

Fa'asāmoa Bioethics and Healthcare decision-making in New Zealand

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Abstract

This paper addresses the shortcomings in the bioethics literature and the need to adequately address the lack of data on Pacific-specific healthcare decision-making in New Zealand. It provides evidence to address this gap in the bioethics literature whilst contributing to the discourse of decision-making undertaken by Sāmoan Healthcare Professionals (HPs) (such as General Practitioners, Hospital Doctors and Nurses) as well as the separate healthcare decisions undertaken by Sāmoan medical patients. This research articulates the cultural tensions and limitations in dichotomizing cross-cultural approaches to bioethics, whilst providing the plausible basis to develop a broad knowledge base of cultural factors, ethical practices, influences and understandings that are associated with fa'asāmoa bioethics in New Zealand. The interface between fa'asāmoa bioethics and health care decision making highlights the importance of capturing the social, spiritual, cultural and historical variables which fundamentally shape the beliefs of Sāmoan HPs as well as Sāmoan medical patients in New Zealand. These factors are not only complex but they also play an important role in the initiation, development and maintenance of fa'asāmoan bioethics in healthcare decisions. The task for the HP is to use his/her clinical skills to promote the patient's wellbeing which requires that the patient's own values and goals of care (Kaldjian 2004) are integrated in the healthcare decision-making process (Brock 2009). Considerable attention will be directed to the field of bioethics whilst focusing on the clinical realities of HPs decision-making (Siegler 1978). Given that New Zealand's current system of healthcare decision-making for HPs is guided by the New Zealand Medical Association Code of Ethics (also based on the Beauchamp and Childress (2013) four principles of biomedical ethics), in addition to the Code of Health and Disability Services Consumer's Rights, it is arguably characterised as individualistic and self-autonomous. Further research into fa'asāmoa bioethics may support the New Zealand HPs working with Sāmoan medical patients and alongside Sāmoan HPs through the development of a bioethical framework whilst enriching and adding value to the healthcare decision-making discourse.

Keywords: Fa'asāmoa bioethics, healthcare, decision-making

Introduction

Fairbairn-Dunlop (2006: 9) once claimed that: "the Pacific challenge is to develop a post-colonial ethics discourse which is Pacific in philosophy and locally grounded in context". On this rhetoric, Nie (2008: 91) claims that culturally diverse people demand a unique set of bioethical principles and rules that reflect the richness of distinct cultural settings. Therefore, it is imperative for different cultural groups to develop their own bioethics frameworks.

Today, Sāmoans represent the largest proportion of the Pacific population in New Zealand (Statistics New Zealand 2017) alongside the Cook Islands Maori, Tongan, Niuean, Fijian and Tokelauan. There are similarities as well as unique distinctions in cultural beliefs, history, language and social structure across the diverse Pacific diaspora in New Zealand. Tukuitonga and Finau (1997) indicate that sub-groups exist within each group whilst there are others with multiple ethnicities as well as a high proportion born and raised overseas or in New Zealand. Anae et al (2017: 48) take a step further by acknowledging the pressing demands confronted by the "pioneer generation" (or the parents of first generation overseas born/raised children (i.e., the new generation)), which often took precedence such as raising their new generation children and adapting to a new country. The new generation had to also grapple with rebuilding learnt traditional knowledge of *fa'asāmoa* and *fa'amatai* (Sāmoa's Chiefly System), such as *tautua* (service) and *fa'aloalo* (respect), from their pioneer parents, contextualised alongside other issues of identity and social justice (Anae 1998, 2002, 2006).

When examining other cultural and religious perspectives to health, alongside a holistic socioecological framework, health is not strictly conceptualised as the absence of disease and infirmity but a state of social, mental, physical and spiritual well-being (Finau 1997). In numerous health studies, most Pacific patients acknowledge their faith in God (Pacific Health Research Centre 2003). Such faith affirming comments is often misinterpreted and overgeneralised by culturally incompetent providers as the adoption of a fatalistic approach to health outcomes (Tukuitoga 2001). The Medical Council of New Zealand corrected this misconception although it had published an article from Dr Colin Tukuitonga twelve years earlier which claimed that Pacific people are often fatalistic and apathetic in matters of health (Medical Council of New Zealand 2013). This critical gap in knowledge requires further research for more measurable evidence of cultural competence by Health care providers to monitor patterns of use, disparities in health status, or whether quality indicators are in place to determine accountability (Chin 2000).

In the healthcare setting, data from the Medical Council New Zealand 2013 workforce survey, indicate that Māori and Pacific peoples (2.7 percent and 1.8 percent respectively) remain under-represented in the medical workforce (Ministry of Health 2016). However, with the rising number of Māori and Pacific medical students, it is envisioned that this could lead to an emergence in Māori and Pacific doctors (Pacific Perspectives 2013).

Horner (et al 2004) and McNeil (et al. 2002) argue that HPs should be adequately equipped with cultural competence skills to better understand the health-related attitudes, beliefs and local realities of other ethnic groups or social class groups. Of primary consideration in cross-cultural practice is for increased sensitivity on the part of HPs (Brislin 1993; Koenig 1997). Tiatia (2008) further indicates this will help address the lack of access to quality health care, help remove barriers such as mistrust of the HP community and reduce covert biases (i.e., gender and cultural stereotyping) both HPs and patients arguably bring to the processes of patient care. With this in mind, it is questionable whether the current delivery of healthcare services in New Zealand have been informed by evidence-based research specific to cultural competence practice in the healthcare setting.

This paper will attempt to conceptualise fa'asāmoa bioethics of both Sāmoan HPs and Sāmoan medical patients. Moreover, to develop a fa'asāmoa bioethics framework to better assist HPs involved in some aspect of cultural competence and healthcare decisions for Sāmoan medical patients. It explicates the significance of Sāmoan cultural reference points such as *tapu* and *tofa sa'ili* (Tamasese 2009) as being integral to *Fa'asāmoa (Sāmoa's Customary System)* and utilises these cultural reference points to address the paucity of evidence in the application of fa'asāmoa bioethics in healthcare decisions.

