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MANAGING CULTURAL DIVERSITY IN MEDICAL CARE

Christina Rose, Nils Fischer

German Reference Centre for Ethics in the Life Sciences (DRZE), University of Bonn, 53113 Bonn, Germany.
Tel: +49 228 3364 1930. Fax: +49 228 3364 1940. Email: rose(at)drze.de. Email: fischer@iwe.uni-bonn.de. www.drze.de

Abstract: Times of "globalization" bring with themselves a considerably high amount of migration – a fact which, again, causes an increasing degree of such cultural diversity. Since literally every individual in his or her life is likely to somehow depend upon medical care, the challenge of cultural diversity and intercultural understanding in this context is a substantial issue when talking about international stability at the individual and societal level. Focusing especially on the interpersonal relationship and the face-to-face dialogue between physician and patient, this paper provides means for improving mutual understanding and patients' compliance. It is based upon the methodological-hermeneutical concept of Intercultural Philosophy. From this point of view, e.g. a robot can *never* adequately care for a patient, because for convalescence it is also crucial to care about emotional, social and psychological constitution. In the tradition of the IFAC Committee Social Impact of Automation the paper goes beyond the wide use of technology in medicine today. It, thus, offers a starting point for a constructive interdisciplinary discourse between philosophy, medical ethics and the engineering community about whether technology-based medical treatment is a barrier to ethical behavior and a threat to stability – especially in intercultural settings.

1. INTRODUCTION

"Migration, ethno-cultural diversity, health and health care are closely interlinked in many ways. Due to worldwide migration, globalisation and also European enlargement, European communities are becoming more and more diverse on the local level as well."

This introductory description of the Amsterdam Declaration towards a migrant-friendly hospital (MFH 2004:1) matches perfectly the contemporary challenge of cultural diversity in health care, as it can be observed worldwide: Times of "globalization" bring with themselves a considerably high amount of migration – a fact which, again, causes an increasing degree of cultural diversity, especially in immigration countries. Among these are the USA, Canada, Australia, New Zealand and, in Europe, Switzerland and Germany. Since literally every individual in his or her life is likely to somehow depend upon medical care, the challenge of cultural diversity in this context is a substantial issue when talking about international stability on the individual and on the societal level. Thus, during the last years, an increase of interest in medical-ethical issues related to cultural diversity could be notified. The discussions include questions like: Should it be allowed to transplant tissue coming from donors in developing countries? How should a gynaecologist react when being asked to reconstruct a young woman's hymen in order to restore her virginity? How should politics and physicians deal with patients who live in a country without having a residence permission? Which risks and which chances does migration bring with itself for a person's mental health? Which influence do religions and value beliefs have upon the needs and treatment desires of patients with different cultural backgrounds?, and many more.

Focusing on the *individual* level, namely the relationship between physician and patient, the paper aims at identifying core *communication* problems in this area and, subsequently, to provide means for improving the dialogue between the two parties. These suggestions are based upon the methodological-hermeneutical concept of Intercultural Philosophy.

Despite training intercultural competence, communication between *human beings* in this context is only too often deemed to fail because of a lack of understanding and trust. This fact casts a critical light on the increasing use of ever more *technology* in terms of both, medical machinery and information systems in hospitals (e.g. telemedicine, automatic control of health systems or special design systems). If technological systems take over main communication elements between medical personnel and patients, the danger of misunderstanding and the loss of compliance, thus, *again* rises immensely. It is, therefore, crucial, to counter-act this trend by strengthening the dialogue between medical personnel and patients and to open ways towards a more human orientation in the medical profession.

However, a physician's higher degree of intercultural competence may in some cases still not be sufficient, as many examples, especially from the clinical practice, demonstrate (a number of which is reported about in Ford / Dudzinski 2008). In such cases, certain additional communication assistance may be needed at the *societal* level so as to help overcome misunderstandings and establish better mutual understanding.

