

What “Patient-Centered Care” Requires in Serious Cultural Conflict

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No external funding to report.

Abstract

The recent movement to provide “patient-centered care” has been hailed as a progressive step forward in meeting the needs of the very diverse patient population of the United States. The focus on patient-centered care has been embraced at all levels of American medicine: professional organizations, public advocacy groups, hospital administrators, medical school leadership, insurance carriers, and nursing schools. But while the ideal of patient-centered care is universally endorsed, the ethical obligations it entails have only begun to be explored. One of the most difficult circumstances in which to provide patient-centered care is in deep cultural conflict, where the values and priorities of the patient are in direct opposition to those of the clinical team. Given the mandate to provide care that is “culturally and linguistically appropriate,” the author asks what obligations providers have to meet patient demands when it is inconvenient, challenging, or, at the extreme, offensive and antithetical to mainstream values. Barriers are examined that patient-centered care in such cases is disruptive to the work-flow of the service, requires acknowledgement of illegitimate values, or entails discriminatory practices that constitute a personal insult or affront to the provider. The strategy invoked for this analysis is a search for common values that might provide a bridge between patients and providers in deep cultural conflict. The author concludes by responding to these important barriers to providing patient-centered care.

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Consider the impasse between the patient and the clinician in the following case:

A male radiologist is called by the ED to perform an evaluation for an intra-uterine pregnancy. The patient has come to the ED with bleeding and abdominal pain. The patient's beta-HCG is around 250. When the radiologist arrives in the patient's room, he finds her covered in a burqa, and the patient's husband explains that she needs to remain covered and that the male radiologist will not be allowed to perform the necessary exam. The patient says nothing. There appears to be no language barrier.

In the context of the recent movement to provide “patient-centered care,” cases like this one present a serious challenge to the clinical team: what the patient – or at least the person speaking for the patient – considers necessary for her values to be protected is in direct conflict not only with the standard of care, but with the standard operating procedures in contemporary US medical settings. The standard of care in a suspected ectopic pregnancy is a diagnostic vaginal ultrasound, and the standard operating procedure is that the clinician assigned to the case (of whatever gender) does the exam and the exam is performed in a hospital gown. Against the backdrop of the already almost unmanageable clinical load in US emergency departments, what type of attention and accommodation does “patient-centered care” demand when that effort threatens to

cause significant strain in a service already stretched thin? And even if certain accommodations *can* be made, is the extra effort ethically warranted?

Patient-Centered Care: The New Mantra

The movement of “patient-centered care” is now embraced at all levels of American medicine: professional organizations, public advocacy groups, hospital administrators, medical school leadership, insurance carriers, and nursing schools all invoke the concept as a mantra. As just one example, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association committed to patient-center care in their 2007 “Joint Principles of the Patient-Centered Medical Home,”¹ which the AMA voted to adopt in November 2008.² There is hardly a statement issued about healthcare quality improvements that does not appeal to “patient-centered care” as the guiding principle and goal. But as bioethicist Howard Brody points out in his recent critique of the field of bioethics, the more fundamental questions of what patient-centered care demands are often neglected in this movement. Taking seriously the idea of the “medical *home*” and the deeper implications of the obligation of “hospitality” that it entails, he writes, “For all the good intentions of patient-centered care and the medical home, it may be too easy to become overly focused on which electronic-health-record program works best, or on how to get properly reimbursed for group meetings for diabetic care and education. What has to happen in a medical office so that patients feel welcomed on arrival and throughout the visit?”³ Extending this line of questioning into the in-patient setting, we need to ask what patient-centered care obligates us to, especially if we are to make good on the

promise of the joint-principles that call for care that is “culturally and linguistically appropriate.”⁴

As difficult as it may be to alter clinical practice to become welcoming and satisfying to patients in ordinary settings and situations, it is, of course, all the more challenging to achieve this when the needs of the patient conflict with the deeply held values and priorities of the providers. But patient-centered care cannot be reserved only for the easiest, most compliant, most mainstream patients. If patient-centered care requires attentiveness to patients’ needs that is culturally sensitive, we need to determine what obligations we have to meet those needs when it is inconvenient, challenging, or, at the extreme, offensive to mainstream values. How far are we obligated to go in meeting the culturally based needs and demands of patients, given our pluralistic society that is getting more diverse all the time?