By interrogating the four principles of bioethics [“commonly referred to as “principilism”] (Beauchamp and Childress 2013; MacLeod and James 1997), this paper will also investigate whether the principilist approach could be enriched alongside a Fa'asāmoa bioethical framework for healthcare decision-making by contextualising the collective values which are fundamental to both Sāmoan HPs and Sāmoan medical patients. This approach could also serve as a useful starting point to support New Zealand HPs when being consulted by Sāmoan medical patients during the medical exchange or working alongside Sāmoan HPs.

Background to the development of Bioethics

Jonsen (2000) claims that the terms bioethics, healthcare ethics and biomedical ethics are often used interchangeably. Although first documented into literature as late as 1969 (Jonsen 1998, 2000, 2002, 2005), the field of bioethics had already emerged in response to the technological advancements of the 1900s. However, Rothman (1991) disputes this claim by arguing that human experiments and ethical risks have been practised for “millennia”.

Between 1945 and 1965, wartime research focused specifically on responding to military needs at the time whilst simultaneously improving health care for the civilian sectors with the initiation of organ transplantation, brain surgery, heart surgery, the use of antibiotics and life-sustaining machines—the dialysis machine, the pacemaker and ventilator (Jonsen 2000). The rapid changes in technology, gave rise to unique moral issues and ethical dilemmas which warranted further attention. HPs and Scientists during the 1950s would meet to address questions about how to decide on these contentious ethical areas, from resource allocation due to the lack of medical supplies. Health laws and regulations proliferated in the ensuing decades, taking into consideration the ethical principles and guidelines to determine who lives and who decides (Rich 2013).

Unethical lapses in biomedical and behavioural studies resurfaced in Europe, following the Nazi medical experiments of World War II in Europe (Rothman 1987; Truog 2012) whereby the Nuremberg Code was issued in 1947, to ensure that researchers must recruit competent research subjects who understood the nature of the research and voluntarily gave informed consent (Annas and Grodin 1992).

Similarly, in the United States, the 40 year Tuskegee Syphilis Study (1932–1972) comprised of 399 Tuskegee-based African American men with syphilis (infected) who were observed and untreated, in comparison to the control group of 200 Tuskegee-based African American men (uninfected) (Rich 2013). Two years after the unethical practices of this study were exposed by a medical reporter, the National Research Act was enforced in 1974, followed by the establishment of the National Commission on Protection of Human Subjects of Biomedical and Behavioral Research (Commission). This was the first commission of its kind in the United States which led to the development of the three fundamental principles to help guide any research using human subjects—respect for persons, beneficence, and justice. This was adopted in the Commission’s first report in 1979, known as the Belmont Report (National Institutes of Health 1979).

Also in 1979, Beauchamp and Childress published the first edition of *Principles of Biomedical Ethics*, which comprised of the four bioethical principles: autonomy (i.e., the right of the individual seeking healthcare treatment to make her/his own independent choice)—now referred to as respect for autonomy in its seventh edition (Beauchamp and Childress 2013), non-maleficence (i.e., as stated in the Hippocratic oath: “above all, do no harm”), beneficence (i.e., acting in the best interests of the individual), and justice (i.e., adhering to principles of equality and fairness). Three of the Beauchamp and Childress bioethical principles were espoused in the Belmont Report 1979 (National Institutes of Health 1979).

In their model, Beauchamp and Childress advocate that in working through difficult questions, the four main principles must be considered. The solution to the problem that best meets these principles is the one that is most justified. This approach also aligns with Jiwani’s principlist approach (2008), whereby a principle-driven approach is useful for resolving ethical dilemmas by

applying such principles to cases (Jiwani 2008). However, one must first explain how these principles are applicable to the context of healthcare decision-making, through the analysis of alternatives in order to determine which aligns most with the favoured principles. The case study examples (discussed later) will be used to explicate bioethical principles adopted by both HPs and medical patients during the healthcare decision-making process.

However, Western bioethics is largely influenced by the four principles outlined by Beauchamp and Childress (2013). It has not only developed into the eminent bioethics textbook constituting the diverse strands of contemporary bioethics (Pellegrino 1993), the four principles of bioethics have become one of the most useful tools for HPs involved in healthcare decision-making for analyzing and resolving bioethical problems. This approach has also been favoured by early Western bioethicists, first in the principles for research ethics articulated by Henry Beecher in 1966 in his criticism of research practices applied to healthcare. Beecher (1966) argued for peer review of research, protecting the rights and welfare of research participants, and ensuring appropriate informed consent. Beecher also exhorted researchers to reform the status quo, by cautioning both researchers and the public about unethical research practices in the United States, including the Tuskegee Study alluded to earlier (Beecher 1966).

Lee (2010) and other ethicists (Sokol 2009; Walker 2009) also critique the use of principlism across culturally diverse communities according to different grounds. Walker claims that principlism is an incomplete ethical framework when the crucial elements of a broader ethical debate are not considered. Walker argued that the four principles are inadequate for managing other ethical issues which arise in the healthcare setting. Walker pointed out that some moral principles are culturally specific which reinforces the inadequacy of the four principles to capture the diverse discussion of bioethics.

Sokol (2009) argues that Walker's idea of principlism is too simplistic and collapses when specification (described by Sokol as the process by which context-sensitive norms apply to the four universal principles specific to situations) is not balanced alongside common/universal morals. Sokol further clarifies the position of cultural specific norms as situated within a broad ethical framework of universal moral principles.

Before covering this in detail, it is instructive to offer a brief overview of bioethics by presenting two comparative cases. The first case covers key ethical dilemmas facing HPs when working with Asian families, followed by second case covering ethical dilemmas facing Sāmoan HPs when undertaking healthcare decisions for medical patients.

Case study 1: Asian Bioethics

Windsor et. al., (2008) explored cultural competence in the mode of communication when telling the truth to Asian families in a hospital setting with particular emphasis on breaking bad news, identifying the locus of decision-making within a family and end of life care decision-making. The three models of decision-making endorsed in this context were patient autonomy, non-maleficence, and beneficence. However, a full disclosure model (focusing on the progress prior to informed consent for treatment) was considered less appropriate for patients from other diverse cultures, as discussed further in Case Study 2.

