

# Ethical Issues of Decision Making and Communication in Health Care: An Intercultural and Interfaith Perspective

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## Abstract

The purpose of this research was to elucidate the main ethical issues that arise during decision-making and medical communication influenced by interfaith and intercultural differences. The statistical analysis of information retrieved from the United Nations official web site, as well as the analysis of secondary data taken from the literature sources, were applied to achieve the goal set. The outcomes of the study reveal that in Germany, Russia, and the United States, ethical problems in decision-making and communication in healthcare exist since the cultures and faiths of these countries' populations vary. Moreover, beliefs become more diverse due to the increasing number of migrants and medical tourists. It was found what ethical peculiarities of a particular religion can affect decision-making and communication during the provision of medical services to patients undergoing treatment in Germany, Russia, or the US. The results of the research can be applied in the scientific studies on ethical issues that arise in healthcare, as well as in the process of setting diagnosis, providing preventive care, treatment, transplantation, and euthanasia.

**Keywords:** bioethics, euthanasia, intercultural communication, interfaith communication, medical ethics, medical tourism, palliative care

## INTRODUCTION

Nowadays, a large number of religions exist in the world. The most popular ones are Christianity, Islam, Hinduism, Buddhism, etc... (East & Magus, 2018). As a consequence of globalization, many newly created religions have appeared. Thus, among the population of any country, there are representatives of various faiths (Piacentini *et al.*, 2019; Safonov, 2020). Each religion has its own beliefs. For example, the last days of life are perceived uniquely (Koval'ová, 2016). Ignorance of these peculiarities brings a number of difficulties in doctor-patient communication if they both are carriers of different cultures and faiths. For example, a lack of understanding makes the medical care process impossible (Piacentini *et al.*, 2019). In this perspective, the problem of doctor-patient interaction is not limited only to the language barrier. Various obstacles related to the process of health care delivery also exist. The moral and professional duty of a doctor is to provide the most effective medical treatment, using all necessary measures, even if they are contrary to religion. At the same time, a physician should convince the patient to

voluntarily accept this help, rather than knowingly deceive a person. Even if, after trying to be persuaded, the patient refuses treatment, the medical practitioner is obliged to accept this decision (Palazzani, 2018).

These days, many nations are faced with difficulties in communication in healthcare. Often, political decisions do not help doctors fulfill their professional duties. Thus, in some countries, it is forbidden to treat a patient who does not have health insurance (Kuczewski, 2017). In such cases, the physician faces stark choices: to follow his/her vocation and provide medical assistance to everyone who needs it or to be a law-abiding person. Despite the numerous discussions on the principles of healthcare ethics, many issues in establish-

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ing communication in this area remain unresolved because of specific cultural rules and beliefs. In this study, the available information about the most widespread religions and their peculiarities in the medical field was analyzed and systematized. These data are considered relevant for the decision-making process and doctor–patient interaction.

### Literature review

According to the United Nations (UN) organization, world population migration over the past 9 years has increased by 0.7%, which is 51 million people. Hence, in 2019, the number of international migrants globally estimated 272 million (The United Nations, 2019). What is more, in 2019, regionally, Europe hosted the largest number of international migrants (82 million), followed by Northern America (59 million), Northern Africa, and Western Asia (49 million). The United States remains the most popular among migrants, with about 51 million migrants living here. Germany and Saudi Arabia take second place (about 13 million persons with an immigrant background each), and the fourth is the Russian Federation, with about 10 million foreign citizens (The United Nations, 2019). People from different parts of the world come to these countries and start to live in a nation with a unique culture, religion, history, and model of communication with medical workers. As a result, more than 15% of residents with a diverse culture and beliefs live in the US and Germany, while about 8% reside in Russia (The United Nations, 2019).