2. THE INFLUENCE OF CULTURAL DIVERSITY ON THE PHYSICIAN-PATIENT RELATIONSHIP

2.1 Some general considerations concerning the contemporary Western physician-patient relationship

During the Second World War, the Nazis treated unconsenting prisoners cruelly in the name of medical science. To avoid future abuse like this in medical research, the Nuremberg Code (1947) was established for human experimentation, which includes the doctrine of the truly informed consent in medical research. This doctrine is not only relevant to the researcher's work, but also to the contemporary physician's role. As a reaction to the Nazis' barbarities, the role of the physician in Western public thinking has moved away from its traditionally rather paternalistic status: Same as the researcher, the physician, too, is obliged to seek informed consent from the patient before starting any treatment (UNESCO 2005:7). The term "informed consent" implies that firstly, the patient has to be sufficiently informed so that he understands about the risks, chances and alternatives, and that, secondly, he or she has, *on this base of information and understanding*, to *free-willingly agree* to the recommended treatment. The requirement of an informed consent for medical performance, thus, functions as a counterbalance in order to increase the level of equality in the physician-patient relationship.

But theory often enough does not match the actual state: Physicians' as well as a patients' everyday experiences make the claim for an informed consent sometimes sound rather utopistic. Generally, the relationship between patient and physician starts from the point on when the patient contacts the physician for the first time because he or she needs professional medical help. Looking at this situation from a communication-oriented viewpoint, it is obvious that the relationship between the two is not very likely to be that of equal partners in conversation: The patient normally is not able to help him- or herself anymore and thus contacts some person whom he or she assumes to have a higher degree of knowledge. All the information he then gains about his disease, possible medical treatments, risks and chances are selected and provided by the physician. Never mind how thoroughly this person explains situation and reasons, the patient has to believe and trust in the physician's judgements rather than being able to make autonomous decisions. Even though in Western thinking the physician's professional ethics explicitly implies respecting the patient's right of self-determination, the gap of knowledge and experience as well as the patient's desire for help and recovery will always stand between them. From the beginning on, the physician is, by these circumstances, deemed to somehow dominate the decision-finding process concerning an appropriate treatment, whether he wants it or not. The authority he or she possesses has an ambivalent character: His or her "authority (a)" roots in the more theory- and experience-based degree of information as well as in the use of medical terminology and the general ability of elaborate speaking. This rather neutral kind of "authority (a)" is complemented by the "authority (b)", meaning a higher degree of power.

2.2 The dialogue between physician and patient as a normative dialogue

Descriptive sentences merely provide information on facts. They can be subject to verification or falsification. Descriptive scientific approaches, thus, describe and explain *facts*. Even though physician and patient *seem* to exchange information on facts, e.g. about medical conditions, body functions, and medical effects of treatments, the dialogue between them must not be mistaken to be descriptive. This interpretation would fall short of essential aspects of their communication situation. If the patient asks the physician to restore or protect his or her health, this request is not merely a descriptive sentence. Instead, it implies a complex individual point of view, including e.g. a special meaning of the term "health" or an individual idea about the degree of risks and costs to be accepted in order to follow this aim. Accordingly, the arguments brought forth by the physician imply an individual set of norms and values, e.g. his or her interpretation of the duties to heal and to beneficence. The arguments offered by both parties within a physician-patient dialogue, thus, are *normative* statements, supported by individual norm and value judgments and promoting instructions for further acting which they derive from these judgements. This special character of such statements is vividly mirrored by the flood of case discussions within medical ethics, dealing e.g. with issues concerning the beginning of life (preimplantation genetic diagnosis, prenatal diagnosis, abortion, etc.) or its end (euthanasia, advance decision, etc.), or referring to the field of enhancement (e.g. neuroenhancement, aesthetic surgery, life extension, doping in sports, etc.), to name only a few.

Following the principle of autonomy, in common Western thought any treatment is only ever legitimated when *both*, physician *and* patient, have chosen it, as an outcome of rational consideration, exchange of arguments and shared decision-finding. As a consequence, the dialogue between physician and patient is to be characterized as a consent-oriented normative dialogue.

2.3 Cultural diversity as a challenge for the dialogue between physician and patient

As we have seen so far, each decision concerning the treatment of a patient must respectfully take into consideration the underlying individual value convictions and beliefs of the patient's concerns. Misinterpretations and conflicts between physician and patient are always possible – *intra-* as well as *inter*culturally. Their *intensity* may rise with the degree of cultural difference, but not their *character*. Cultural diversity does not as such necessarily cause any conflicts, as long as physician and patient share the same or a sufficiently similar opinion. But even if it is not *necessarily* the case that norm and value conflicts arise, it is, however, the more *likely*, the more a physician's and a patient's cultural backgrounds differ from each other.