Kung (2007) highlights the underlying tensions faced when grappling with finding a middle ground between competing ideologies such as between ideas of science and religious practices or the secular and the sacred. In Dr Jing-Bao Nie's (cross-cultural and international bioethics expert) review of *The Way of Asian Bioethics* by Michael Cheng-tek Tai (2008), he asserts that it is deeply flawed to adopt the Western approaches of bioethics without considering the cultural and social context (Nie 2008:91). Furthermore, Tai believes that the influential "four principles" of Beauchamp and Childress (2013)—autonomy, beneficence, justice and nonmaleficence—are not universally binding and should be modified.

Tai's solution was originally applied to an Asian bioethics context (Nie 2008) which is often irreconcilable with Engelhardt's approach to bioethics. Engelhardt (1997), is a well-known Western Bioethicist in China, notably dichotomizing Asian bioethics and Western Bioethics and other non-Western bioethics. Other Asian bioethicists including Fan (2011) are part of the 'Engelhardt circle' (Nie 2007). Similarly, Fan (1997: 309) argues that the "Western principle of autonomy demands self-determination, assumes a subjective conception of good and promotes the value of individual independence, whilst the East Asian principle of Autonomy requires family determination, presupposes an objective conception of the good and upholds the value of harmonious dependence."

Nie (2007: 145) challenges Fan's dichotomizing of the principle of autonomy: One Western and the other Eastern Asian which makes it as controversial as Fan's claim that the Western to Eastern cultural differences are "incommensurable". Nie (2007: 143) further claims that "a long rooted stereotype in my view—exists to these complex questions. It characterizes Asian bioethics as communitarian, collectivist or family-centred, in contrast to Western bioethics which is portrayed as individualistic in essence". By formulating a transcultural bioethics framework, Nie investigated bioethics in China from a Chinese-Western perspective (Nie 2011) whilst drawing on an interpretive or transcultural approach to bioethics, resisting cultural stereotypes, upholding common humanity and morality and through the acknowledgement of the richness, dynamism, internal plurality within every culture, whether in China, the West or elsewhere.

Pacific bioethics literature

"Pacific people judged the quality of their health care by their sense of whether or not the *va* [sacred space] was being respected. Consultations are more than just a commercial transaction in which doctors provide a service and patients pay; when the relationship between patient and health professional respects the *va*, then, to the Pacific person, there is a completely different quality to the relationship" (Primary care for Pacific People 2012).

du Plessis and Fairbairn-Dunlop (2009: 110) claim that there are a number of inter-related and cross-cutting themes which set the context for a comprehensive debate about the continuation of Pacific bioethics. Tamasese (2009: 116) approaches the distinction between the Sāmoan indigenous concepts of *tapu* and *tofa sa'ili* whilst attempting to situate these indigenous concepts in "the contemporary Sāmoan experience and understandings of the ethical." On this premise, Tamasese

(2009) captures the different system of ethical practices and understandings between the indigenous experience and the contemporary experience. Further research is needed to explore and document Pacific bioethics before it is lost which has given rise to what knowledge should be retained, passed on, to whom and how this should be done (du Plessis and Fairbairn-Dunlop 2009: 111).

du Plessis and Fairbairn-Dunlop (2009: 111) also claim that in Pacific communities knowledge is shared communally with the overall objective of achieving good life for all its members. This also echoes Anae's (2001) conceptualisation of *aiga* (meaning Family in Sāmoan) as one of the most central features of *Fa'asāmoa* or as Fleming *et al* (1997) note, if individualism is the essence of the Western culture, then being part of a family—*aiga, anau, magafoa, kaiga, kainga, and kawa*—is the essence of Pacific Islands cultures (Fleming *et al* 1997). Tamasese (2009: 123) further adds that “Collective decision-making is privileged in Sāmoan indigenous culture” as it adheres to the principles of *tapu* and *tofa sa'ili*. These principles are inseparable and implicit in the spiritual expression and collective practice of *tofa sa'ili*. For example, in the Sāmoan indigenous context, the principles of *tofa sa'ili* and *tapu* are reflected in the decision-making powers of *matai* (Sāmoan chiefs) with *matai* designated sacred roles with presumed divine designation.

Tamasese (2009: 116) claims that “engaging in meaningful debates about bioethics and Pacific research is a constructive contribution to an extremely complex problem”. Moreover, Tamasese asserts that bioethical declarations that dismiss the recognition of the sacred are essentially the same as rejecting the indigenous Pacific context.

Fa'asāmoa bioethics literature

Lee (2007: 1) claims that “Any issues facing Pacific peoples must be discussed in the context of both the islands and their diasporas, taking the processes of ‘world enlargement’ and transnationalism into account”. Anae *et al* (2017) agree with Lee's claim given the implication that *matai* (Chiefs) born overseas or outside Sāmoa (i.e., transnational *matai*) are deemed as not as authentic networks of connection or exchange in comparison to *matai* born in Sāmoa and continue to reside in Sāmoa (Gershon 2012, 2007; Gough 2006, 2009).

Suaalii-Sauni (2017: 175) provides further guidance by unpacking the core elements of custom principles, an area which is largely under-theorised, to further assist with the development of evidence-based Sāmoan indigenous knowledge, effectively seeking to minimise any misinterpretation and manipulation of custom. The essence of *Fa'asāmoa* culture underpinning *Fa'asāmoa* bioethics (Anae *et al.*, 2001; Gilson 1970; Meleisea 1995; Meleisea *et al.* 1987; Shore 1982; Suaalii-Sauni 2006; Tamasese, Peteru and Waldegrave 1997) are largely conceptualised by the values of *alofa* (love), *tautua* (service, to serve), *usita'i* (obedience, to obey), *fa'aaloalo* (respect, deference) and *mamalu* (dignity).

