Cross Cultural Newsletter
26 June 2013

Dear Members

As usual, this is to report back to you that we had over 40 members attending last night's meeting. I am happy to let you know that in the past year, we have been regularly having over 40 attendances at each meeting.

On the 25th June, the session was a follow-up on the previous talk on "Cross Cultural Psychosocial Management of Children in Need of Care and protection" given by Glorianne and Craig from CYFS. With the help of members, we have been able to create 4 case scenarios comprising of dilemmas that clinician often encountered in their daily activities.

For obvious confidential reasons, the case vignettes are hypothetical but sufficient to illustrate real life issues. As they still contain real dilemmas, our members are asked to keep the strictest of confidentiality. Most of our members remarked that these sessions proved to be very useful, especially when they were combined with a prior talk like this time. As long as confidentiality is observed, this form of presentation would suit our pragmatically orientated members most.

Last evening, the workshop comprised of four case scenarios. The panelists were Glorianne, and Craig from CYSF and Kay McCabe clinical psychologist currently working at Kari Centre. Patrick Au served as the moderator.

As clinical dilemmas usually centre around ethical conflicts (child care and protection is no exception), I started by introducing health (medical) ethics. Being no ethicist myself, I could only share with our members about my own experience and give a simpleton's view which never-the-less contain enough information to guide us through our thoughts whenever we experience ethical dilemmas.

I defined ethics as a guide to our behaviours, whether they are right or wrong. However, I emphasised that there is no absolute right or wrong but a weighting of which action is relatively more correct (or wrong).

As to how to determine the ethical appropriateness of one's actions, there are two major ethical models: the deontological (based on virtues); and the consequential schools. The former comprises of ethical principles (virtues) determined by ethicists and philosophers. These principles form moral standards the following of which would determine the correctness of one's actions. The consequence of the action is not deemed significant. On the other hand, the consequential school examines the consequence of ones actions which should ideally be to achieve the best possible outcome for most of the people concerned.

An illustration of the difference between the two schools is exemplified by "one must never lie even if it were to protect someone." For the consequential school, there are exceptions depending on consequences.

I then highlighted several common health ethics such as "non-malfeasance (do no harm), primacy of relationships, beneficence, and the more western concepts of individual rights such as autonomy, self-determination (consent), privacy (confidentiality) and equity of access.

While there are differences in ethical standards between East and West, most cultures share the common theme in that both emphasis on non-malfeasance and primacy of care as most important, taking priority above all others.

As to "individual rights", if one changes the word "individual "to "family", most of the ethical issues on individual rights would apply well to oriental families. The establishment of commonalities would often help clinicians working across cultures to develop common codes to guide them. Further, the prioritising of ethical principles such as "do no harm" over and above others would help clinicians to make a choice should several of the ethical standards conflict with each other.

Having described ethics in at the most simple manner, I then shared with the audience a flow chart of mine, showing how one can combine the two schools of thought to deal with dilemmas.

In short, simple actions that follow ethical principles pose no problem. But the problem arises when ethical values conflict with each other. This is especially so when doing clinically work across cultures in which ethical principles often differ. In these cases, setting priorities, finding commonalities in health ethics (e.g." do no harm"), or using the consequential school of reasoning to find the action giving the best overall welfare or least harm to clients would help.

Ultimately, a number of religious philosophies, especially Buddhism emphasise the importance of self-reflection and conscience as the final overseer for our actions. (This does not apply to those with little conscience. However, these latter persons are few and far in between).

Ethical behaviours do not end at making a well-reasoned decision. Seeking consultation to shed light on our blind-spots is deemed necessary.

More importantly, as any decision would incur some harm to the client or some other parties, attempts to lessen the harm by support are equal, if not less important ethical behaviours.

I finished by giving a hand-out on the tentative flow-chart and description about commonalities of ethics between cultures for the reference of our members. But please note that they are not fool-prove but only serve as suggestions when members endeavour to do ethical deliberations over ethical problems. Your judgment and discretions are called for.

We then presented 4 case scenarios (only had sufficient time for three).

They illustrate various stages of the ethical decision flow-chart:- viz
"Is there an ethical problem" (depicting the clinical and cultural difficulty in deciding whether abuse/harm exists);
"The Fatal Samaritan" (illustrating the ethical conflicts about helping parents having euthanasia wishes towards their suffering children);
" the Scylla and Charybdis" (exemplifying the conflict encountered by the clinician when the act of caring for the child gives the disturbed mother reason to survive; but also generating doubts about whether the child would be harmed in the course);
and the last " give and take" (about taking away the parental control and inducing shame but giving in return, unstable and poor care for the child).

These scenarios stimulated much discussions and deliberations. There was no time for the last one.

For those interested in the debates, for reasons of confidentiality, a DVD would only be available to our allied professional members. When you request for such, please let us know your profession and just indicate that you would only keep this to yourself, not circulate around.

Finally, the lessons I have learnt from this presentation are :- the importance of matching actions to the seriousness of risks; more importantly, also the importance of having an initial but informal consultation with CYFS whenever doubt arises, and , last but not least is the importance of working closely with CYFS like a team.

Other carry-home messages are that across cultures, the technique of reframing often proves to be successful. This is especially relating to the term "abuse" which would cast shame in most cultures.

However, using another one indicating the presence of a disharmony in the family would help the team to go a long way to increase acceptance of CYFS, not as a law enforcer of disciplinarian, but a helper to provide assistance.

The last message to learn is the concept of "repercussions ". Although for most of our members who work with adult clients would set our prime allegiance to them (e.g. parents). We often concentrate on the welfare of these client-parents, but overlooking and not taking action to prevent harm to the child in order to protect the parents would also create a repercussion which would ultimately hurt the welfare of our adult clients (consequential model of thinking).

The concept of "repercussions" or commonly known as "short term pain, long term gain" principle would be useful to help us not to be biased in our ethical decisions. Again, there were many discussions. The meeting finished at 8.15pm

FUTURE SESSIONS. I am trying to invite speakers to talk on various subjects : e.g. the management of trauma in the oriental population; health and effective coping in elderly migrants, issues of International students, and the long overdue talk on Gi-gong disorders (we have just witnessed such a case recently).Please watch for the flyer.

DVD Those requiring the DVD, please contact Dianne Evans (our new administrative coordinator) at dianee@adhb.govt.nz**.**

For this occasion only, we have to limit the DVD distribution to our members who are allied professionals (including psychologists, counsellor, social workers, OT, nurses, psychiatrists, doctors and interpreters) - thanks to those who have already responded.

Please also indicate to Dianne you agree to keep the DVD and the contents to yourself. I hope you would understand the importance of confidentiality and must apologise for imposing this requirement on you.
Once again, thank you for your support.

We do require you to send Di a $2 stamp in order to cover postage of the CD.

Internal Mail:
Di Evans, Cross Cultural, Mental Health, Bldg 7, Level 4, Greenlane.

To post by mail:
Di Evans, Cross Cultural, Mental Health, Auckland District Health Board, Private Bag 92189, Greenlane, Auckland, 1142.

DVD orders that have been received should be posted out by next week. Some handouts are available but we will not send out the Case Scenarios due to the sensitive, private nature of the content.

Thank you again for you continued interest and support.

I look forward to seeing you all at our next meeting.

S Wong

On behalf of the Cross Cultural Group

Preview of next session

Next Meeting
Tentative date
Tuesday 27th August
Please watch out for the flyer at the end of the month to find out who our Guest Speaker will be.