Introduction

Today we are not only living in an age of globalized information technology but also in a time of cultural and religious pluralism. This pluralistic society requires a rethinking of the nature of ethical medical practice and a reexamination of medical education programs to ensure culturally sensitive and ethically responsive practitioners for the future.

Medicine as a culture

Any discussion of culture must begin with the recognition that medicine is a culture. Although practition-
ers within medicine may differ, they share a common body of knowledge, history, value system, rules and norms. As a group, medical practitioners share common circumstances and conditions, and have developed particular ways of acting in relation to those conditions. As a culture, medicine holds extraordinary knowledge that is of great human importance. In return for access to this special knowledge, society accords the medical culture special rights and privileges, including the power to determine the practice and regulation of bestowing the special knowledge it holds. As a result, medicine’s cultural knowledge serves as a form of power in the larger society.

To illustrate the significance of medical culture to ethically responsive practice and to highlight the implications for medical education the discussion begins with a case example. The case of K’aila involves one of the most difficult problems in pediatric ethics, namely, a parent’s refusal of life-saving treatment for a child. Although religious and cultural beliefs influence all stages of pediatric care, it is when life-saving treatment is refused for a child that the issues involved are highlighted. When a case ends up in the courts, the saving of a child’s life is usually supported over and against the parents’ religious or cultural beliefs on the grounds that children have a right to mature into autonomous persons who can then choose their own beliefs. The case of the Aboriginal baby K’aila, in which the parents refuse a liver transplant for their child for spiritual reasons, challenges the usual approach in biomedicine and the courts. A detailed discussion of this case can be found in chapter 10 of A Cross-Cultural Dialogue on Health Care Ethics. The following discussion is based on that chapter.

Case summary

K’aila was born at home in an Aboriginal community in Alberta. At 3 months he was examined by a pediatrician who made a diagnosis of abnormal liver function requiring a liver transplant. The pediatrician explained to K’aila’s parents that liver transplantation was a standard therapy with an 80% to 85% survival rate and he urged them to allow K’aila’s name to be placed on a transplant centre’s active waiting list. However, K’aila’s parents, following their own spiritual beliefs, expressed serious worries over the proposed liver transplant. From their perspective they would be committing a grave error if they tried to recreate their son’s body using an organ from another person, which according to Aboriginal beliefs would bring with it the spirit of the other person. K’aila’s parents based all of their daily decisions on their Aboriginal spiritual beliefs.

K’aila’s parents were well educated. As time passed they felt pressure to approve transplantation for K’aila. However, with the help of others they studied about transplantation and its problems of rejection and susceptibility to infection. In their view the 5-year survival rate after transplantation looked close to 60% to 65%. This information, together with their Aboriginal cultural beliefs, led them to finally tell the pediatrician that they would refuse a transplant for their son. Their doctor, with his different biomedical cultural perspective, found it difficult to accept the parents’ decision. Consequently, the pediatrician reported the situation to the Alberta Department of Social Services with the desire that K’aila be taken from his parents so that a transplant could be performed, enabling K’aila to live long enough to mature and make his own autonomous life decisions (consistent with the doctor’s cultural perspective). The parents, however, avoided this result by leaving Alberta and going to the neighbouring province of Saskatchewan. The pediatrician reported this to the Alberta Department of Social Services who contacted the Department of Social Services in Saskatchewan. In Saskatchewan, a court application was made requesting that K’aila be taken into custody so that a liver transplant could be performed without the parents’ consent. In the end the court rejected the application for custody and upheld K’aila’s parents’ right to make their own decision — not because of their spiritual beliefs but because of uncertainty over the side effects and ultimate outcome of the liver transplant. The parents returned to Alberta with K’aila and lived at their home until his death at 11 months.

Case discussion

The pediatrician, from his biomedical cultural perspective, and K’aila’s parents, from their Aboriginal
spiritual approach, were both seeking K’aila’s best interests. From the pediatrician’s biomedical perspective a liver transplant was the best way to avoid the harm that would result if K’aila’s liver dysfunction was allowed to run its course. But from K’aila’s parents’ perspective, the harm entailed in the transplant was not offset by the possible benefits. The parents’ judgement was also coloured by their Aboriginal understanding of how one’s spirit functions in relation to one’s body and its organs, along with their reasoned evaluation of the risks and benefits associated with organ transplantation. The conflict between physician and parents was not about whether to pursue K’aila’s best interests — both were attempting to do this. The conflict was over what K’aila’s best interests were when seen from different cultural perspectives (remembering that modern biomedicine is itself one cultural perspective among others such as Aboriginal spirituality). In addition, in this case there was a conflict of authority: medical versus parental. Parental authority is ethically and legally based on the parents’ responsibility to love and care for their children, including looking out for their children’s best interests. A physician’s authority depends on the acceptance that physicians have specialized knowledge to give accurate diagnoses and prescribe treatments when the expected benefits outweigh reasonable risks. Both of these conceptions of authority (that of the parents and that of the physician) are culturally contextualized, and in this case the cultures were very different, resulting in an authority conflict.

In health care, it is often through the parents’ attempts to do what is in the best interests of their children that values, different from those assumed in the biomedical, cultural perspective, manifest themselves. Physicians need to be aware of the value assumptions embodied in their biomedical approach and be sensitive to the values assumed in the spiritual and cultural worldview within which the parents are attempting to live their lives. This is clearly manifested in the following account of K’aila’s parents’ struggle to reach a decision, a struggle that in its analysis engaged both the biomedical and the Aboriginal perspectives.