By advancing a *Fa'asāmoa* bioethics approach which draws out insights and wisdom from *Fa'asāmoa* values and customary practices, Tai (2008) also provides some guidance. In mutual participation there are ways to respect a patient's right as well as the role of the family, in which the decisions are shared jointly between the individual patient, family members and the physician (Nie 2008). The same rhetoric could also be applied through a transcultural lens, as conceptualised by Nie (2011), taking into consideration the *fa'asāmoa* context of Sāmoans living in Sāmoa and outside

Sāmoa. Arguably, there are plausible grounds for acknowledging the pluralistic conceptualisation of what constitutes fa'asāmoa as experienced and understood by Sāmoans in practice.

On this rhetoric, I agree with Tamasese conceptualisation that fa'asāmoa bioethics involves both *Tofa Sa'ili* (*Tofa* means wisdom in Sāmoan; *Sa'ili* means to search in Sāmoan) the search for wisdom, knowledge and truth; and *tapu* (meaning both sacred and taboo in Sāmoan). This search is largely grounded in a sense of connectedness to all things. According to Tamasese (2009), Sāmoan thinking is relational, pointing out the ethical dilemma underlying the tensions between searching for the wonder of God (as reflected in Francis Thompson's (1908) "God chasing" ideology) or wanting to know God (as reflected in Karl Barth's (1919) "God sickness" ideology). The latter is to assert arrogance. This practice draws on insights of contemporary Sāmoan practitioners who practice Sāmoan traditional healing whilst attempting to situate the two main indigenous Sāmoan reference points (*tofa sa'ili* and *tapu*) in contemporary Sāmoan experiences and understandings. Ultimately, Tamasese (2009) claims that the bioethics underpinning the pursuit of objectivity is likened to a "dance with and between power and vulnerability" (Gunn-Allen 1998: 64–65). As collective decision-making is an expression of what Tamasese describes as the Sāmoan indigenous reference.

Medico-legal context in New Zealand

In order to understand how healthcare decision-making is conceptualised, I will provide a brief outline of the medico-legal context regulating both HPs and medical patients in New Zealand.

Three years after the 1991 Harvard University study (examining the incidence of adverse events and negligence in hospitalized patients) the Health and Disability Commissioner Act 1994 (the Act) was passed into law which led to the establishment of the New Zealand Office of the Health and Disability Commissioner (HDC). The HDC is the leading authority responsible for the promotion and protection of Health and Disability Service Consumer (HDSC) rights. The Act enables the HDC to undertake independent investigations as the 'consumer watchdog'. In 1996, the Code of Health and Disability Services Consumers' Rights (the Code), the independent nationwide advocacy service, and the HDC complaints resolution service was also established. The Act is also the medico-legal attempt at balancing: a resolution of complaints⁴, quality improvement⁵ and provider accountability—ensuring providers are held accountable for their actions.

Another relevant Act is the New Zealand Health Practitioners Competence Assurance Act 2004 (HPCA Act), which covers all health professionals, and provides mechanisms to ensure healthcare professionals are competent, registered, subject to regulation and also protects the health and safety of all New Zealanders (Ministry of Health 2016). It also requires that standards of clinical competence, cultural competence and ethical conduct are set by professional registration bodies and ensures that all healthcare professionals are familiar with the concept of cultural competence and is critical that it be demonstrated by them (Ministry of Health 2016).

Patient rights have been codified into a number of documents that are standards such as the Code, mentioned earlier, which includes medical informed consent and the advance directive.

⁴Resolving complaints in relation to health and disability services.

⁵Using the learning from complaints to improve the safety and quality of health and disability practices and systems and to promote best practice and consumer-centred care to providers.

Before the New Zealand Medical Association (NZMA) Code of Ethics was reviewed in 2014, it was heavily criticized as predominantly a Eurocentric, individual patient-focused monocultural document—separate to the doctor as independent practitioner and based on the four principles of Beauchamp and Childress (Gray 2014).

Healthcare decision-making in New Zealand

When faced with complex and irreversible medical situations often involving dynamic and nontransparent decisions that determine the outcome of life-sustaining treatment, these healthcare decisions often translate into far-reaching consequences for the medical patient and their relatives. This highlights the need for HPs to also consider whether they are vulnerable to systematic reasoning biases (such as, gender, political, cultural or religious biases) which can affect the quality of healthcare decision-making especially in the case of severely ill patients. Kaldijan (*et al.* 2005) claims that a systematic approach to healthcare decision-making must be accessible to HPs and should be reflected in the style of healthcare decision-making that they undertake. Although partially resembling other approaches adopted in bioethics, this approach will recognise the ethical dilemmas in clinical practice that usually emanate as a result of a dynamic process of assessment as opposed to a prediagnosed assessment. Such a flexible approach makes it open to explore other issues which appear to be ethical at first but may actually relate more to insufficient communication, interpersonal conflict or at worst, incomplete awareness of existing clinical options.

The role of HPs religious beliefs in professional practice needs to be clarified in the wider medico-legal context. Other critical factors include personal beliefs such as religious commitment, culture and emotions. As paraphrased by Schleger, Oehninger and Reiter-Theil (2010: 3) "clinical situations that are characterized by complexity and uniqueness require particular sensitivity and competence regarding ethical issues". This supports the claims from recent studies highlighting the need to explore the ethical justification for healthcare decision-making and the need for thorough discourse on the quality of healthcare decision-making (Pfaefflin et al 2009; Rubin and Zoloth 2000; Kaldijan 2004). There is sufficient evidence presented for a case to develop a *fa'asāmoa* bioethical framework to help guide HPs and key decision-makers.

However, there is a lack of focus on patient empowerment in the literature and how HPs can better assist their patients during this empowerment process. The communication strategies of HPs can help to reinforce two types of communication approaches during the healthcare decision making process: (1) Communication-limiting marked by dependency and patient passivity; or (2) Patient-centred marked by open, active collaborative and full engagement (Roter 2005). Doak et al (1996) further highlight why patients should be guided to anticipate the next steps of their healthcare decisions specific to their healthcare context. When HPs provide patients with guidance about what to anticipate it helps facilitate patient empowerment. It also aims to ensure the doctor-patient experience is manageable, particularly for patients from different cultures and a low health literacy background.

