studies were conducted in Iran, Turkey, Japan, Hong Kong, Sudan, India, Kuwait, and Pakistan (Abbas et al.: 2008; Wasserman et al.: 2015).

In the climate of globalization, health practitioners urgently have to understand the bioethics of different cultures. The ability to take cultural cues in the healthcare setting may result in an improvement in the patient's quality of life, especially during difficult times. The health care provider needs to know to look for similarities to overcome differences and to know what differences require sensitivity. As an interdisciplinary problem, euthanasia is investigated by lawyers, sociologists, philosophers, and physicians.

Recent research and publications on the matter are just beginning to accumulate in the literature; the problem is far from the final resolution. The right to life is the right of every person protected by the state. The States are doing everything so that human life was out of danger (Zhuravlev & Yurevich: 2013). There is much to say about the right to life, but now humanity is confronted with another question: does a person have the right to die? Does the guaranteed right to life imply the right to independently decide on the end of this life? To what extent can a patient delegate this right to other people, in particular to his/her close ones? Therefore, the issue of ethical decision-making in medical setting within the intercultural context is undoubtedly relevant. Thus, *the purpose of this article* is to analyze and investigate capacity criteria across cultures, as well as the boundaries of delegating responsibility for the patient's health to other people.

## 1. METHODS

For convenience, the generally accepted Huntington's classification of civilizations was used (Figure The division of world cultures is below:

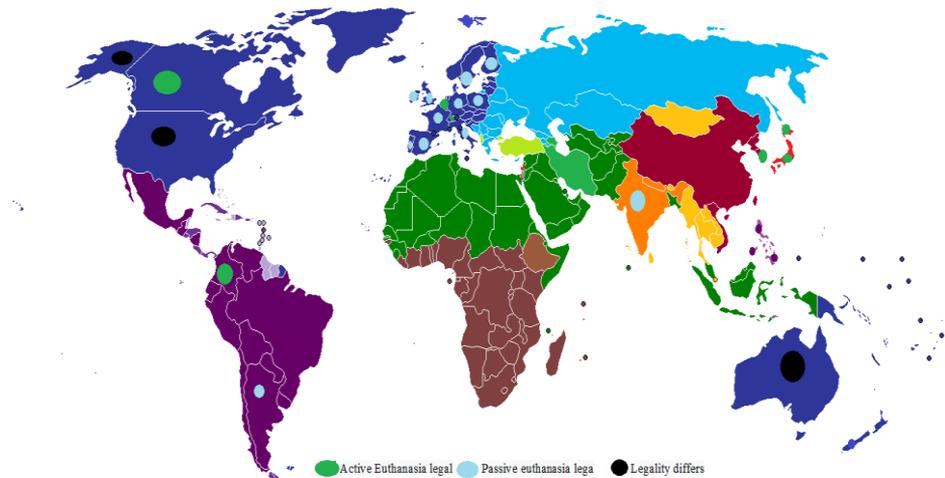
1. Orthodox civilization, turquoise blue;
2. Western civilization, dark blue;
3. Islamic civilization, green;
4. Hindu civilization, orange;
5. Confucian civilization, dark red;
6. Japanese civilization, bright red;
7. Latin American civilization, purple;
8. African civilization, brown;
9. Buddhist civilization, yellow.

To analyze differences in decision making in Western culture, statistical analysis was applied to data from open sources as of 2017. The following countries were selected for analysis: the USA, Netherlands, Canada, Belgium, and Switzerland. Data were taken from The Third Portal, the Sigrid Dierickx 2016, and the Third Interim Report on Medical Assistance in Dying in Canada.

Obviously, there is no opportunity to study all the existing practices of euthanasia that were held in different countries and cultures. The cases were selected by the principle of minimum difference. Some ethical dilemmas in decision making, such as eugenics, abortion, homo- and allotransplantation, remain unresolved. These problems deserve a separate study because of scale.

## 2. RESULTS

Figure 1 demonstrates that in Western culture, namely in Canada, the USA, Germany, Sweden, Switzerland, Germany, Belgium, the Netherlands, Italy, Spain, Portugal, and Australia, people are the most tolerant to euthanasia.



