

## From the Editors

In his book, *Illness and Culture in the Postmodern Age* (University of California Press, 1998), David B. Morris offers a biocultural model in which illness, with its biological and cultural components, always stands at the crossroads of both biology and culture. Given Morris's point that illness is a biocultural construct, it follows that individual and institutional decision-making in healthcare also involve a biocultural construct that experience suggests is too often overlooked, to the detriment of all decisionmakers. In the following Special Section, "Culture, Health, and Bioethics," the authors explore the importance of understanding the cultural processes and concomitant challenges that necessarily play a crucial role as patients, providers, and policymakers grapple with healthcare decisions.

In their paper, "Cultural Collisions at the Bedside," Gorlin, Strain, and Rhodes sound the alarm that front-line physicians are currently being given the impossible task of simultaneously: respecting cultural diversity, supporting autonomy, providing medical care in the best interest of their patients, and attending to cost containment. No one would argue that these are not all noble goals, but in the words of Isaiah Berlin, "Some among the Great Goods cannot live together." The authors challenge society to accept responsibility for deciding that some values will sometimes be compro-

mised and to decide which values will be shortchanged. To continue as if no values need be sacrificed is unfair to those who are suffering the burden of society's bad faith.

Recognizing the need for a means of making the practice of ethics consultation in a pluralistic setting morally sound, authors Carter and Klugman argue for an expanded use of the interpretive methods employed in the social sciences as a key to understanding the interactions between culture, health, and bioethics. Their cultural engagement model offers an approach to enlarge the function of the clinical ethicist from one of problem solving and dispute resolution to a larger role as facilitator of cross-cultural diplomacy.

These problems of culture and bioethics are crystallized in the paper by Hernández-Arriaga, Aldana-Valenzuela, and Iserson in their examination of the clash of Mexico's traditional Catholic and secular values with the religious practices of the Jehovah's Witnesses—an import from the United States and one of Mexico's fastest growing religious groups. However, anthropologist Susan Orpett Long cautions that, even within more homogenous groups, ethical debate may not be readily resolved because the culture itself contains mixed messages and symbolically ambiguous terminology that affect individuals in varying ways in their daily lives. Understanding the complexity of ordinary experience and the often inconsistent

values of “real people” is critical if we are to find our way in the complex landscape of ethical dilemmas.

In “Informed Consent: Does It Take a Village?” Kuczewski and McCrudden point out that some bioethicists suggest that contemporary medical ethics is biased toward values of individual rights and self-determination, with the result that biomedical ethics may be ill equipped to deal with patients from cultures that do not share these values. For instance, families of persons from less individualistic cultures sometimes request that the physician not provide bad news to patients. These authors argue, however, that the process of informed consent can only be waived by the patient. They base their argument on analyses of (1) the epistemology of clinical cultural relativism and (2) the role that the doctrine of informed consent plays within the culture of the clinic.

In his paper on bioethics in Eastern Europe, Prodanov addresses the issue of the internationalization of bioethics and he questions whether bioethics, as an American product, can be spread across the globe as easily as such Western commodities as Coca-Cola, fast foods, and trendy fashions. For societies that are struggling to re-create themselves, the cultural and political legacies of the region present challenges in maintaining important local

values while supporting the larger move toward democratic and humanistic relations in healthcare systems.

The increasing interest in a global bioethics is also the focus of Takala’s paper, which regards what she sees as the limitations of the four principles approach: the attempt to create a global framework for bioethics on the principles of autonomy, beneficence, non-maleficence, and justice. She contends that even if globally understandable, the principles are not the expression of a common moral language that is universally shared.

If taken seriously, then, the challenges of including globalization and multicultural perspectives in clinical and bioethics reasoning are daunting. Cultures give different weight to primary values, individuals within cultures are affected differently by their culture, and the concepts and methods of bioethics developed in one culture can be misapplied or even be disjunctive in another culture. Turning to the clinical practice of medicine across national boundaries to anchor ideas seems to make sense until we realize that approaches to disease are also culturally driven, as are the categories of illness themselves. Unpacking the importance of these insights will be the continuing task of medical ethics in the twenty-first century.