Cultural Differences We Already Accommodate

Some instances of cultural or religious difference do not meet with much provider-resistance in operationalizing patient-centered care. In fact, providers are quite comfortable meeting religious or cultural demands in certain circumstances. Consider, for example, widespread policies that recognize and respect diverse belief-systems, such as blood-transfusion policies for patients who are Jehovah’s Witness or accommodation of dietary requirements that are religion-based. What sets these categories of cultural or religious demands apart from what is being asked of the provider and institution in the ectopic pregnancy case above is that the demands are not considered: 1) disruptive to the work-flow of the service; 2) illegitimate; or 3) *ad hominem*, i.e., perceived as a personal

insult or affront to the provider. We find it acceptable – and even obligatory – to meet patients’ religious or cultural needs in situations that do not involve these three problems because we define accommodation as easy to achieve. Let’s examine each of these problems in turn to see if they constitute an exclusion-criteria, whereby patient-centered care would ask too much of or exceed what could reasonably be expected from providers and institutions.

Take the issue of (1) disruption to the work-flow first, using the examples of blood-transfusion policies or dietary requirements. Accommodating cultural or religious demands in these instances is not thought to slow down productivity or hamper the delivery of care. But that fact may be better explained by the structural incorporation of these demands into institutional and clinical practice than by the inherent ease of accommodating what is being requested. Early on, when such demands were novel, they probably did cause significant interruption to clinical care, as providers and institutions struggled with how and whether to meet those demands. Now they are simply included in the menu (sometimes, literally) of clinical care and patient services, with a standard protocol of accommodation, so they are not viewed as disruptive or inconvenient. So one lesson to draw about our ability to meet patient needs in cases of cultural or religious difference is that when demands are relatively novel, they may cause interruption in a way that they might not, once a standard method for handling them is developed; we can’t refuse accommodation merely because a system for accommodating that request hasn’t yet been worked out.

The second feature of the patient-demands we routinely accommodate is that they are not considered (2) illegitimate, but are implicitly sanctioned as worthy of that

accommodation. But do we view these demands as legitimate because they are inherently reasonable and justifiable – religiously, culturally, or morally – or because providers are accustomed to these categories of demands? There may not be anything *more* legitimate in the demands we are used to accommodating than the demands now being made by newer immigrant or religious groups. Take the case of blood refusal in patients who are Jehovah’s Witness: every medical student learns about the right to refuse unwanted transfusions as one of the standard clinical ethics cases used in training. From the very beginning of medical school, then, clinicians see this aspect of the care of Jehovah’s Witness patients as standard and appropriate, even though the patient’s choice may result in a preventable death. On the face of it, there would seem to be nothing *less* reasonable than losing a patient who has a very good prognosis, yet we define blood refusal in this population as a legitimate religious choice. “Legitimate,” then, is not a matter of what can be justified on grounds of the dominant culture’s values, but what we have come to accept in the range of cultural or religious difference in the United States. And while it is laudatory that we respect the value of *this* religious group, it is also the case that there are somewhere between two and five times as many American Muslims (the religious subgroup that might don a burqa) as American Jehovah’s Witnesses. There are over 1 million Jehovah’s Witness “publishers” (as adherents call themselves) in the United States,⁵ which is a significant population; but there are somewhere between 2.5 and 5 million Muslims, according to various estimates.⁶ While the American Muslim population is certainly not a monolithic group, and many American Muslim women do not wear a burqa as part of their religious observance, there are many that do. Given the American commitment to religious pluralism and tolerance, if one religious or

cultural belief or value is deemed legitimate and worthy of respect, then our default position must be that they all are.

The third feature of the cultural differences that we routinely accommodate is that they are not (3) *ad hominem* with regard to the provider: the requests do not discriminate against certain categories of providers by race, gender, sexual orientation, etc. The dominant culture's commitment to equality and non-discrimination makes it difficult – on principle – to accommodate a demand that certain categories of clinicians be excluded from providing care. It is often viewed as an affront to one of the most deeply cherished American values when a patient refuses to be treated by a fully qualified care-giver from a particular demographic. When a patient refuses to be seen by a man, or a woman, or someone of a particular ethnicity or sexual orientation, it feels like prejudice and discrimination; when the patient-demand involves a dietary preference or refusal of certain treatment, it strikes no such nerve. But this is precisely the kind of situation that reveals a profound cultural conflict: i.e., where one person's values are incommensurate and incompatible with another's. It is in this very circumstance that the question about our obligations to patient-centered care becomes most urgent – and most challenging. Keeping these three problems in mind, let's return to our case.