Such migrants require medical support and assistance more than locals since the process of migration is often associated with stress (Joseph, 2016; O’driscoll *et al.*, 2017). Besides, the type of activity of migrant people is usually connected with high risks of injuring or getting sick (Demintseva & Kashnitsky, 2016). Migrants do not always seek medical help as soon as a need arises, thereby spreading, for example, infectious diseases to the others (Kuczewski, 2017; Mipatrini *et al.*, 2017). There are many reasons for such a delay. Among them are lack of registration and fear of being deported or repatriated (Rodriguez, 2019; Schumann, 2016), poor language skills, inability to explain the problem or fear of being misunderstood (Piacentini *et al.*, 2019, Periyakoil *et al.*, 2016), differences in religion, and mistrust to treatment methods that contradict one’s native culture (Walker & Lovat, 2017). The problems of medical communication are encountered not only by migrants but also by medical tourists (Hanefeld *et al.*, 2017). Often, these are people who are forced to ask for medical help outside their home country. This may happen because one cannot be cured at home, owing to the lack of sufficient equipment, specialists, and medicine (Adams *et al.*, 2017).

Medical workers are to help everyone who needs it. And in the case of treating patients from other countries, many challenges may arise. Even if the doctor knows a patient’s native language to some extent, communication may be ineffective and cause distrust to the physician. This might happen due to the fact that any language has nuances that are required to

know to achieve the desired result of a conversation (Cain *et al.*, 2018; Phipps, 2017). In such cases, communication should be carried out with the help of a properly trained interpreter, who is a specialist in medicine (Cain *et al.*, 2018). Interaction between a medical practitioner and a patient is affected by age, gender identity, education, degree of familiarity, culture, and their origin (Cain *et al.*, 2018). For this reason, doctors should be competent in cross-cultural issues to help a foreign patient solve health problems (Cain *et al.*, 2018).

Physicians ought to understand that people have inner dignity and cannot be compared (Walker & Lovat, 2017). For a successful recovery, it is necessary not only to make every effort to comply with the protocols but also to remember about the influence of the patient’s psychological state on the treatment effectiveness (Cain *et al.*, 2018). Recently, for example, in the US, elective practices introducing medical workers to programs and peculiarities of healthcare systems of different countries have appeared at the medical faculties of many universities (Harrison *et al.*, 2016).

### Problem statement

The presence of diverse cultures and religions, as well as the ability of their representatives to cross the borders and continents, leads to the concentration of individual beliefs on each territorial unit. In turn, the unhindered movement of citizens around the world leads to the spread of many diseases, for which immediate medical care is often required. In addition to language knowledge or the presence of an interpreter, trust to the physician is essential to achieving a high level of mutual understanding. Knowing the characteristics of the religious and cultural values of representatives of a particular country will contribute to achieving such trust.

This study was aimed at revealing ethical issues that may arise when making decisions and establishing healthcare communication in the light of interfaith and intercultural differences. The experience of Germany, Russia, and the US were considered in the process of examination. To achieve the goal set, it was necessary to solve the following tasks:

1. Determine which religions were professed in the examined countries and which have appeared recently in view of residents’ migration.
2. Discover with representatives of which religions medical communication occurs as a result of medical tourism.
3. Identify those features of religions that affect the ethics of decisions and medical communication.

### MATERIALS AND METHODS

The statistical analysis of data retrieved from the UN official website was used to examine the impact of the intercultural and interfaith component on decision-making and communication processes in healthcare (The UN organization, 2020). The study was limited to three countries: Germany, Russia, and the US. Thus, it was found what religions are practiced by the reviewed nations. It was also determined from which

countries the general influx of migrants comes, and what share of the total population consists of migrants. Data statistical analysis allowed investigating what religions are professed by the newcomers and how their cultural and religious beliefs contradict the faith of the indigenous population. It was also discovered what challenges were caused by these disagreements in establishing communication during the provision of medical care.

At the next stage of the study, analyzing the information available at the International Health Care System Profiles website, particular aspects of the legislation related to migrant healthcare in the examined countries were identified. Moreover, ethical issues that medical workers face in assisting registered and unregistered citizens of other countries are analyzed (International Health Care System Profiles, 2020).

Statistical analysis of medical tourism data published in the International medical travel journal (2020) revealed the citizens of which countries are applying for medical care to Germany, Russia, and the US. By analyzing the UN data, the beliefs of such individuals were outlined. Furthermore, it was taken into account that the prevalence of medical tourism in these countries was not only the result of the highly qualified medical personnel and the availability of modern medical equipment. The secondary reason for medical tourism was also determined as excellent communication in healthcare from an ethical point of view.

