A SCALE FOR ASSESSING MULTICULTURAL ETHICAL SENSITIVITIES TO INFORMATION DISCLOSURE ON HIV/AIDS AND CANCER

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ABSTRACT

This study relates health care services marketing to culturally sensitive physician's duties of information disclosure on HIV/AIDS and Cancer. An ethical scale to assess multicultural ethical imperatives of medical residents to information disclosure is developed, validated and checked for convergent, discriminant and nomological validities. Health care marketing implications are discussed.

INTRODUCTION

In general, health care services offered in hospitals and clinics are progressively market-positioned (e.g., San Augustine, Long and Pantzallis 1992), market-oriented (e.g., Raju, Lonial, and Gupta 1995), customer-oriented (e.g., Hoffman and Ingram 1991), and quality-focused (e.g., Whipple and Edick 1993). However, health care services needed to satisfy customer (patient and family) and market (the public at large or society) in relation to sensitive cases such as treating HIV/AIDS patients have not been extensively researched or documented. Even though HIV/AIDS is a major epidemic affecting the United States to which marketers must adequately respond (e.g., Hill 1989), research on the quality of health care services to HIV/AIDS patients and patient's families has received very little attention in the literature. This paper concerns a very critical aspect of HIV/AIDS and Cancer service quality: a methodology for assessing the ethics of diagnostic information disclosure on HIV/AIDS and Cancer without the patient's informed consent. This aspect of critical care and service has received no attention in the health care marketing literature.

The Context of the Problem

Information on patients is routinely collected, disclosed, and acted upon in health care. The personal nature of the information either identifies or allows identification of individuals. Information privacy is concerned with control over access to personal information in either health or medical records. Confidentiality is concerned with control over the use of personal information once it has been disclosed. There is a basic obligation to maintain confidentiality of information if that information was provided with an expectation of confidentiality. However, no one likes breaking bad news on HIV/AIDS or cancer. The task is difficult and needs considerable tact (Buckman 1984), especially since almost all patients want to be told (Oken 1961). As a result, many patients and relatives have bad news disclosed by "junior" doctors who have little experience in dealing with patients, and very often tell relatives rather than the patient because they find it easier to break the news at second hand (Faulkner, Maguire and Regnard 1994). America attracts many "junior" doctors from abroad who are required to go through rigorous hospital based medical residency before a license for public medical practice is granted. Often these medical residents are asked to disclose the "bad news" and are found to exhibit culturally varied patterns in doing so. Our research attempts to capture this culture-variance.

Legal and Ethical Aspects of Information Disclosure

The issue of confidentiality is problematic in the case of AIDS. Every state in the United States has laws protecting the confidentiality of medical information related to AIDS and HIV (English 1991). AIDS is a reportable illness in every state, but a positive HIV antibody test is not reportable in several states, even though it
may become reportable due to "public health" considerations (Gostin 1989). In addition, many states have recently enacted specific statutes providing additional confidentiality for HIV test results and, in some cases, for other HIV-related information (Gostin 1989).

The issue of sexual partner/spouse notification has been the focus of extensive legal and ethical concern. Health care providers are reluctant to disclose information about infected individuals to sexual or needle-sharing partners because they do not want to discourage individuals from voluntarily seeking testing. At the same time they are seriously concerned about the risks to those who are exposed to sexually (unprotected) active infected persons. In addition, they are worried about the potential for conflicting legal liability, for breach of confidentiality, or violation of duty to warn. There is no widespread established duty to warn sexual or needle-sharing partners of HIV-infected individuals unless statutes or court decisions in specific states impose such a duty. However, a growing number of states are enacting statutes that permit physicians to notify partners without incurring liability for breach of confidentiality in doing so (Gostin 1989).

When describing a framework for an ethical analysis of a proposed HIV positive screening program, Beyer et al. (1986) used four ethical principles: a) Respect for persons: this principle requires that individuals be recognized as autonomous and that they have the right to control their own destiny and to decide what will or will not happen to them; included under this principle is the right to privacy and the requirement of informed consent; b) The harm principle: this limits an individual's freedom based on how one's choices affect others; c) Beneficence: requires that we act on behalf of the interests and welfare of others; potential risks must be weighed against potential benefits; d) Distributive Justice: requires equal distribution of benefits and burdens of particular actions. All four principles apply to information disclosure, with or without patient's informed consent.

Theoretical Background for Hypotheses Formulation
Culturologists suggest that our thought processes are culturally conditioned (Harris and Moran 1979). In general, Orientals (e.g., Asians, Middle-Easterners) analyze in ideograms and visualizations, whereas Occidental (e.g. North America, Europe) cultures tend to use concepts and paradigms (Harris and Moran 1979). Concepts have assumed the role of becoming the basic building blocks in Occidental (Western) theory and culture (Rexeisen 1984). For instance, Americans tend to view the world as being filled with thoughts and ideas, and hence separate subjectivity from objectivity, giving greater weight to quantitative rather than qualitative assessments (Stewart 1971). This in turn has led American researchers to focus on the "object" and to deemphasize "context" in their rush to dichotomize relations into subjective and objective. As a contrast, Oriental (Eastern) thought holds that meaning cannot be derived outside the context. We tested the following hypotheses:

H1: In general, attitudes of American residents toward HIV+ve-related information disclosure would significantly differ from those of Eastern residents.

H2: In general, attitudes of American residents toward terminal cancer-related information disclosure would significantly differ from those of Eastern residents.

H3: In relation to HIV+ve-related information disclosure, American residents would uphold the rights of the patient significantly more than those of the patient's family or society.

H4: In relation to HIV+ve-related information disclosure, Eastern residents would uphold the rights of the patient significantly less than those of the patient's family or society.

H5: In relation to cancer, American residents would uphold the rights of patient significantly more than those of the patient's family.

H6: In relation to cancer, Eastern residents would uphold the rights of the patient's family significantly more than those of the patient.

H7: In relation to HIV+ve-related information disclosure, Eastern residents would not significantly differ