Otherness versus Commonality

The women in the burqa and her husband seem to possess values incommensurate with those of the American mainstream. Part of why incommensurable values seem to create an unbridgeable chasm between individuals is that, in such conflicts, each person is regarded as radically “other,” too different for the kind of kinship that engenders

empathy and understanding. Deep cultural conflict always has as its starting point this focus on “difference,” on how “they” appear different from “us.” It is hard to overcome the impasse that disparate values generate when the interpretation of radical difference stands. But if underlying those very real cultural and religious differences is a commonality that runs deeper, the divide will no longer seem as wide. I want to argue that, indeed, there is a set of universal values that underpins the claims of those whose views seem entirely different from ones own. If we can see that what matters to “them,” matters to “us,” we won’t turn out to have the gaping differences we first appeared to have. If we can see commonality and overlap in values, we not only can find solutions to patient-provider conflicts that are truly patient-centered, but we are more likely to think the effort worth our time.

Before we reconsider the “otherness” of the couple in the case we are discussing, it is worth laying bare the story we might tell about the situation that focuses wholly on difference. There are a host of assumptions we might make that create a divide that seems very wide indeed. We might think, for example: that because the husband is speaking for patient, he dominates and controls her; that the wife wants to participate in her care, but her husband is robbing her of her autonomy; that the husband is refusing necessary medical care based on a parochial modesty, putting his wife’s health (and even life) in jeopardy; that if he were not there, she’d consent to the exam; and, that they are uneducated, probably illiterate. Keeping these possible assumptions in mind (again, we might make all or none of them), I want to present an alternative story about this couple that questions this interpretation of them.

The framework that I want to use to tell this alternative story is a Kantian one that claims a foundation of universal values at the root of all of our particular and disparate moral commitments. It is a moral framework articulated by the 18th century philosopher Immanuel Kant, whose central tenet was that all human beings share the same basic “Moral Law,” which Kant named the “Categorical Imperative.”⁷ Leaving the nuances aside, this moral claim amounts to a version of the age-old Golden Rule: “Do unto others as you would like them to do unto you.”⁸ Kant’s formulation of this principle is slightly more abstract, but the essentials are the same: “Act in a way that your action can be willed at the same time as a universal law of nature.”⁹ The Kantian view is an anti-relativistic position that holds that common, universal values are simply instantiated differently in different times and places; they all trace back to the very same principle of the Categorical Imperative. When we see these very different instantiations, it is easy to recognize the differences that distinguish one set of values from another and miss entirely what is common between them. But to see the differences without the common thread runs the risk of making those value-differences seem greater than they actually are – to the point where the other’s value system appears too foreign or alien to be considered legitimate and justified. With that as the background, then, we can turn to our case to see if the underlying values and beliefs that anchor the couple’s demands are really that different from our own. I want to look at three values that I will claim are universal and merely instantiated (or cashed out) differently: autonomy, informed consent, and bodily privacy.

A Focus on Commonality: the Universal of Autonomy

To make the case that all human beings value autonomy, I want to offer a fairly general “working definition”: autonomy as the “right of self-governance.” This value is not to be confused with “patient autonomy,” which is significantly different and quite specific: i.e., “the right of patients to make medical decisions and exert control over their medical care.” Patient autonomy is a very American concept, and I wouldn’t try to claim it as a universal. Americans demand far more control over their medical decision-making than even other Western countries with comparable medical systems and healthcare. The universal for autonomy, then, amounts to a more generic desire for self-governance.