Leveraging the secondary data analysis of the information extracted from the scientific literature, including books and journals, features of each religion, identified at the stage of statistical analysis, were unveiled. Hence, the peculiarities of religious traditions that can influence the decision-making process and communication in the healthcare system were investigated.

## RESULTS

Each migrant brings to the host country not only his/her working abilities and the dream of a better life but also cultural background and personal beliefs. Table 1 provides information on which countries are sending migrants to Germany, Russia, and the US, as well as migrants' religions.

As can be seen from Table 1, the local population of the investigated countries is practicing several religions. German people adhere to Catholic and Protestant faiths. Among the US residents, there are representatives of almost all religions existing in the world. The most common are Protestants, Catholics, Mormons, Jews, Muslims, Buddhists, and Hindus. In Russia, Christianity (Orthodox, Catholics, Protestants), Islam, Judaism, Buddhism.

In addition to national religious practices, migrants, and medical tourists add a few more to the list of religions that physicians should be aware of to provide proper medical treatment. Considering a migration to the US, it can be mentioned that representatives of almost all known religions live and receive medical services in this country. Migrants and medical tourists supplemented the Russian religion list with Taoism and Confucianism, and Germany - with Islam, Buddhism, and Judaism.

The main indicator of a high-level healthcare system is not only the availability of qualified specialists and modern medical equipment but also a high average life expectancy of citizens. Moreover, among the features of well-established doctor-patient communication, which consider intercultural and interfaith differences, is medical tourism. Table 2 presents data on the development of medical tourism in the discussed nations. Besides, it outlines representatives of religions to which medical workers provide services.

**Table 1: Religions of host countries and migrants (The UN organization, 2020)**

Country	Religion	Percentage of migrants in the total population for 2019	Origin of migrants	Religion of migrants
Germany	Christianity (Catholicism, Protestantism)	15.7%	Turkey	Islam, Christianity
			Poland	Roman Catholicism, Orthodoxy, Protestantism
			Russia	Christianity (Orthodoxy), Islam, Buddhism, Judaism and Protestantism
			Kazakhstan	Islam
			Romania	Orthodoxy
			Italy	Catholicism, Protestantism, Judaism, Islam
			Greece	Orthodoxy
Russia	Christianity (Orthodoxy, Catholicism, Protestantism), Islam, Judaism, Buddhism	8.0%	CIS countries	Islam, Islam, Christianity, Buddhism, Judaism
			China	Buddhism, Islam, Christianity, Confucianism, Taoism
			Vietnam	Buddhism, Confucianism, Taoism
			Afghanistan	Islam
			Turkey	Islam, Christianity
USA	Protestantism, Catholicism, Mormonism, Judaism, Islam, Buddhism, Hinduism	15.4%	Mexico	Catholicism, Protestantism
			India	Hinduism, Islam, Buddhism, Jainism, Sikhism
			China	Buddhism, Taoism, Confucianism, Christianity, Islam, Judaism
			Philippines	Catholicism, Islam, Protestantism, Church of Christ
			El Salvador	Christianity

The US health services attract those tourists whose home country does not have appropriate healthcare technologies in oncology, orthopedics, organ transplantation, cardiac and plastic surgery (Table 2). Even though the cost of medical services in the US is rated as the highest in the world, this country attracts nearly 800,000 medical tourists every year. It is in third place in the provision of medical care for international patients, after Thailand (1200,000 medical tourists a year) and Mexico (1000,000 people). Nevertheless, Americans consider it more profitable to undergo treatment, for example, in Mexico. Germany is the most popular destination for those medical tourists who seek treatment from orthopedists, oncologists, and cardiologists. Annually, about 200,000 tourists obtain medical care there. As for Russia, it has a wide range of healthcare services provided to tourists. In particular, dentistry, in vitro fertilization (IVF), orthopedics, cosmetic surgery, eye surgery, cardiac surgery, and so on.

Consequently, to establish successful doctor–patient interaction, religious beliefs should be taken into account and respected. Table 3 below describes the specific aspects that each faith brings to medical communication.

Physicians should be informed that patients who practice Christianity are expecting to be given valid medical information, even in the event of fatal illnesses. People professing Confucianism and Taoism are not accepted to talk about death. For this reason, specialists should not communicate the terminal diagnosis to the patient since it is regarded as unethical.