**Figure 1.** Euthanasia prevalence across Huntington's civilizations

The above listed countries have a highly developed economy, a reference point for progress in medicine. In *Western culture*, personal autonomy and the right to self-determination are essential. In Medicine, this moved the focus to the empowerment of the patient as an active participant in the decision-making process, including at his/her end of life. People have the opportunity to make informed decisions about their own interests.

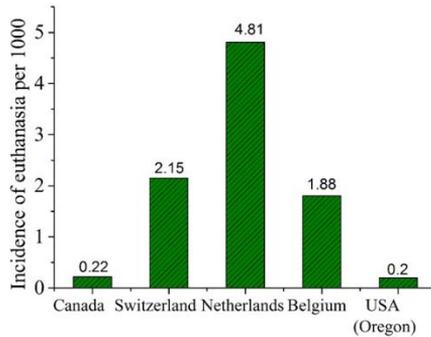
In India, euthanasia practice was implemented only in 2018. Family, especially the head of the family, plays a crucial role in making a decision to end someone's life. In public hospitals, healthcare is paid for by the state, so the decision to stop the life-sustaining therapy may depend on another patient in need waiting in line. There are cases when a decision may be affected by economic constraints and by the understanding that a chose treatment is futile, especially when there is no hope of recovery or cure. Because the family is the locus of decision-making, highly respecting the doctor, it is difficult to imagine serious disagreements between them regarding the decision (not) to withhold the life-support system (Shekhawat et al.: 2018).

North and South Korea are an excellent example of the culture's influence on ethical decision-making in medicine. Initially, they were the same Confucian cultures, but after the division at the 38th parallel, South Korea fell under the influence of the Western culture. This influence can be traced by the attitude towards euthanasia. Historically, the influence of Western culture on South Korea was a matter of survival. Military and technical assistance from Western countries prevented South Korea from being defeated in a war with its communist neighbors.

The Islamic culture does not practice euthanasia for religious reasons. The mercy killing is ethically wrong and falls under the broader guidelines from the Quran and the Sunnah. Islam teaches that if Allah gives life, then he has the absolute power to take it back.

In African culture, euthanasia is not practiced, even in economically developed South Africa (Figure 1). There were attempts to legalize it under the influence of the West, but euthanasia was excluded from options for terminal patients because it "contradicts the Doctor's Oath.

In the Orthodox culture... In Russia, for example, euthanasia is also not legal. Discussion on euthanasia is often a response to demands made by euthanasia supporters in Western Europe and the USA. Russia stands out from Western countries with the reaction it has to this problem. Data in Figure 1 shows that in *Latin American culture*, only two countries practice euthanasia: Colombia and Argentina. The Colombian culture formed under the influence of traditions and customs of local Indians and immigrants from Europe (Spaniards) and Africa. Thus, Colombia is a multicultural country, where each region has unique characteristics. The majority of the population professes the Catholic faith, as in the countries of the Western culture.



**Figure 2.** Euthanasia prevalence across Western civilizations in 2017

Disagreements in making ethically correct decisions in medicine exist not only at the ethno-cultural level. The Netherlands take the lead in the prevalence of euthanasia (48%), while in the United States and Canada, this indicator is the least (2%) (Figure 2). This result indicates that the Netherlands is one of the first to legalize euthanasia. One may also see the prolonged influence of the so-called “Protestant Ethic” in this (Riesebrodt, M., 2016, pp. 55-84). In the USA, euthanasia was allowed in 5 states. The United States, however, distinguishes passive euthanasia from active euthanasia.

### 3. DISCUSSION

Now, some issues surrounding decision making in bioethics remain debatable. The right decision in healthcare can save lives. Out of the 18.975 terminal patients identified as likely dying within a few hours or days, 10.8% either stabilised or improved. The researchers concluded that even in the context of palliative care, it is not easy to confirm the diagnosis with absolute certainty (Clark et al.: 2016). A wide variety of research studies suggest that breakdowns in the diagnostic process result in a staggering toll of harm and patient deaths. These include autopsy studies, case reviews, surveys of patients and physicians, voluntary reporting systems, using standardised patients, second reviews, diagnostic testing audits, and closed claims reviews. A study relating to forecasts made for terminal patients showed that only 20% of them were spot on (within 33% of the actual survival time) (Berner & Graber: 2008).