What is important to understand about autonomy, though, is that one can self-govern by making decisions, or one can self-govern by deferring to someone else’s superior expertise. A satisfactory expression of my autonomy does not necessitate my always being the one literally making a particular decision. Consider married or partnered couples: typically each person carves out spheres of expertise and one member of the couple tends to defer to the other on decision-making in that particular sphere. That deference to someone else’s expertise does not result in either party feeling compromised in their autonomy because superior expertise is a justified and rational ground for putting the responsibility of decision-making in another’s hands. To willingly, voluntarily hand over a decision, though, is quite different from having the right to make a decision taken away against one’s will or express wishes. When one’s autonomy is compromised in this way, one feels it acutely. The feelings of being oppressed, forced, or coerced flag instances when one feels robbed of one’s autonomy as opposed to situations where one is gladly unburdened of a decision one feels unqualified

or incapable of making. In those situations, one feels: relieved, unburdened, freed, and grateful. Take an institution that is not well-understood in mainstream American culture: the arranged marriage common in certain Middle Eastern or Asian cultures. It is a very different circumstance when two parties enter into an arranged marriage with their respective consent, in contrast to an arranged marriage that goes against the will of one or the other party. But in cases in which the two individuals *do* consent, not only have they exerted their autonomy in that consent, but they are likely to feel that this important life-decision was made in the appropriate way by the appropriate (re: competent, qualified) persons. So while an arranged marriage is by definition an oppressive institution according to mainstream American values, it is *not* an oppressive institution to those who view it as the most prudent way to assure a happy and long-term union. What seems oppressive and an affront to autonomy to one person may not seem oppressive or an affront to another. We all have a vested interest in having our autonomy respected, but what that means across different people, cultures, and times can differ significantly.

Returning to our case, then, from the mainstream American view, we worry that the patient's lack of participation in the decision-making about her illness indicates a thwarting of her autonomy. Clearly there are grounds for fearing that she is not exerting any "patient autonomy" in this case, and we place high value on this species of autonomy. But the question is: does she? There are two possibilities: she *does* want to exert her right to make her own medical decisions, but she is being prevented by her husband; or, she is comfortable (in fact, feels relieved) yielding to her husband on such matters, that is, she defers to him because of what she perceives to be his superior wisdom in this arena.

Thinking about our earlier assumptions in this case, we need to ask, then: is he her oppressor, robbing her of the power to make her own decisions; or, is he her protector, freeing her from the burden of the decision-making in this case? Of course, I don't know the answer to this question, but what I have tried to argue is that an assumption of malevolence on the part of the husband is premature and makes him into a moral villain without justification. But there are stakes involved in this villainizing: it can undercut the providers' resolve to work cooperatively with him in finding a patient-centered solution to this dilemma.

A Focus on Commonality: the Universal of Informed Consent

However one wishes to exert one's autonomy in medical decision-making – either by making the actual decisions or by deferring to someone else's judgment – we all have a stake in those decisions being properly informed, reflective of our values, and legitimately endorsed. In other words, there is a universal value of informed consent. The working definition I will use for “informed consent” is: “the patient or trusted advocate is adequately informed about the patient's condition and treatment options, and s/he agrees to or chooses one of the proposed treatments/diagnostics.” No one wants therapies or procedures done to them without either the patient's knowing what they are and why, or the patient's chosen “surrogate,” “advocate,” or “decision-maker” knowing. The trusted surrogate could be anyone: a spouse, children, a friend, or even a physician.

If we assume in our case that we have a benevolent advocate in the husband, rather than someone who is working against his wife's core interests and values, we will be a step closer to bridging the gap between “us” and “them.” But are there grounds for

seeing him this way? I believe there are. First, he brought her to the ED for treatment, so he must have her healthcare interests in mind. Second, from the bleeding, it was obvious to him that this was a gynecological problem, and yet that did not deter him from securing treatment. These facts are significant. If we think about the Taliban days in Afghanistan, when women's bodies couldn't be viewed by men and women weren't allowed to practice medicine, women simply died at home, unable to obtain treatment. The husband is hoping for an outcome that spares his wife this fate. If the husband was not working towards a medical solution that safeguarded his wife's health, then he would not have brought her in for care.

How would we typically work with a benevolent advocate who is in disagreement with the clinical team about what ought to be done medically? Our first obligation would be to ensure that the surrogate is knowledgeable about the medical condition, prognosis, and treatment options. What does he know about her condition? Two essential elements of informed consent are "disclosure" – what has the decision-maker been told – and "understanding" – how much of that information has been adequately processed.¹⁰ Specifically in this case, does he understand that there is a possibility of an ectopic pregnancy? Does he know what is at stake for his wife if that is the correct diagnosis? Does he know that an ectopic pregnancy is potentially life-threatening? Does he know that the ultrasound is needed to diagnose an ectopic pregnancy?