If relevant beliefs and resulting values collide unnoticed and *if* they cannot be figured and, thus, sorted out properly, this may lead to irritations and dissents the roots of which remain

unclear to both, physician and patient. Grave consequences may be the loss of trust and even the breakdown of the physician-patient relationship. To avoid this it is necessary that both sides are at least to some extent able to *understand* the other one and to take his or her opinion seriously into consideration. It should be obvious that in this context stereotypes and prejudices are inadequate and dangerous, because they may make it impossible for a physician to have a differentiated look at the patient as a *person* with his or her *individual* socio-economical, biographical and also migration-influenced background. But generalizations on both sides can turn out to be harder to circumvent than we wish for it, however. Improving the intercultural competence of physicians, thus, promises a better chance for intercultural stability on the individual level. The question remains how this aim can be achieved.

3. APPLYING THE APPROACH OF INTERCULTURAL PHILOSOPHY ON THE PHYSICIAN-PATIENT DIALOGUE

3.1 The physician-patient dialogue as a polylogue

In order to improve mutual understanding and, in this way, to counteract culture-caused challenges, the concept of *Intercultural Philosophy* has been established during the last twenty years as an approach for the inner-disciplinary intercultural dialogue. Intercultural Philosophy understands itself as a methodology for a culture-sensitive practice of philosophy. It offers a culture-sensitive orientation for *all* fields of philosophical discourse – including discourses on normative questions, as they appear in the physician-patient relationship. In order to indicate that not only two, but many viewpoints are invited to try to find interculturally acceptable answers to philosophical questions, the communication concept of Intercultural Philosophy is frequently called "polylogue" instead of "dialogue" or "discourse". It implies that all participants are fundamentally equal partners and that, as a consequence, all traditions have the same rights and chances to influence one each other. Though this is hardly ever reality, the polylogue serves "as a regulative idea for practicing philosophy on a global scale" (Wimmer 2007:89).

Despite the fact that in the physician-patient dialogue there are generally only two persons involved and that, thus, the number of participating cultures is restricted to a maximum of only *two*, this regulative idea of fundamental equality and the intention of a radical openness to any kind of culture turns out to be highly helpful for this special kind of communication, too. Following this way of thinking, the physician-patient "polylogue" can be regarded as the attempt to *firstly* make both points of view adequately audible, including their own individual and cultural context. This initial step should guarantee that the opposed, culturally situated arguments and points of view are deliberately taken into consideration, not in order to judge about them, but *in the first place* to *understand* them properly. The chances for a good compliance and for informed consent may rise when both perspectives have equal moral rights. Because of this, the polylogue requires the attitudes of mutual respect, of listening and of learning. For medical practice, this includes the abandonment of individual mono-cultural and often ethno-centric indication. Only then, on this base of equality and mutual awareness, the second "level" of the polylogue can, *secondly*, aim at finding consensus (Rose 2007:129-136), – e.g. about the patient's future treatment.

3.2 Mono-cultured centeredness

One of the main problems manifests itself in the necessarily always existing culture-centeredness of human thinking. Franz Martin Wimmer (2007:83-87) identifies four types of such centrism throughout history: expansive, integrative, separative, and tentative centrism. Following Wimmer, a person with the attitude of *expansive centrism* holds the own faith, knowledge and progress, which builds the center of the own culture, as being exclusively true and rightful. Opposed to this, the centre's periphery is judged to be pagan, superstitious, backward and underdeveloped. Expansive centrism, thus, leads to the conviction that the own cultural centre has to expand and supersede in order to eliminate each and every "foreign" thinking and acting in the periphery. Out of immediately obvious reasons this force-including approach does not offer any opportunity for the informed consent of a patient.

The attitude of *integrative centrism* also is characterized by the belief of possessing unique knowledge, development and rationality. But its bearers draw a different consequence out of it concerning their relationship to "foreigners", because they rely upon the idea that their own centre forms an ideal so attractive for the periphery that sooner or later their way of thinking and acting will be adopted by the others – and that, thus, there is no need for further efforts. Although the attitude resigns from using any physical force, integrative centrism is also not likely to promote an informed consent, because it, too, bears the same conviction of objective superiority as expansive centrism does.