As concerns vaccination, it is not officially prohibited by any religion. Nevertheless, in many countries, misinterpretation of God’s laws to avoid this procedure has become a trend. The aforementioned is often caused by distrust of the vac-

cine and uncertainty about its safe effect on the body. The so-called palliative care, which should facilitate the last days of life for a terminally ill person experiencing severe pain, is not prohibited by most religions.

As for organ transplantation, the attitude to this procedure varies across different religions and nations. For example, in Christianity, a donation is considered a manifestation of love for one’s neighbor and is permitted if it does not harm the donor. The Russian Orthodox Church is opposed to the presumption of consent to posthumous organ donation. During his/her life, a person must express a desire to become a donor after death by signing relevant documents. Judaism allows transplantation after death, with the consent of the donor and his/her relatives. In many countries and religions, the donation from the deceased is possible only if brain death is ascertained by healthcare professionals. Islam prohibits deceased organ donation without the donor’s life consent or relatives’ approval after the donor’s death. The recipient, in turn, must agree for organ transplantation from a deceased donor. In Muslim countries, some additional features of doctor–patient communication exist. In particular, if a person needs a blood transfusion, then either he/she or his/her relatives must give permission for this. Moreover, a male doctor is forbidden to examine a female patient without her relatives present. Active euthanasia is allowed only by Protestantism, in a few countries, for example, in the Netherlands.

## DISCUSSION

Most existing cultures emphasize on intangibility and the impossibility of disposing of life in an arbitrary way (Palazzani, 2018). It is recognized as the greatest value given from above that must be protected by all means if this does not threaten

**Table 2: Medical tourism (adapted from the International medical travel journal [2020])**

Host country	Number of medical tourists per year	Branch of medicine	Home country	Religion
USA	800,000	Oncology, orthopedics, organ transplantation, cardiac surgery, plastic surgery	All countries	Representatives of all religions
Germany	255,000	Orthopedics, cardiology, oncology	Russia UAE Saudi Arabia Netherlands United Kingdom Austria USA Israel	Christianity (Orthodoxy), Islam, Buddhism, Judaism, Protestantism Islam Islam Catholicism, Protestantism, Islam, Hinduism, Buddhism Christianity, Roman Catholicism Catholicism, Protestantism Protestantism, Catholicism, Judaism Judaism, Christianity
Russia	20,000	Dentistry, in vitro fertilization, cosmetic surgery, eye surgery, cardiac surgery, orthopedics	China South Korea Japan Vietnam Thailand India	Buddhism, Taoism, Confucianism, Christianity, Islam, Judaism Buddhism Shinto, Buddhism, Christianity Buddhism, Christianity Buddhism, Islam, Christianity, Hinduism, Sikhism Hinduism, Islam

**Table 3: Religious views on medical issues (based on the data retrieved from Cain *et al.* [2018], Palazzani [2018], Walker & Lovat [2017])**

Religion	Terminal diagnosis is communicated to the dying	Vaccination	Palliative care	Organ transplantation	Active euthanasia	Other aspects
Orthodoxy	Yes	Yes	Yes	Yes	No	Fetal therapy is not allowed
Catholicism	At the patient's discretion	Yes	Yes	Yes	No	Fetal therapy is not allowed
Protestantism	Yes	At the parents' discretion	Yes	Yes	Depends on a country	
Islam	-	Yes	Yes	Yes	No	A male doctor can see the female patient's body only in the presence of relatives. Blood transfusion is performed with the consent of the patient or his/her relatives.
Judaism	-	Yes	Yes	Yes	No	
Confucianism	No	Yes	-	-	Illegal	
Taoism	No	Yes	-	-	Illegal	

other people. The central role in preserving health and life belongs to medical workers and patients. Most religions support the patients' right to be informed of their state of health. The professional duty of the physician is to tell the truth about the person's health (Walker & Lovat, 2017). Although some religions, such as Confucianism and Taoism, do not welcome discussions about death. In the case of curing a Confucianist or Taoist, the physician may hide some facts and, thus, comply with ethical standards without violating professional duties. The duty of the patient is to be informed and accept the cure and care of the physician (Palazzani, 2018). The principle of patient autonomy is considered ethical. The spirituality and religious beliefs of the human subject must be respected by the physician. Though in case the patient refuses an appropriate treatment, the physician should try to convince him/her to be cured without verbal coercion or forceful persuasion (Palazzani, 2018). If a doctor is faced with a tough choice, then that decision is considered ethical, which will bring more benefits to others, and from which there will be less harm to a greater number of subjects of the situation (Walker & Lovat, 2017).