The parents’ very articulate defence of their refusal was based on both the unacceptability of the outcome and the means to achieve the outcome. They argued that post-transplantation life was potentially more of a harm than a benefit. The harm they described was in part attributed to the clinical uncertainty of outcome and the effects of immunosuppressant drugs. But another part of the harm that they sought to avoid was the spiritual impoverishment of fighting to keep K’aila alive by “recreating h.” Kaila’s mother described her son as a beautiful butterfly that had landed in her hands, but whose presence could only be prolonged by tightening a grip that would destroy all that was beautiful. The spiritual impoverishment of the transplant was a critique of the means recommended to preserve K’aila’s life. The moral harms of the transplant involved the use of another person’s organ, the suppression of the body’s natural rejection of the new organ, and the suffering involved in the procedure, recovery, and long-term effects of immunosuppressants. These combined to present a picture of saving life at all costs, where Kaila’s parents drew on their spiritual values and judged that the costs were too great.1

In this case the court sided with the parents — not because recognition was given to spiritual values of their Aboriginal culture (upon which they based their parental decision-making authority for K’aila), but because, from the Eurocentric biomedical cultural perspective, the potential benefits of a liver transplant did not sufficiently outweigh the potential harms. However, with technologic medical advances in the management of immunosuppression, the court decision would likely go the other way, ignoring the values embodied in the Aboriginal spiritual perspective upon which the parents were attempting to care for their son.

The K’aila case suggests that conflict is likely in Canadian health care delivery. As illustrated in this example, there is an essential link between culture, power and ethics. The ability of people to express their culture is related to their collective power in society and to the power they are able to exercise in a particular social context. In the case of K’aila’s parents, the culture of medicine wielded more power and authority. The differences between their culture and the medical culture became a site of struggle in which the legitimization and production of particular forms of knowledge and experience created central areas of conflict. During the legal battle to resolve this conflict, the authority of medical knowledge was a given.
Even though their decision not to accept transplantation was largely based on their cultural and spiritual beliefs and values, the legal battle was waged within the domain of medical discourse. Their cultural and spiritual beliefs were “other” than the Eurocentric culture of western medicine and therefore did not hold authority in the medicolegal system of ethical decision-making.

**Implications for medical education**

Overall, K’aila’s case shows how culture and ethical practice is intimately connected with the structure of social relations that produce forms of oppression and dependency. Culture is not simply a way of life for a particular group of people but is a process of “production through which different groups in either their dominant or subordinate social relations define and realize their aspirations through unequal relations of power.” The conflict created by the cultural differences revealed what knowledge was given authority, who had power and how power relations were reproduced and manifested during what was deemed to be an ethical decision-making process. In this way, the conflict revealed the strong link between culture, power and ethical medical practice.

This essential link between culture, power and ethical medical practice means that medical education must move beyond technical rationality and instrumentalization of knowledge that erases questions of power, culture and ethics. K’aila’s case exemplifies the real world of “messy indeterminate” medical practice. Falling outside the categories of existing theory and technique, the application of medical theory and scientific “truth” is not a straightforward process. Medical practitioners are placed in the position of having to improvise. For example, although ethical theory may have directed the physician to act in K’aila’s “best interest” it was the “best interest” that became the site of conflict when K’aila’s parents disagreed with the physician’s idea of what constituted “in the best interest.” Schon describes that as the practitioner improvises to name and frame the problem, certain things are noticed and attended to. What is noticed is a product of the disciplinary knowledge of the practitioner as well as the political, social and economic perspectives he or she brings to the situation. In K’aila’s case, the physician named and framed the problem based on one of medicine’s cultural values — that of preserving physical life. K’aila’s case exemplifies how the cultural definitions and values internalized during the medical educative process provided the constitutive rules for the physician’s later ethical decision-making practice.

If medical schools are to create culturally sensitive and ethically responsive practitioners, medical education can no longer be a matter of deciding what theory to teach and what teaching strategies to use to impart that theory. Fundamentally, education of culturally sensitive, ethically responsive medical practitioners requires the following: (a) an understanding of how the educative process joins medical knowledge and power; (b) the development of a pedagogy that can bring questions of power, culture and ethics to the forefront during the process of medical knowledge construction; and (c) the opportunity for students to learn how to work collaboratively with diverse cultures and values. Overall, the educative process requires a conscious consideration of the culture, power and ethics of medicine and how these play out in clinical practice.

**Conclusions**

All medical education involves the learning and teaching of medical culture and ethics. Although cultural and ethical theory may be presented as “content” at some point in the medical curriculum, every interaction between students and educators is a lesson in culture and ethics. Because culture, power and ethics are so integrally connected, the capacity to practise ethically rests upon having an awareness of the ways in which power is structured into the cultural practice of medicine. To become ethical practitioners, medical students require the opportunity to develop an awareness of the social positioning of medicine, including the various forms of power that medicine as a culture holds, and raise critical questions about the power that they as medical practitioners are being “educated” to hold. Without such awareness, medical practitioners may not possess the necessary knowledge or skills to make ethically informed and culturally sensitive choices in the current pluralistic society.
References


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