Separative (or multiple) centrism is an attitude in which people assume that every claim of truth and right is always culture-relative and relevant to only one out of many centers. As a consequence, they promote tolerance and peaceful co-existence. Such an attitude *does* circumvent the problems caused by mono-cultural superiority-thinking as they result from expansive as well as from integrative centrism. But it brings with it the problem that differences are rather cemented instead of open to mutual review. Separative centrism, thus, also does not seem to build a good foundation for any intercultural physician-patient dialogue, because relativism does not help in this case: The success of a treatment depends upon a consensus decision. An informed consent can only be found when both points of view find a mutually acceptable solution despite their differing "centers".

On the one hand, these three types of centrism are equally unacceptable. On the other hand, there does not seem to exist any possible way of rational thinking which is *free* from centrism. Therefore, Wimmer suggests – so to say as the lesser of all evils – a *tentative (or transitory) centrism*, which is characterized by the aim of convincing and which he describes as follows: "By a process of *convincing* I

understand a qualified form of influencing somebody, which ought to be distinguished from manipulating as well as from persuading. [...] Only processes of *convincin*g ought to be considered being decisive, even if persuading as well as manipulating practically may lead to the same effects" (2007:85; italics by the author of this paper). Tentative centrism allows the physician to base his or her position on good reasons gained from his or her own professional knowledge and experience. But although being "absolutely" convinced of the own indication, it also is the physician's duty to accept openly the (possibly) different view of a patient (who is equally convinced of being right). Such consent-oriented communication is fundamentally open concerning its potential outcome.

3.3 Intercultural misunderstandings

Another main problem for the intercultural discourse are *intercultural misunderstandings*. Seeking new impulses for action, it is crucial to bear in mind that *inter*cultural misunderstandings are not structurally different from *intra*cultural ones. This implies that both are in the same way open to sociological and psychological analysis and explanation. What actually leads to misunderstandings are often enough not the differences themselves but rather dogmatic ideas about "the foreign", stereotypes and prejudices. If these factors influence the dialogue between physician and patient, the risk for a conflict is increased and the prospect of a successful treatment is endangered. Thus, it is promising to enhance the intercultural competence of physicians. Pursuing the aim of avoiding intercultural misunderstandings, the Swiss philosopher Elmar Holenstein (2003) introduces a collection of "best practices", which here should be taken as a basis for suggesting some action alternatives in intercultural physician-patient dialogues.

3.4 Action alternatives in intercultural physician-patient dialogues

Holenstein generally assumes that humans, when being confronted with equal conditions and situations, in principle tend to react in equal ways. From this "anthropological principle", he draws two conclusions. Firstly, he gains from it the idea of "nos quoque" ("we do it, too"), meaning that if we encounter something completely inacceptable in a foreign culture, it is not unlikely that we will find comparable, if not worse occurrences in our own culture, may they be historical or contemporary experiences. Secondly, he assumes that in analogy, in the foreign culture, too, there must be some persons who object to these scandalous actions: "vos quoque" ("you do it, too"). It is, thus, illegitimate to draw any value judgement merely dependent upon the borderline between two cultures. Cultures are inhomogeneous within themselves. An adequate picture of a culture (which does not result from stereotyping and shortcuts) must, thus, be free from any kind of appraising racism, whether relying e.g. on the colour of skin, geographical origins, or language. Accordingly, when contrasting two cultures with each other, the highest degree of caution is required.

It is equally important to *generally* respect another person as a rational being, able to make his or her own decisions – independent from his or her special cultural background. Before attributing illogical thinking to a person from another culture, Holenstein believes that it is, therefore, better to assume that one has misunderstood him or her. But verbal expression is not the sole aspect of inter-personal communication which can transport information. Therefore, the *teleological* implications of a statement must be evaluated in the same way as the rational (i.e. the logical) aspects of a statement in order to understand the full meaning. That means: Not only those things which are *said* have to be taken into account, but also those which are implicitly *meant* and transported *non-verbally*. Especially dialogues like that between physician and patient are, by their nature, hardly ever that of equal partners. Here, aspects like subtle expressions of wishes and fears play an important role, noticeable e.g. in the patient's look, mimic, posture, or intonation.