Health literacy experts claim that the patient-centred approach helps to address the knowledge gaps in the medical exchange (Weiss 2007; Sudore and Schillinger 2009). Zarcodoolas et al (2006) further highlights the importance of incorporating a component of cultural literacy in health literacy. In this healthcare context, cultural literacy is the ability to adopt culture and social identity to act on and interpret information.

Cultural competence is also a vital component to improving patient health outcomes. Tailoring communication to ensure it is patient-centred is a useful starting point. Roter (2005) agrees that the Doctor-patient relationship is one which is characterised as reciprocal, whereby each party influences the other during the healthcare decision-making process of the medical exchange. The Medical Council of New Zealand (2006) argues that HPs need to be culturally competent in communicating with a cultural diversity of patients with cultures different to their own. As the more competent a HP is in terms of understanding a patient's context, the more meaningful, acceptable and relevant the treatment is to the patient.

Fa'asāmoa bioethics in healthcare decision-making by Healthcare Professionals

To discern how *tapu* (or sacred relations) might inform Fa'asāmoa bioethics "is to suggest that it carries with it an ethic of care—one framed in relational terms, where those relations have a sacred essence" (Tamasese 2009: 121). In this way, Tamasese (2009) advises Pacific researchers seeking to understand Fa'asāmoa bioethics to undergo critical self evaluation of their own constraints or limitations and that of their cultural reference point. This approach is pivotal to the seminal work of Arthur Kleinman (1980, 1988, 2006) focusing on the need for critical self-reflection by medical students and HPs in the act of care-giving. A similar rationale is indicative of the nature of human interaction in the caring process. In this case, MacLeod and Egan (2007: 241) point out how essential it is that "each professional has an understanding of themselves, their personal values and their own insights". This might be achieved through a number of means such as "personal reflection and supervision". Tamasese (2009) claims that one must have an understanding of the wider context of Fa'asāmoa bioethics which is inseparable from understanding of the principles of *tapu* and *tofa sa'ili* (Tamasese 2009).

In comparison to Case study 1, this Case study looks at the experience of a Sāmoan HP and Sāmoan medical patient involved in healthcare decision-making.

Case Study 2: Fa'asāmoa Bioethics

Dr Hopoi (personal communication, 5th July 2017), a Sāmoan General Practitioner in New Zealand, states that it is not uncommon for other Sāmoan HPs to view the Doctor-patient relationship as one which is *tapu* and spiritual when expressed as *tautua* through the act of imparting knowledge and through the administration of care towards her medical patients. This echoes Sister Vitolia Mo'a analysis whereby *tausiga* is deemed as an ethical responsibility meaning 'to care for'. Alongside this, the expression of *tapu* and *tautua* in the faasāmoa are implicit in the duty to share in the carrying of burdens (Personal communication, Suaalii-Sauni 2007:33–60 in Suaalii-Sauni 2017: 177).

In many Asian and Pacific Island cultural traditions, the individual may have (and want) little input into the decision-making process, rather healthcare decisions may be decided by the family as a whole or relegated to the patient's doctor (Hattori et al., 1991; Long and Long 1982). On this rhetoric, by developing a Fa'asāmoa bioethics framework of healthcare decision-making it would enrich the decision-making experience of both HPs working alongside Sāmoan HPs and with Sāmoan medical patients by dispelling any cultural preconceptions, misinterpretations or dichotomizing stereotypes associated with fa'asāmoa bioethics (as alluded to in Table 1 below):

Table 1: Western bioethics vs Fa’asāmoa bioethics

Bioethical values in healthcare	Common assumptions of Western bioethics	Common assumptions of Fa’asāmoa bioethics
AUTONOMY	Individualism (inalienable)	Collectivism (often abdicated to loved ones)
DECISION-MAKING	Individual, independence	Holistic/shared approach, Interdependence
TRUTH TELLING	Full disclosure and clarity	Partial disclosure and ambiguity
ADVANCE CARE PLANNING PERCEPTIONS	Liberal, nonintrusive, reduces family stress	Authoritarian, highly intrusive, increases family stress
DECISIONAL AUTHORITY	Biomedical/bioethical reasoning	Familial relationship, love

(Adapted from Johnstone and Kanitsaki 2009).

The Fa’asāmoa Bioethics framework for decision-making is not intended to replace foundational bioethical principles by providing pragmatic solutions to challenging healthcare decisions through ethical justification (Kaldijan, Weir and Duffy 2005). Such a process allows room for transparency which thereby allows HPs to articulate a course of action and facilitate consensus based on a shared understanding of values or goals. In effect, this enhances clarity in healthcare decisions, whilst facilitating dialogue with medical patients and HPs who are impacted by such decisions.

Conclusion

In this paper, I presented evidence in response to the call by prominent academics, Fairbairn-Dunlop (2006), Nie (2008), Tamasese (2009), Suaalii-Sauni (2017), Anae et al (2017) to name a few. The call to dispel any dichotomised cross-cultural notions of bioethics, to add value to this discourse, to interrogate our uniquely diverse customs and values, grounded in our own local realities, whilst capturing the complex nature at the interface between fa’asāmoa bioethics and healthcare decision-making in New Zealand. In the same rhetoric, I call all HPs to develop their own transcultural healthcare decision-making frameworks, which could be enriched alongside the NZMA Code of ethics and Beauchamp and Childress’s principles of bioethics. This research also serves to raise the bar of HP culturally competent behaviour, whilst encouraging HPs to consider critical self-reflection of their own personal values and belief systems before administering care to their medical patients. In closing this paper, I will direct you to the words of Sāmoa’s former Head of State, Tui Atua Tupua Tamasese Ta’isi Tupuola Tufuga (Tamasese): “If bioethics is about the value of life and the value on life, then for Sāmoans and other Pacific nations who privilege the sacred, bioethics is about a respect for the sacred, for the *va tapuia*. Bioethical declarations that refuse to recognise the sacred will ultimately refuse to recognise the indigenous Pacific context.” (2009: 123–24).