It is to be expected that for people of various cultures, finding communication methods that will bring a positive result from the dialogue may be difficult. Poorly established intercultural communication leads to the fact that patients are less likely to visit hospitals. However, even if they do, a counseling interview may become somewhat long-lasting due to mutual misunderstanding. In such situations, the language barrier can cause confusion, mistrust, and, as a result, patient non-compliance with doctor's recommendations (Piacentini *et al.*, 2019). The best option to establish successful medical communication with foreign patients is to visit them at home, where the environmental context can provide information about a person's cultural background. Such a visit is considered more patient-friendly (Piacentini *et al.*, 2019).

Often, both patients and medical workers become dependent on the political system of the country. For instance, the US law does not provide a legal framework for the granting of

healthcare to unregistered citizens (Kuczewski, 2017, Rodriguez *et al.*, 2017). Such patients can only receive emergency care, while further treatment without medical insurance is not possible. Hence, the major part of migrants who cannot afford to take out an insurance policy is doomed to self-medication or to be repatriated. In the case of self-medicating an infectious disease, the infection can spread to others, and this may become a national threat. The only way out from this situation is to provide necessary medical care to all individuals, regardless of the person's place of origin and documents' availability. Then medical workers will not be faced with a choice of what they should do from an ethical point of view and what they can do from a legal one (Sillup *et al.*, 2017, Kuczewski, 2019). The situation in Russia is quite similar to the US. Foreigners without health insurance are provided only with free emergency medical care, intensive care, and in some cities, inpatient care (for no more than three days) (Demintseva & Kashnitsky, 2016; Utyuzh *et al.*, 2016). In Germany, migrant treatment is also subject to health insurance. Thus, the equal rights of all individuals to receive preventive, palliative, and other medical services are not ensured (United Nations, 2018).

Very often, healthcare specialists go to other countries to provide medical care to the population, which has an increased need for it. For example, doctors can help countries affected by natural disasters or hostilities (Harrison *et al.*, 2016). In such situations, the difficulty of intercultural interaction is maximally manifested. It would be advisable to establish specialized courses, the task of which will be to teach global health professionals' ethical standards in decision making and doctor-patient communication in the intercultural and interfaith context.

## CONCLUSIONS

The presence of many cultures and religions in the era of free movement around the world poses numerous challenges to healthcare. It is paramount to provide everyone with equal rights to receive the required medical treatment, regardless of

intercultural and interfaith differences. To do this, it is essential to establish successful doctor–patient interaction, which, together with the physician’s knowledge, experience, and modern medical equipment, will ensure the effectiveness of medical therapy.

The research explicated that due to population migration and medical tourism from other countries, the list of faiths practiced in Germany, Russia, and the US has increased. Accordingly, apart from Catholics and Protestants, in Germany, there are representatives of Orthodox, Islam, Buddhism, and Judaism; in Russia - Confucianism, and Taoism; and in the US - Jainism, Sikhism, Confucianism, and Taoism.

The spread of religions has led to many ethical issues in doctor–patient intercultural communication. Already in the diagnostic stage, many ethical discrepancies between people of various faiths emerge. Islam forbids examining a female patient by a male doctor without her relatives. According to Confucianism and Daoism postulates, a terminally ill patient should not be informed about the terminal diagnosis, since death is not discussed by representatives of these religions. During the mass vaccination campaign, physicians should understand that it is allowed for representatives of all faiths. Religions do not prohibit the improvement of the physical and psychological state of a terminally ill person at the end of life, as well as organ transplantation. However, active euthanasia is approved only by Protestant churches in several countries.

The results of the current study can be used by researchers engaged in the examination of ethical issues in the health-care system arising from interfaith and intercultural differences between patients and doctors. The obtained data can help medical workers who encounter the treatment of patients belonging to different cultures.

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