A Focus on Commonality: the Universal of Bodily Privacy

Finally, the value that appears to be most at odds with contemporary American mores is bodily privacy. Perhaps no other aspect of this case makes the couple look

more parochial (or dare I say “backward”) than this one. And yet, as with the other two values of autonomy and informed consent, I want to argue that bodily privacy is a universal and there is less distance separating us than one might think. As a working definition, I will claim that “bodily privacy” can be defined as: “a concern that parts of the body remain concealed from the view of strangers.” In every culture, there is a distinction made between the “public” and “private” body. All cultures draw a line between what parts of the body are permitted to be seen and what parts are not permitted to be viewed by the public eye. And, all cultures draw lines demarcating what constitutes the “public eye” and in what contexts body parts can be seen and by whom.

In this case, the woman adheres to an institution called Purdah, which literally means “curtain” (written in Persian and Urdu as: پردہ, and in Hindi as: छान छान). It is the practice of preventing men from seeing women through both physical segregation and the covering of the woman’s body.¹¹ It is practiced in parts of the Middle East, Pakistan, and India. If you are a woman living under Purdah, then only close male relatives and other women would have seen even your hands, eyes, arms, neck, face, and hair. The Burqa is the garment women often wear when they are living under Purdah. To understand the context of this woman in the ED, we need to think about the relationship of Purdah to the American teaching hospital. Think how casual we are in a teaching hospital about the number of people who interact, exam, question, and simply view a patient in that setting (e.g., triage nurse, other nurses, medical students, residents, phlebotomists, ED techs, attending, specialists, their residents – the list goes on and on...). If we give a conservative estimate, the number of individuals interacting with the patient once in the examination room could be 10-15. How many of these

individuals would have been men? Conservatively, let's put the figure at 5-10. Now imagine what it is like to have this experience: it is the first time any part of your body is exposed to a man not related to you, and suddenly various parts of your body are viewed by 5 (or more) men in a short period of time. By the time radiology is called, the male resident may be the 5th (or 10th) man to come into the room.

The natural objection to any attempt to put ourselves in her shoes is that it seems too far a stretch to try to imagine this experience. We would likely respond by saying that we can't even imagine having this level of bodily modesty. We think of ourselves, in the dominant American culture, as too board-minded to have concerns like this. In the context of medical care, we perceive ourselves as understanding that the body needs to be exposed and examined in order for us to safeguard our own health. We might conclude, then, that we can't feel or experience what this woman feels.

To counter the assertion that we are "above" such parochial concerns, I want to take us on a "Thought Experiment," where we can take a turn being a "them" in that "us-them" dichotomy. Philosophers use thought experiments to give insight into a problem that we might be otherwise blinded from seeing because we sit too close to it. The strategy of a thought experiment is to ponder through a parallel situation to the original one being considered and then analogize the insights gained there back to original problem. For this thought experiment, I want to take us to Germany, to a typical gynecology practice.

If you were a typical patient coming for an appointment for an annual gynecological exam, the nurse would escort you to a room with a curtained area in the corner, with a stool on which to place your clothes. The nurse would instruct you to

take off all of your clothes and come to the examining table, placing your feet in the stirrups. And then the nurse would leave. No gown or drape would be offered. The gynecologist (the “Frauenarzt”) might be in the room while you disrobe and walk to the table, or typically he would come in once your feet were already in the stirrups. (There are more women now entering the field of gynecology, but there are still more men in the specialty than women). There would be no nurse is present for the exam. The exam, health history, and post-exam discussion would be conducted with you naked in front of the physician. Putting yourself in this exam room, how would you feel? Do any of the feelings from this possible list describe it: embarrassed, vulnerable, ashamed, mortified, humiliated, violated, or powerless? Now to exacerbate a situation already difficult for an American patient, imagine that there had been 5 male clinicians (or more) who had come into the room at various times during your appointment and were involved in different aspects of your care...

A powerful objection one might immediately raise to this thought experiment is that the two cases are not analogous: the experience of an American woman in a German gynecology practice is *not* the same as the experience of a Muslim woman living under Purdah in an American ED. The objection would run: the level of exposure is not at all comparable in the two cases, so no insight can be gleaned and applied from the one case to the other: in the Germany case, there is complete bodily exposure; in the burqa case, there is almost no exposure. The rejoinder to this objection is that the level of exposure, relative to our respective cultural boundaries, is *exactly* the same. In each culture, the “public vs. private body” is simply demarcated by different standards. Great care is taken in every culture to protect the “private body,” but we merely define this differently

in different places. When those culturally-prescribed boundaries of privacy are crossed, the patient acutely feels the violation of those boundaries.