Holenstein's last suggestions aim at improving mutual understanding by avoiding misinterpretations. Firstly, he recommends tandem work on equal terms. For the physician-patient dialogue this means that not only the patient should be regarded as an object of interpretation for the physician, but that he or she should, instead, have the same opportunity to ask questions concerning the statements and conclusions of the physician. Secondly, caution is required when trying to gain information on a certain culture: Self-images of their members as well as the impressions of outsiders may be subject to overestimation, embellishment and superelevation as well as to underestimation, diminishment or denigration. In addition, codices (like constitutions or Holy Scriptures) can transport a biased picture of any culture or religion, because they only represent a certain *target state* rather than the *actual* state of any culture. It is, thus, never sufficient to assume that any target state is *generally* reached (e.g. that a Muslim patient is *never* likely to suffer from an alcohol-caused liver malfunction) merely because of the fact that this is assumed within a certain codex (e.g. like the prohibition of alcohol within the Koran). The actual state (e.g. concerning the patient's *actual* use of alcohol) must always be monitored as well.

Only if all these efforts of intercultural understanding are born in mind and their outcomes are balanced, it is *possible* (yet unfortunately not necessarily the case) that a well-founded picture of the person opposite, be it the patient or the physician, is to be gained. Finally, it is advisable to let educated interpreters translate the outcomes of one's interpretations and – by this – to make their contents accessible to the person concerned, so that he or she has the opportunity to review and – if necessary – to contradict them.

4. CONCLUSIONS AND PERSPECTIVES

4.1 Intercultural competence in medical education – utopia and reality

In the same way as ever, the human qualities of listening and role-taking as well as that of understandable self-explanation are as essential to the medical profession as the physician's

expertise, because culture-based differences especially hinder an informed consent when their existence remains unnoticed. A certain basic knowledge of at least the most prominent cultures within the physician's working country might support successful medical action. But with such basic information on cultures a certain danger of stereotyping is also enforced, because there is no "Muslim / Asian / African / etc. patient as such". It might, in some cases, be the wish of a patient that his or her spouse, trusted family member or group leader is included in the process of decision finding. But this shift of personal to community consent cannot be connected with the patient's culture. As well as this, there appear cases where a patient with the *same* background strongly refuses such consultation, because it might hinder him or her to make an individual, though not group-conform decision. In order to avoid consolidations into a too simple picture, the physician must bear in mind that his or her background knowledge probably suits only ever *partly* and only *possibly* in a concrete case – and neither *compulsory* nor *fully*.

Thus, it is *more* important to establish a higher degree of intercultural sensitivity and the ability of recognizing conflict potentials – than simply acquiring *rudimentary* cultural or religious knowledge. This can be achieved by providing physicians with a certain amount of possible alternatives for culture-sensitive acting in repetitive patterns of intercultural patient-physician dialogues.

At this point, a chance is becoming visible for mutually enriching interdisciplinary cooperation between medicine, philosophy, cultural sciences, anthropology, and linguistics. Its desirable output would be to develop, implement and evaluate a new curriculum for intercultural competences within medical practice. This curriculum may not only be an optional, singular kickoff, but a comprehensive methodology, accompanying students of medicine during their whole time at the university and – if it may be allowed to spin this utopia still a bit further – including obligatory placements in foreign, non-European countries.

In America, debates on the development and characteristics of such curricula have been going on for some years now (exemplarily: Betancourt 2006; Gregg et al. 2006, Koehn et al. 2006). But even though the issue of intercultural understanding in physician-patient dialogues is obviously relevant to intercultural stability on the individual level, up to very recently there was little chance for implementing such a curriculum in medical education all across Germany, as it seemed. One of the problems standing in the way was the fact that with the improvement of relevant technology and with the exponential rise of possibilities to heal and to save and extend life, future physicians are under an immense pressure concerning their core medical education. It is, thus, understandable that the persons in charge of medical education hesitated to integrate even more learning materials and courses into the curricula – even though students would probably have found such courses highly helpful. Most recently, however, first steps have been made into this direction, e.g. at the Charité in Berlin and at the University of Bochum. Some of those people who are ready, willing and able to face this challenge of implementing courses for intercultural competence into medical education have very recently joined together, as the German-wide working group "Cultural Diversity in Medical Practice". This group has agreed upon developing guidelines for teaching intercultural competence in medical education. This is a good starting point for achieving the more ambitious aims described above. Long-term efforts into this direction might even include the extension of the concept, adding special training for patients and for medical personnel like nurses and paramedics. This last point would be really promising, because physicians in everyday practice are under an immense time pressure. Those people, thus, can take over the more of the dialogue, the more competent they are. And this holds not only for genuine medical expertise, but also for intercultural competence. To the extent we can move the interpersonal contact down to this level (for at least a portion of the interpersonal contacts), the time pressure on the physician will be reduced.

