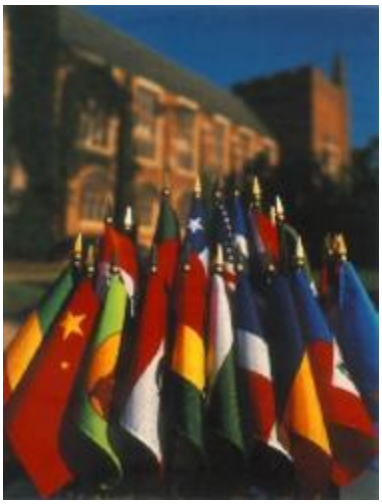

Multiculturalism in Medicine

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The United States of America is a country of immigrants. Many different religions, ideologies, cultures, etc., co-exist. All of these people, at some time or other, will access the health care system. Given what is known about the ethical treatment of patients and ethical actions of heath care professionals, what is the best way to face the various needs and demands of such a diverse population? If we think we must draw some lines with respect to refusing some requests or barring certain practices, how are we to justify so drawing them? This essay discusses these issues.

In offering medical services there are often two kinds of health care systems to consider. First, in many countries there is a public system (funded primarily by taxes) that is usually accessible yet is often limited in its resources. Then there is often also a private health care system, funded primarily via payments by private insurance or by occasional private individuals paying cash. Some countries have a predominantly public health care system (for instance, the Canadian system is almost entirely public, except for cosmetic procedures and the like), while some countries like the USA have a predominantly private health care system. The British system has both a public National Health Service as well as a thriving private system that has arisen in the face of the many shortcomings present in the National Health Service.

While resource limitations are a problem with all health systems, the problem is usually far worse in the public systems funded through taxation. As a result, many individuals involved in health policy research are seeking to determine which clinical services are most valuable and appropriate and which ones are of more limited value. Their motivation is to make the best use of public funds by only funding those procedures known to be most effective, and not funding procedures that are of very limited value or no benefit whatsoever.

The fact is that some common medical practices have no rational clinical basis in the sense that they provide no benefit relative to the potential risks. Perhaps the best known

example is that of circumcision in newborn infants, which is still carried out in 27% of Canadian newborn boys [1]. Other practices such as “female circumcision” can be frankly mutilating and even downright harmful, yet may be considered acceptable or even desirable in some cultures [2]. In a public health care system with limited resources, it makes sense either not to fund such procedures (in the case of male circumcision) or to explicitly forbid them when they are obviously harmful (as in the case of female circumcision). This is not to suggest that all clinically unnecessary procedures should be forbidden – only that they should not be offered by the public health care system funded by tax money.

The Oregon Health Plan (OHP) [3] has been widely heralded as a landmark innovation in public health care policy that rations public medical resources by a system of prioritizing funding for health care. This is done through a process of systematically ranking publicly offered medical services, an approach that has drawn substantial international interest as a rational model of medical resource allocation.

In 1989, Oregon enacted legislation to provide basic health care to all residents on Oregon Medicaid, their public health care system. This required that services be prioritized to determine what would or would not be covered – effectively establishing a rationing plan. To do this, the Oregon legislature created a Health Services Commission charged with producing a list of health care services ranked in priority “according to comparative benefits of each service to the entire population being served.” They heard testimony from numerous panels of physicians from every specialty to assess how well each treatment that might be funded affected quality of life. From this they established a “cost-effectiveness value” for each “condition-treatment pair”. The final product was a priority list of 709 condition-treatment pairs in ranked order. Based on the available state funds, a line was drawn on the list - any treatment above the line was covered; any treatment below the line was not. This turned out to be at the 587th condition-treatment pair.

While the Oregon system is not without its critics [4], the plan strikes me as a particularly fair and rational approach based on a process of public consultation coupled with clinical efficacy research. I would advocate this model as a good starting point for meeting the various needs and demands of a diverse population. This is not to suggest that the plan would necessarily apply to all residents – only those getting publicly-funded health care would be participate, and wealthier individuals with private insurance would participate in a different (presumably more generous) plan.

Finally, there are a number of practices that are harmful to patients to the extent that they should be forbidden even when well-meaning individuals sometimes seek them. These include the previously mentioned practice of female circumcision, a number of dangerous quack remedies [5], and possibly the practice of euthanasia. Deciding which ineffective or potentially harmful practices should be tolerated (as we do with male circumcision), and which ones should be forbidden (as with female circumcision) is not always an easy task, but application of the principle of nonmalfience is certainly one approach that has special merit. Still, the principle of nonmalfience may sometimes be

in direct conflict with the principle of patient autonomy in the cases of patients seeking ineffective or dangerous treatments. In my book, the principle of nonmalfience takes absolute priority. After all, was it not Hypocrites who said “First do no harm”?

References

[1] Patrick Sullivan. Infant's death another nail in circumcision's coffin, group says. CMAJ 2002 167: 789-a

[2] E. H. Kluge. Female circumcision: when medical ethics confronts cultural values. CMAJ 1993 148: 288-289.

[3] A. McPherson. The Oregon plan: rationing in a rational society. CMAJ 1991 145: 1444-1445.

[4] Jonathan Oberlander, Theodore Marmor, and Lawrence Jacobs. Rationing medical care: rhetoric and reality in the Oregon Health Plan. CMAJ 2001 164: 1583-1587.

[5] For more information on potentially harmful quack remedies, visit www.quackwatch.com. This site is operated by a retired psychiatrist, Dr. Stephen Barrett, and is filled with hundreds of reports on dubious products, services and theories, all presented in a highly engaging manner. I particularity recommend the section “Cheers and Jeers from Quackwatch Visitors” where Dr. Barnett places his fan mail and his hate mail.

Appendix

The International Society for Equity in Health (www.iseqh.org) seeks to “promote equity in health and health services internationally through education, research, publication, communication and charitable support.” It is concerned with exactly the sort of questions that have been raised here: How does one ensure fairness in access to health care resources? What procedures should not be made publicly available in a socialized health care system? How do we deal with cultural and economic factors that impact on the demand for health care services? They begin by offering two working definitions:

Equity in Health: The absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.

Inequity in health: Systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.

Also, the journal for the society, the International Journal for Equity in Health (http://www.equityhealthj.com), features a small number of articles that are helpful to address these issues. These and other sources identify a number of questions that need answering:

• How is fairness in a health care system to be assessed?

• Should health equity be measured at the individual or the group level?

• To what extent are health status inequalities sensitive to the type of health measure used?

The interested reader is referred to these resources for more information.