What constitutes the “private body” in these three cultures: in Germany, in the dominant US culture, and in cultures with the institution of Purdah? The line between the “private” and “public” body is drawn by what parts of the body are allowed to be viewed in ordinary or commonplace public settings. We might name these three lines as the “Sauna Standard” in Germany, the “Bathing Suit Standard” in the US, and the “Burqa Standard” under Purdah. In Germany, the “Sauna Standard” gives us a good understanding of how liberal the culture is with the “public” body: public saunas are almost universally mixed gender, and full nudity in the sauna is the norm; in fact, nudity is often strictly enforced in saunas because it is considered to be most hygienic. It is then no wonder that in the practice of medicine this same approach to nudity is used: the practice of gown-less exams mirrors bathing-suit-less sauna participation exactly. In contrast, in the practice of American medicine, the hospital gown utilizes the “Bathing Suit Standard.” Consider the body parts that are routinely exposed in someone wearing a hospital gown: hands, arms, neck, face, hair, back, legs, feet – the exact body parts revealed by a bathing suit and a level of exposure allowed to be viewed on any beach or pool in the US. Returning then to our case, *none* of these body parts are included in the “public body” for a woman living under Purdah. On the “Burqa Standard,” the level of exposure in a hospital gown is just as much a violation of bodily privacy as the “Sauna Standard” is for us. It is not any more surprising that this conservative Muslim woman would resist wearing a hospital gown than that an American woman would insist on a drape or gown at a German gynecology visit.

Now let's reconsider the husband's insistence on his wife staying cloaked in the burqa. Don't the power dynamics of medicine make it hard for patients to speak up when they feel humiliated or vulnerable? Wouldn't many of us wish for an advocate who would protect our interests and priorities in a situation like the German gynecological exam? Many of us would consider a partner or spouse a hero for advocating for us about such a sensitive matter. So once again, we need to ask whether the husband is the oppressor, preventing her from getting the care she needs, or her protector, safeguarding her interests and values when she feels powerless to do so.

What Might Patient-Centered Care Look Like in This Case?

With this new focus on the commonality between us and this couple – recognizing an overlap in our common core commitments to autonomy, informed consent, and bodily privacy – is it now possible to move past “us vs. them” thinking? Despite culturally relative instantiations, these different needs and demands are variations on the same values. How do we deliver patient-centered care that honors their values, while providing good medical care, given the possible limitations to what a busy, over-stretched ED can offer?

If our dual-goal is to safeguard her health while safeguarding her values, we can take each of the three values in turn to see how we could best meet her needs. Starting with autonomy: whether she wishes she could exert control over her own medical care but is being prevented, or whether she gratefully defers to her husband, this is the marriage (and culture) she is in and he appears to be the decision-maker. Ideally she could be asked whether she wants to speak to the clinical staff without her husband

present, but it is hard to imagine her saying “yes:” on either reading – that he is her oppressor or protector – she will be returning to this marriage when this healthcare crisis is past. But our role in healthcare is not to change cultures, and, short of addressing abuse, it isn’t to change marriages.

Then, with her implicit consent that he is the surrogate decision-maker, the husband needs to be given a carefully, sensitively described picture of the medical facts of his wife’s case, the risks she is facing, the purpose of the diagnostics, the consequences if an ectopic pregnancy is missed. Of course, this suggestion does not sound any different from what any clinician would do in any circumstance, and in the essentials, it isn’t. But there is a world of difference between discussing care-options with a surrogate seen as unreasonable and self-interested and negotiating care with a surrogate thought to have his loved one’s best interests at heart. As all professional negotiators know, a conversation to resolve a serious conflict proceeds very differently when both parties view each other as having the same values and goals. In talking respectfully with the husband, we might solicit his concerns, ask for information about the parameters he sees for her care, and ultimately request his help.

Protecting her need for a high level of bodily privacy means working with her to minimize the amount of bodily exposure she has and controlling the gender of the providers she comes in contact with. Can the number of people who interact with this patient be minimized? Can a female ED resident or attending do the pelvic exam? Can a female tech or radiologist do the pelvic ultrasound? Can these exams be done while she is still wearing the burqa, using additional drapes?