The conclusion so far is, thus, a claim for the development, implementation and evaluation of a new educational concept into medical education, based upon the methodological approach of Intercultural Philosophy, in order to improve future physicians' intercultural competence. With this claim, the paper has gone even beyond its focus, the individual level, and reached the societal level of intercultural stability (4.3). Changing to this level, it is essential to analyze the role of Engineering and Automatic Control in the light of these outcomes (4.4).

4.3 Reaching the societal level – an outlook

Even after implementing such courses within the curricula, there will, however, always remain cases in which conflicting norms, values and beliefs make a decision-finding impossible – intra- as well as interculturally. If a point is reached at which there is no chance for consensus between physician and patient, then a shift from the individual to the societal level may be an alternative approach: For such cases, greater hospitals have meanwhile quite frequently established a clinical ethics committee, an institution which may help improving intercultural stability when the dialogue on the individual level between physician and patient has failed, acting on the societal level. It would be helpful if the members of such committees, too, would be skilled in intercultural mutual understanding. But even though the UNESCO Division of Ethics of Science and Technology in 2005 has published a guide for establishing bioethics committees (UNESCO 2005), unfortunately, there is no recommendation included concerning intercultural training for their members or, at least, suggesting the participation in the committees' activities of a person specially trained in this area.

There are also *positive* initiatives to be noticed at the international level, like the *Amsterdam Declaration towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe* (MFH 2004), which offers additional ideas about creating an atmosphere more adjuvant for intercultural mutual understanding and trust within health care, especially in clinics.

4.4 The intercultural-interdisciplinary challenge for medical and engineering professions

As mentioned above, most physicians suffer from an immense time pressure, which is especially true for surgeons and primary care providers. The more time is spent with one patient, the less is available for another. Thanks to highly advanced new technologies, in some cases machines can compensate this problem. Due to this, the engineering profession constantly keeps gaining influence on the medical profession. But regarding the *interpersonal* problems which constantly appear and which are the more likely, the more the cultural backgrounds differ, it seems highly implausible that the mere increase of technology can overcome this challenge. In contrary, the increase of medical machinery and information systems threatens to endanger the important aspect of *meeting in person* quantitatively and qualitatively as much as possibly. Instead of practicing to understand the individual patient through intensive and extensive consultation, the modern physician has to gain the knowledge of an engineer himself. But this is plainly impossible.

The social impact of automation and control in this context is clearly visible. Thus, the engineering community must take face its responsibility of a *Human Centered System Design* – taking into regard the needs of the patients as well as the user-friendliness for the medical personnel. In order to overcome the described confrontation of engineering and medical profession in hospital and in patient care, the interdisciplinnary dialogue *must* be opened in order to include engineering on equal terms. This discipline is as relevant as the others to the issue of managing cultural diversity in medical care, and it has own, genuine capacities, approaches and discourses. Such an inclusive dialogue would even reach beyond the activities recently started in Germany and could e.g. also include an exchange concerning the implementation of intercultural competence in engineering and in medical *education.* It might for example be fruitful to design interdisciplinary modules, the topic being "intercultural competence in interaction with medical care and human centred system design", where students can mutually enrich themselves through their different backgrounds and experiences. But not only education, but also e.g. system, research and trial design are to face analogical challenges.

Let us, finally, have a look at the parallels and interacting challenges regarding the interdisciplinary dialogue itself. Taking into consideration analytical aspects of this paper, the interdisciplinary communication is faced with accordant problems as the intercultural, because every discipline has its own history, methodological approach and vocabulary. Thus, this dialogue may as well lead to misunderstandings. It is, therefore, most promising to follow the principles of the polylogue here as well. Especially, prejudices have to be overcome and a mutual process of learning has to be initialized.

This paper has focussed on the dialogue between patient and physician, in order to demonstrate the challenge of mutual intercultural understanding by using this example. Up to now, however, it has become visible, that theses considerations can be widened further and further and that the challenge is, in times of globalization, omnipresent and omnirelevant. Misunderstandings too often lead to decline and even violence, on the individual as well as on the societal level. Improving mutual understanding by strengthening intercultural competence, on the opposite, can help install such stability – in medical care as well as in all other fields of academic as well as societal interaction.

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