Among scientists, there is no fully positive attitude towards euthanasia. In a study of medical attitudes towards euthanasia in Iran, it was found that because of religious and cultural context, nurses did not consider euthanasia acceptable under any circumstances (Alborzi et al.: 2018). One of the main pro-euthanasia arguments is based on the right to self-determination and on the principle of autonomy. Supporters argue that people have the right to control their own body. Therefore, a capable person must be able to determine when and how he/she will die (Tham et al.: 2017). Religious and medical views are indeed different and may conflict, although in general, they should not be contradictory.

Traditional African American folk beliefs about health and disease focus on herbal remedies and the magical aspects of a disease (Eiser & Ellis: 2007). Many religious groups, especially Muslims, are now spread throughout the world. Considering the growing trend of globalization, it is important that health systems take into account the religious beliefs of a wide range of ethnic and religious groups of people when considering abortions and killing (Bülow et al.:2008). The issue relating to the principles of ethics and morality of bioethics remains open. Scientists show that their results are in conflict with the common morality hypothesis of Beauchamp and Childress, which would imply domain-independent high morality ratings of the principles. Their findings support the suggestions by other scholars that the principles of biomedical ethics serve primarily as instruments in deliberated justifications, but lack grounding in a universal "common morality" (Christen et al.: 2014, p.47).

## **CONCLUSION**

Culture has a profound influence on how ethical decisions are made in medicine. In Western culture, euthanasia is most welcome. Upon that, there are differences within the culture. Islamic, African and Orthodox cultures reject euthanasia completely, so in the healthcare system of these countries, ethical decision-making is in the red. In bioethics, religion is the most influential; the attitudes towards the patient's personal needs are also essential, though. The statistical analysis showed that euthanasia is most often practiced in the Netherlands (48%), and least in the USA (2%). Thus, medical decisions must be made in an ethical context. Our previous studies show racial and ethnic differences in death preferences that make up cultural barriers.

## **BIBLIOGRAPHY**

- ABBAS, SQ, ABBAS, Z & MACADEN, S (2008). "Attitudes towards euthanasia and physician-assisted suicide among Pakistani and Indian doctors: A survey", *Indian Journal of Palliative Care*, 14, pp.71–74.
- ALBORZI, J, SABETI, F, BARAZ, S, MILADINIA, M, SAIDKHANI, V & SHARHANI, A (2018). "Investigating of Moral Distress and Attitude to Euthanasia in the Intensive Care Unit Nurses", *International Journal of Pediatrics*, 6(11), pp. 8475-8482.
- BERNER, ES & GRABER, ML (2008). "Overconfidence as a cause of diagnostic error in medicine", *The American journal of medicine*, 121(5), pp.2-23.
- BROGDEN, M (2001). *Geronticide: Killing the elderly*, Jessica Kingsley Publishers.
- BÜLOW, HH, SPRUNG, CL, REINHART, K, PRAYAG, S, DU, B, ARMAGANIDIS, A & LEVY, MM (2008). "The world's major religions' points of view on end-of-life decisions in the intensive care unit". *Intensive care medicine*, 34(3), pp. 423-430.
- CHATTOPADHYAY, S & DE VRIES, R (2012). "Respect for cultural diversity in bioethics is an ethical imperative", *Medicine, Health Care and Philosophy*, 16(4), pp. 639–645.
- CHATTOPADHYAY, S & SIMON, A (2008). "East meets West: Cross-cultural perspective in end-of-life decision making from Indian and German viewpoints", *Medicine, Health Care and Philosophy*, 11(2), pp. 165-174.
- CHRISTEN, M, INEICHEN, C & TANNER, C (2014). "How "moral" are the principles of biomedical ethics?—a cross-domain evaluation of the common morality hypothesis", *BMC medical ethics*, 15(1), p. 47.