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References

- Anae, M., 1998. "Fofoaivaoese: The Identity Journeys of NZ-born Sāmoans." Unpublished PhD Dissertation, Auckland: University of Auckland.
- Anae, M., Coxon, E., Mara, D., Wendt-Samu, T., and Finau, C. 2001. *Pasifika Education Research Guidelines*. Wellington: Ministry of Education.
- Anae, M. 2002. "Papalagi Redefined: Towards a NZ-born Sāmoan Identity." Pp. 150–169 in *Pacific Diaspora: Island Peoples in the United States and Across the Pacific*, ed. P. Spickard. Hawaii: University of Hawaii Press.
- Anae, M. 2006. "Sāmoans in Settler and Migrant Peoples of New Zealand." Pp. 230–235 Albany: David Bateman Ltd. <http://www.teara.govt.nz/en/samoans>.
- Anae, M., Tominiko, F., Fetui, V and Lima, I. 2017. "Transnational Samoan Chiefs: Views of the Fa'amatai (Chiefly System)." *Journal of Sāmoan Studies, Volume 7, Number 1, 2017*: 38-50.
- Annas GJ, Grodin MA, eds. *The Nazi doctors and the Nuremberg Code: human rights in human experimentation*. New York: Oxford University Press, 1992.
- Beauchamp, T. and Childress, J. 2013. *Principles of Biomedical Ethics, 7th Edition*. New York: Oxford University Press.
- Beecher, H.K., Ethics and Clinical Research. *New England Journal of Medicine*. June 1966 Reprinted with commentary by Harkness, Lederer and Wikler, in Bull WHO 2001.
- Brislin, R. 1993. *Understanding culture's influence on behavior*. Orlando, FL: Harcourt Brace.
- Brock, D.W. 2009. "Cost-Effectiveness and Disability Discrimination." *Economics and Philosophy* 25(1): 1–23.
- Chin, J. 2000. *Culturally competent health care*. Public Health Reports. 115: 25–33.
- Doak CC, Doak LG, Root JH. 1996. *Teaching patients with low literacy skills (2nd edition)*. Philadelphia, Pennsylvania: JB Lippincott Company.
- Du Plessis, R. and Fairbairn-Dunlop, P. 2009. *The ethics of knowledge production – Pacific challenges*. UNESCO: Blackwell Publishing Ltd.
- Engelhardt HT JR. 1997. "Japanese and western bioethics: studies in moral diversity." Pp. 1–10 in *Japanese and Western Bioethics Studies in Moral Diversity*, ed. K. Hoshimo. Dordrecht: Kluwer, Academic Publisher.
- Fairbairn-Dunlop, P. 2006. Address to the UNESCO Ethics of Knowledge Production Conference, Otago University 12–14 February, 2006. Cited in Ethics of Knowledge Production Conference Report, New Zealand National Commission for UNESCO, Wellington. Available online at http://portal.unesco.org/shs/en/files/9932/11571219621_Conference_Report.pdf [Accessed 19 August 2017] cited in Du Plessis, Rosemary and Fairbairn-Dunlop, Peggy. 2009. *The ethics of knowledge production – Pacific challenges*. (UNESCO: Blackwell Publishing Ltd): 111.
- Fan, R. 1997. "Self determination vs. family determination: two incommensurable principles of autonomy." *Bioethics* 11(3/4): 309–322.
- Fan, R. 2011. "Family-oriented surrogate decision making and Confucian bioethics." *Bioethical Law & Ethics*. 5(2): 1–20.
- Finau, S. A. 1997. "Health, environment and development: towards a Pacific paradigm." *Pacific Dialogue: Journal of Community Health and Clinical Medicine for the Pacific* 3(2): 267.
- Fleming, R.M., Taiapa, J., Pasikale, A. and Easting, S.K. 1997. *The common purse: income sharing in New Zealand families*. Auckland University Press with Bridget Williams Books, Auckland, New Zealand.
- Habermas, J. 1995. *Moral consciousness and communicative action*. Cambridge, MA: The MIT Press.
- Gershon, I. 2007. "Viewing Diasporas from the Pacific: What Pacific Ethnographies Offer Pacific Diaspora Studies." *The Contemporary Pacific*, Vol. 19, No. 2: 474–502.
- Gershon, I. 2012 *No family is an Island*. USA: Cornell University Press.
- Gilson, R. P. 1970. *Samoa 1830 to 1900: The Politics of A Multi-Cultural Community; with an introduction and conclusion* by J. W. Davidson. Melbourne: Oxford University Press.