I started this essay with three barriers to meeting patient-demands, namely, those that are not considered: 1) disruptive to the work-flow of the service; 2) illegitimate; or 3) *ad hominem*. The bulk of my argument tried to address (2) the concern that this couple's request was illegitimate. Returning to the first and third concern, providers may resist accommodating this couple's demands because (1) they feel burdensome to an already taxed ED service, and (3) because they feel like the kind of *ad hominem* request that violates the American ideal of non-discrimination. The objection regarding disruption seems easy to meet: if a routinized method is developed for meeting these demands, it will take no more time to fulfill these demands than any other standard special request. More troubling for many providers is the last concern, the "in principle" objection to bowing to any kind of discriminatory request for a certain demographic of clinician. My response to this objection (perhaps controversially) is that ignoring or dismissing the couple's request request is tantamount to being complicit in a kind of psychological or emotional assault, so concerns about discrimination must yield here. It naïve to believe no harm will come to this patient from being forced to submit to a strange man seeing her naked body. The duty "to do no harm" forbids this type of injury to patients, and it trumps the otherwise governing value of non-discrimination. And what if there are no female techs, radiologists, ED residents or attendings on the service? Well, as Kant argued persuasively, we cannot be obligated to do what is impossible,¹² so if there are no available female providers, then the patient needs to be offered the option of transferring to another hospital or accepting the providers at hand. Patient-centered care can only ever obligate us to the real options we have to offer.

Summing Up

Patient-centered medicine is not only a rejection of “my way or the highway” thinking about patient care: it is also a commitment to meeting patients on their own terms, respecting the values they come with to the clinic. We need to enhance our focus on commonality, rather than on difference, especially as the United States becomes more diverse. Patient-centered medicine must avoid the dichotomous thinking of “Us vs. Them” – not only because it is a false dichotomy, but because it lessens our resolve to meet patients where they are. Patient-centered care is a progressive step forward in meeting the needs of patients in US clinics, and all patients are deserving of it.

¹Joint Principles of the Patient-Centered Medical Home.

(<http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>). Accessed April 19, 2011).

²American Medical Association Adopts Joint Principles of PCMH

(<http://www.pcpcc.net/content/american-medical-association-adopts-principles-patient-centered-medical-home>). Accessed April 19, 2011.

³ Brody H. *The Future of Bioethics*. New York, NY: Oxford University Press; 2009, 56.

Brody provides a concise history of the movement of patient-centered care here. He borrows the concept of ‘hospitality’ from fellow bioethicist Laurie Zoloth. Zoloth L. I want you: notes toward a theory of hospitality. In: Eckenweiler, LA and FG Cohn, eds *The Ethics of Bioethics: Mapping the Moral Landscape*. Baltimore, Md: Johns Hopkins University Press; 2007, 205-29.

⁴ Joint Principles of the Patient-Centered Medical Home.

(<http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>). Accessed April 19, 2011).

⁵ Jehovah's Witnesses. Introduction: Overview, History, Religious Texts, Organizational Structure (<http://www.religioustolerance.org/witness2.htm>). Accessed April 19, 2011.

⁶Mapping the Global Muslim Population

(http://pewforum.org/uploadedfiles/Orphan_Migrated_Content/Muslimpopulation.pdf).

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⁷ Kant I. *Groundwork for the Metaphysics of Morals*. J Patton, trans. New York, NY: Harper & Row; 1964: 235.

⁸ Wilson J. *The Culture of Ancient Egypt*. Chicago, IL: University of Chicago Press; 1956; Spooner, WA. The golden rule. In: Hastings, J. *Encyclopedia of Religion and Ethics*, Volume 6. New York, NY: Charles Scribner's Sons; 1914, 310.

⁹ Kant I. *Groundwork for the Metaphysics of Morals*. J Patton, trans. New York, NY: Harper & Row; 1964: 243.

¹⁰ Beauchamp T, Childress J. *Principles of Biomedical Ethics*, 5th ed. New York, NY: Oxford University Press; 2001, 77-93.

¹¹ Purdah. (http://departments.kings.edu/womens_history/purdah.html). Accessed April 19, 2011.

¹² Kant I. *Metaphysics of Morals*. M Gregor, trans. Cambridge, UK: Cambridge University Press; 1996, 513.