- CLARK, K, CONNOLLY, A, CLAPHAM, S, QUINSEY, K, EAGAR, K & CURROW, DC (2016). "Physical symptoms at the time of dying was diagnosed: A consecutive cohort study to describe the prevalence and intensity of problems experienced by imminently dying palliative care patients by diagnosis and place of care", *Journal of Palliative Medicine*, 19(12), pp. 1288-1295.
- COWARD, H & RATANAKUL, P (2006). A cross-cultural dialogue on health care ethics, Wilfrid Laurier Univ. Press.
- DONATE-BARTFIELD, E, & LAUSTEN, L (2002). "Why practice culturally sensitive care? Integrating ethics and behavioral science", *Journal of Dental Education*, 66(9), pp.1006-1011.
- DRABIAK, K, WEGNER, C, FREDLAND, V & HELFT, PR (2007). "Ethics, law, and commercial surrogacy: a call for uniformity", *The Journal of Law, Medicine & Ethics*, 35(2), pp. 300-309.
- EISER, AR & ELLIS, G (2007). "Cultural competence and the African American experience with health care: The case for specific content in cross-cultural education", *Academic Medicine*, 82(2), pp. 176-183.
- GOLOFF, N & MOORE, T (2019). "A Case Study in Cross-cultural Health Care and Ethics: Who Decides What Is in the Child's Best Interest?", *Journal of Hospice & Palliative Nursing*, 21(1), pp. 8-13.
- JHA, V, MCLEAN, M, GIBBS, TJ & SANDARS, J (2015). "Medical professionalism across cultures: a challenge for medicine and medical education", *Medical teacher*, 37(1), pp. 74-80.
- JOHNSTONE, MJ (2019). Bioethics: a nursing perspective, Elsevier Health Sciences.
- LEININGER, MM & MCFARLAND, MR (2006). "Culture care diversity and universality: A worldwide nursing theory", *Jones & Bartlett Learning*.
- LOUW, B (2016). "Cultural Competence and Ethical Decision Making for Health Care Professionals", *Humanities and Social Sciences*, 4(2), pp. 41-52.
- MAUTNER, MN (2009). "Life-centered ethics, and the human future in space", *Bioethics*, 23(8), pp. 433-440.
- MINKOFF, H (2014). "Teaching Ethics: When Respect for Autonomy and Cultural Sensitivity Collide", *American Journal of Obstetrics and Gynecology*, 210(4), pp. 298-301.
- NIKOLAEVA, YV, GRIMALSKAYA, SA, PETROSYANTS, DV, ZULFUGARZADE, TE, MAYSTROVICH, EV, & SHESTAK, VA (2018). "Philosophical View of Multiculturalism in Modern European Cinematography", *European Journal of Science and Theology*, 14(6), pp. 205-214.
- RAMABELE, T (2004). Attitudes of the elderly towards euthanasia: A cross-cultural study, (Doctoral dissertation, University of the Free State).
- RIESEBRODT, M (2016). "Dimensions of the Protestant Ethic" In *the Protestant Ethic Turns 100*, Routledge, pp. 55-84.
- SHEKHAWAT, RS, KANCHAN, T, SETIA, P, ATREYA, A & KRISHAN, K (2018). "Euthanasia: Global Scenario and Its Status in India", *Science and engineering ethics*, 24(2), pp. 349-360.
- THAM, J, KWAN, KM & GARCIA, A (2017). Religious perspectives on bioethics and human rights, (Vol. 6). Springer.
- WASSERMAN, JA, AGHABABAEI, N & NANNINI, D (2015). "Culture, Personality, and Attitudes Toward Euthanasia", *OMEGA - Journal of Death and Dying*, 72(3), pp. 247-270.

ZHURAVLEV, AL & YUREVICH, AV (2013). "The psychology of morality as a field of psychological research", *Russian Journal of Psychology*, 34 (3), pp. 4-14.

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