- Gough, D. C. 2006. "Mobility, Tradition and Adaptation: Sāmoa's Comparative Advantage in the Global Market Place." *Graduate Journal of Asia-Pacific Studies* 4 (1): 31–43.
- Gough, D. C., 2009. "Cultural Transformation and Modernity: A Sāmoan Case Study." Unpublished PhD Thesis, New South Wales: University of Wollongong.
- Gray, B. 2014. "Bioethics for New Zealand/Aotearoa." *NZMJ* 4 July 2014, Vol 127 (1397): 67–76.
- Gunn-Allen, P. 1998. *Off the reservation* Health Research Council of New Zealand. (2003). *Guidelines on Pacific Health Research*. Auckland: Health Research Council of New Zealand.
- Hattori, H., Salzberg, S. M., Kiang, W. P., Fujimiya, T., Tejima, Y., and Furuno, J. 1991. "The patient's right to information in Japan: Legal rules and doctor's opinions." *Social Science and Medicine* 32, 10071016.
- Health Resources and Services Administration. 2001. *Cultural Competence Works: Using cultural competence to improve the quality of healthcare for diverse populations and add value to managed care arrangements*.
- Hopoi, N. 2017. Personal communication. Auckland, New Zealand, July 5th 2017.
- Horner RD, Salazar W, Geiger J, et al. 2004. "Changing healthcare professionals' behaviors to eliminate disparities in healthcare: what do we know? How might we proceed?" *American Journal of Managed Care* 10: 12–19.
- Lo B. (2000). *Resolving Ethical Dilemmas: A Guide for Clinicians*. 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 7–10.
- Jiwani, B. 2008. "Ethically Justified System-Level Decisions in Health Care: Toward a Decision Support Workbook for Healthcare Leaders." Unpublished doctoral research. Alberta: University of Alberta.
- Johnstone, M. and Kanitsaki, O. 2009. "Ethics and Advance Care Planning in a Culturally Diverse Society." *Journal of Transcultural Nursing* 20: 405–416.
<http://dx.doi.org/10.1177/1043659609340803>.
- Jonsen, A. R. 1998. *The birth of bioethics*. New York, NY: Oxford University Press.
- Jonsen, A. R. 2000. *A short history of medical ethics*. New York, NY: Oxford University Press, pp. 99–114.
- Jonsen, Albert R, Siegler, Mark and Winslade, William J. 2002. *Clinical ethics: a practical approach to ethical decisions in clinical medicine*. New York: McGraw Hill, Medical Pub. Division.
- Jonsen, A. R. 2005. *Bioethics beyond the headlines: Who lives? Who dies? Who decides?* Lanham, MD: Rowman & Littlefield.
- Kaldijan, L.C. 2004. *Physician Integrity, Religious Belief and the Adequacy of Medical Ethics*. Unpublished doctoral research. New Haven: Yale University.
- Kaldijan, L.C., Weir, R.F., Duffy T.P. 2005. "A Clinician's Approach to Clinical Ethical Reasoning," *Journal of General Internal Medicine* 20(3): 306–311.
- Kleinman, A. 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley: University of California Press.
- Kleinman, A. 1988. *The Illness Narratives: Suffering, Healing and the Human Condition*. New York: Basic Books.
- Kleinman, A. 2006. *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. New York: Oxford University Press.
- Koenig, BA. 1997. "Cultural diversity in decision making about care at the end of life." Pp. 363–352 in *Approaching death: Improving care at the end of life*, ed. Institute of Medicine. Washington, DC: National Academy Press.
- Kung, H. 2007. "The beginning of all things: science and religion." [Transl. by J. Bowden]. Grand Rapids, MI: Wm. B. Eerdmans cited in Du Plessis, Rosemary and Fairbairn-Dunlop, Peggy. 2009. *The ethics of knowledge production – Pacific challenges*. (UNESCO: Blackwell Publishing Ltd): 112.
- Lee, Marvin J.J. 'The problem of "thick in status, thin in content" in Beauchamp and Childress' principlism' (2010), 36 *J Med. Ethics* 525 at 525.

- Lee, H. 2007. "Introduction." P.11 in *Migration and Transnationalism: Pacific Perspectives*, eds. H. Lee and S.T. Francis. Canberra, Australia: ANU E Press, p. 11.
- MacLeod, R., Egan, A. 2007. "Interprofessional education." Pp. 235–250 in *Education in Palliative Care*, eds. B. Wee and N. Hughes. United Kingdom: Oxford University Press.
- MacLeod, R., James, C.R. 1997. "Improving the effectiveness of palliative care education." *Palliative Medicine*, 11: 375–380.
- McNeil J, Campinha-Bacote J, Tapscott E, et al. 2002. *BESAFE: NMAETC Cultural Competency Model*. Washington: National Minority AIDS Education and Training Center.
- Medical Council of New Zealand. 2006. "Statement on best practices when providing care to Māori patients and their whānau." URL: <http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-best-practices-when-providing-care-to-Maori-patients-and-their-whanau.pdf>
- Medical Council of New Zealand. 2013. *Best outcomes for Pacific peoples: Practice implications*. Wellington: Medical Council of New Zealand, Pp. 17–18.
- Meleisea, M.1987. *Lagaga: A Short History of Samoa*: Institute of Pacific Studies and the Western Samoa Extension Centre of the University of the South Pacific.
- Meleisea, M. 1995. "To whom gods and men crowded: chieftainship and hierarchy in ancient Samoa." In *Tonga and Samoa: Images of Gender and Polity*, ed. J. Huntsman. Macmillan Brown Centre for Pacific Studies.
- Ministry of Health. 2001. *The New Zealand Palliative Care Strategy*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/0/65C53A08E9801444CC256E62000AAD8
- Ministry of Health. 2005. *Pacific Provider Development Fund Purchasing Strategy 2005/06 to 2007/08*. Wellington: Ministry of Health.
- Ministry of Health. 2016. *Health of the Health Workforce. 2015*. Wellington: Ministry of Health. [0/\\$File/_palliativecarestrategy.pdf](http://www.moh.govt.nz/0/$File/_palliativecarestrategy.pdf) (Accessed 2 August 2017).
- Moody, H. R. 1992. *Ethics in an aging society*. Baltimore: Johns Hopkins University Press.
- National Institutes of Health (NIH). 1979. *The Belmont report*. Retrieved from <http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>
- Nie, Jing-Bao. 2005 *Behind the Silence: Chinese Voices on Abortion*. Lanham and Oxford: Rowman & Littlefield Publishers.
- Nie, Jing-Bao. 2007. The Specious Idea of an Asian Bioethics: Beyond Dichotomizing East and West. Pp. 143–149 in *Principles of Health Care Ethics. 2nd edition*, eds. R. E. Ashcroft, A. Dawson, H. Draper, and J. R. McMillan. Chichester, West Sussex, UK; Hoboken, NJ: John Wiley and Sons.
- Nie, Jing-Bao. 2008. *The search for an Asian bioethics*. [Review of the book *The Way of Asian Bioethics* by Michael Cheng-tek Tai]. Taipei County, Taiwan: Princeton International Publishing, 2008.
- Pacific Health Research Centre.2003. *Pacific Island Primary Health Care Utilisation Study* Pacific Health Discipline, University of Auckland.
- Pacific Perspectives. 2013. *Pacific Workforce Service Forecast for HWNZ*. Wellington: Pacific Perspectives.
- Pellegrino, Edmund D. 1993. "The Metamorphosis of Medical Ethics: A 30-Year Retrospective." *Journal of the American Medical Association*: 269.
- Pfaefflin, M., K. Kobert, and S. Reiter-Theil. 2009. "Evaluating clinical ethics consultation." *Cambridge Quarterly Healthcare Ethics* 18(4): 406–419.
- Rich, K.L. 2013. "Introduction to bioethics and ethical decision-making (Chapter 2)." In *Nursing ethics across the curriculum and into practice (3rd ed.)*, eds. J.B. Butts and K.L. Rich. Boston: Jones & Bartlett.
- Roter D. 2005. Health literacy and the patient–provider relationship. Pp. 87–100 in *Understanding Health Literacy: Implications for Medicine and Public Health*, eds. J.G. Schwartzberg, J.B. Van Geest and C.C. Wang. Washington: American Medical Association Press.
- Rothman DJ. 1987. "Ethics and human experimentation." *N. Engl and J. Med.* 317: 1195–9.

- Rothman DJ. 1991. *Strangers at the bedside: a history of how law and bioethics transformed medical decision making*. New York: Basic Books, 1991.
- Rubin, S.B., and L. Zoloth (eds.). 2000. *Margin of error: The ethics of mistakes in the practice of medicine*. Hagerstown, Maryland: University Publishing Group.
- Schleger, H.A., Oehninger, N.R. and Reiter-Theil S. 2010. "Avoiding bias in medical ethical decision-making. Lessons to be learnt from psychology research." *Medicine Healthcare and Philosophy*. DOI 10.1007/s11019-010-9263-2.
- Shore, B. 1982. *Sala'ilua: A Samoan Mystery*. New York: Columbia University Press.
- Siegler M. 1978. *Children's Thinking: What Develops*. Hillsdale, NJ, Lawrence Erlbaum.
- Siegler M. 1982. "Decision-making strategy for clinical-ethical problems in medicine." *Arch Intern Med*. 142: 2178–9.
- Sokol, D. 2009. "Sweetening the scent: commentary on "What principlism misses". *J Med. Ethics*. 2009(35): 232–233.
- Southwick, M., Kenealy, T. W., and Ryan, D. 2012. *Primary Care for Pacific People: A Pacific and Health Systems Approach*. Wellington, New Zealand: Pacific Perspectives. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/primary-care-pacific-people-pacific-health-systems-approach.pdf>
- Statistics New Zealand. 2006. "Quick Stats About Pacific Peoples 2006 - Statistics New Zealand." Statistics New Zealand. <http://www.stats.govt.nz/Census/2006CensusHomePage/quickstats-about-a-subject/Pacificpeoples/income.aspx> (accessed August 19, 2017).
- Statistics New Zealand. 2013. *2013 QuickStats about Culture and Identity*. Statistics New Zealand. URL: <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/pacific-peoples.aspx>. (Accessed August 2017).
- Suaalii-Sauni, T. M. 2006. "Le Matuamoepo: Competing 'Spirits of Governing' and the Management of New Zealand-based Samoan Youth Offender Cases." Unpublished Doctor of Philosophy, The University of Auckland, Auckland.
- Suaalii-Sauni T. 2007. "E faigata le alofa: the Samoan fa'amatai – reflections from afar." In: *Changes in the fa'amatai system: o suiga i le fa'amatai*, ed. A. So'o. National University of Samoa, Apia.
- Suaalii-Sauni T. 2017. *Legal Pluralism and Politics in Samoa: The Faamatai, Monotaga and the Samoa Electoral Act 1963*. In *Small States in a Legal World. The World of Small States*, vol. 1. Springer, Cham.
- Sudore RL, Schillinger D. 2009. "Interventions to Improve Care for patients with Limited Health Literacy." *Journal of Clinical Outcomes Management* 16(1): 20–29.
- Tai, M.C. 2008. *The Way of Asian Bioethics*, Taipei: Princeton International.
- Tamasese, K., Peteru, C., and Waldegrave, C. 1997. "Ole Taeao Afua, The New Morning: A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services." A Research Project carried out by the Family Centre, Wellington: funded by the Health Research Council.
- Tamasese, TAT. 1995. *The Meaning of Pacific Identity. In Englishing my Samoan: A collection of speeches and letters*. Apia, Western Samoa: The University of The South Pacific, Fiji.
- Tamasese, TAT. 2003. "In Search of Meaning, Nuance and Metaphor in Social Policy." *Social Policy Journal of New Zealand* (20): 49–63.
- Tamasese, TAT. 2009. "Bioethics and the Samoan Indigenous Reference." *International Social Science Journal*, 60 (195): 115–124.
- Tiatia, J. 2003. "Reasons to Live: NZ born Samoan young peoples responses to suicidal behaviours. Community Health." PhD Dissertaion. University of Auckland.
- Tiatia J. 2008. *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health.
- Truog RD. Patients and doctors — evolution of a relation- ship. *N Engl J Med* 2012(366): 581–5.
- Tukuitonga, Colin. 2001. "Pacific People's in New Zealand" in Ian St George (ed) *Cole's Medical practice in New Zealand* Medical Council of New Zealand, Wellington.

- Tukuitonga C, Finau S. 1997. "The health of Pacific peoples in New Zealand up to the early 1990s." *Pacific Health Dialog* 4(2): 59–67.
- Walker, T. 2009. "What principlism misses." *J Med Ethics*, April 35(4): 229–231.
- Weiss BD. 2007. *Health literacy and patient safety: Help patients understand. A manual for clinicians (2nd edition)*. American Medical Foundation and American Medical Association.
- Windsor, J., Rossaak, I., Chaung, D., Ng, A., Bissett, I. and Johnson, M. H. 2008. "Telling the truth to Asian patients in the hospital setting." *NZMJ* 28 November 2008, Vol 121 No 1286: 92–99.
- Zarcadoolas C, Pleasant AF, Greer DF. 2006. *Advancing Health Literacy: A Framework for Understanding and Action*. San Francisco, California: Jossey-Bass.