



Perspective

Cultural Competence and Moral Relativism in Cross-Border Bioethics Consultation

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ABSTRACT

Ethics consultants increasingly work across national and cultural borders through visiting fellowships, telemedicine networks, and the growth of international medical travel, and this cross-border practice puts two under-examined tensions on display at once.

The first is practical: what cultural competence, or cultural humility, actually requires of a consultant working outside the normative assumptions of her own training.

The second is theoretical: whether respecting cultural difference in bioethics necessarily commits a consultant to moral relativism, or whether a defensible middle position exists between relativism and an imperialist universalism.

This paper surveys recent literature on both questions and applies it to informed consent practice across family-centered and individual-centered systems and to the jurisdictional gaps created by telemedicine consultation and medical tourism.

We argue that a thin layer of procedural protections against coercion, deception, and exploitation can be defended across cultural contexts even as substantial variation in substantive decision-making practices is respected, though current training standards have only recently begun to build the situated judgment this distinction requires.

Keywords: cultural competence; moral relativism; cross-border consultation; informed consent; global bioethics

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INTRODUCTION

A clinical ethics consultant who trained entirely within one health system inherits, whether she notices it or

not, a set of background assumptions about what counts as a good reason: that the individual patient is the primary decision-maker, that disclosure of a terminal diagnosis is generally owed directly to the

patient rather than filtered through the family, and that autonomy sits near the top of whatever hierarchy of values the consultation is meant to protect. Those assumptions travel badly. When the same consultant is asked, by video link or through a visiting fellowship, to advise on a case in a hospital where family consensus customarily precedes any conversation with the patient, the question of what "good" ethics consultation even looks like stops being a settled matter and becomes the object of dispute itself [1].

Two literatures have grown up around this problem without fully talking to each other. One is practical and modest in its ambitions: it asks what skills, habits, and institutional supports let a consultant work competently across cultural difference, and it tends to produce checklists, training curricula, and reflective practice frameworks [2]. The other is theoretical and considerably less comfortable: it asks whether bioethics, in claiming a set of principles applicable everywhere, is quietly exporting a parochial, largely Anglo-American moral framework under the banner of universal reason, and whether the alternative, some form of moral relativism, is any more defensible [3]. Cross-border consultation forces the two literatures together, because a consultant working outside her home system needs both the practical skill to work well with unfamiliar norms and some settled view on how far those norms can be allowed to override the principles she was trained to apply.

This paper examines that intersection. We first set out what cultural competence has come to mean in ethics consultation specifically, as distinct from the broader clinical-cultural-competence literature it borrows from. We then turn to the harder theoretical question of whether respecting cultural difference commits a consultant to relativism, or whether a defensible middle position exists. The following two sections apply that discussion to two concrete settings where it becomes unavoidable -- informed consent practice across family-centered and individual-centered systems, and the growing use of telemedicine and cross-border consultation networks -- before closing with an assessment of what current training standards do and do not achieve.

CULTURAL COMPETENCE IN ETHICS CONSULTATION: FROM CONCEPT TO PRACTICE

Cultural competence entered ethics consultation largely as an import from clinical medicine, where the term originally described a clinician's capacity to communicate effectively and avoid harm across differences in language, religion, and health belief [4]. Applied to ethics consultation, the concept has proven harder to pin down, because a consultation is not primarily a clinical encounter but a normative one: the consultant is not only trying to understand a patient's beliefs but is being asked, implicitly or explicitly, to adjudicate what should happen when those beliefs

conflict with clinical recommendations or with the values embedded in hospital policy [5].

Table 1. Institutional models for organizing cross-border ethics consultation, compared by cultural responsiveness and procedural burden.

Model	How local norms enter the consultation	Procedural consistency	Main limitation
Resident hospital committee	Committee members are drawn from the local community and culture by default	High -- one settled institutional norm applied consistently	Limited capacity to see its own assumptions as culturally particular
Visiting/traveling consultant	Consultant learns local norms case-by-case, often under time pressure	Low -- consistency depends on the individual consultant's judgment	Risk of superficial cultural learning and unintentional imperialism
Telemedicine consultation network	Consultant is physically remote from the patient's cultural and legal context	Variable -- depends on which jurisdiction's standards the network defers to	Jurisdictional ambiguity over whose norms and law actually govern the case
Hybrid (external consultant paired with local counterpart)	Local counterpart interprets norms in real time for the external consultant	Moderate to high -- consistency improves with sustained partnership	Resource-intensive and depends on a stable, trusted local partnership

Descriptive accounts of cultural consultation services, several built around long-running clinics that see culturally diverse patient populations over many years, suggest that the practical skill involved is less about acquiring a catalogue of facts about particular cultures and more about a disciplined humility toward one's own assumptions -- an orientation the literature increasingly labels cultural humility rather than competence, precisely to avoid implying that the relevant knowledge is ever complete or masterable [6]. This is especially visible in mental health consultation, where diagnostic categories and ideas about what counts as suffering, illness, or appropriate disclosure vary enough across cultural contexts that competence frameworks built for somatic medicine translate poorly without substantial revision [7]. This shift in vocabulary is not merely semantic. A "competence" framing implies a checklist that, once satisfied, certifies a consultant as prepared for any cultural context; a "humility" framing treats every encounter as requiring fresh inquiry, because culture is neither monolithic within a given community nor a reliable predictor of any individual patient's actual values. Training programs built around global health placements have increasingly adopted this humility-first framing, pairing it with explicit attention to the power asymmetries a visiting consultant inevitably brings into a partner

institution [8].

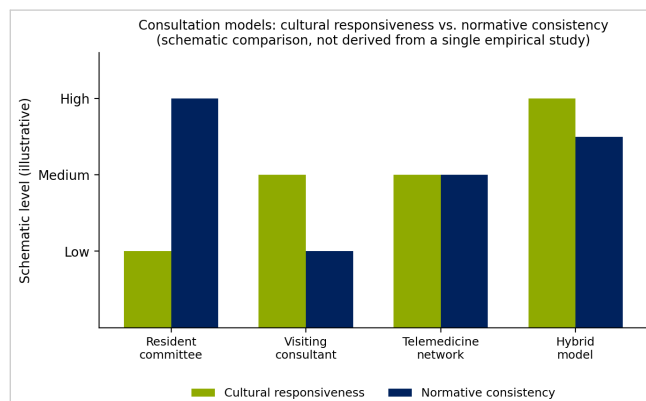
The risk on the other side is treating cultural competence as a purely interpersonal skill, detachable from the substantive ethical commitments a consultant is meant to bring to a case. A consultant who is superbly attuned to a family's communication style but who treats every substantive disagreement as simply "cultural," and therefore not open to challenge, has not resolved the tension between competence and principle; she has abandoned one side of it. Table 1 summarizes four institutional models for organizing cross-border ethics consultation and how each navigates that tension, ranging from a resident hospital ethics committee applying its own local norms to a hybrid model that pairs an external consultant with a local counterpart specifically to manage this trade-off.

UNIVERSALISM, RELATIVISM, AND THE SEARCH FOR A MIDDLE PATH

The theoretical question sitting underneath the practical one is old, but recent restatements of it in the bioethics literature have sharpened rather than resolved the disagreement. One position, sometimes described as critical or rational universalism, holds that certain protections -- against coercion, against deception, against being treated merely as a means -- are not culturally contingent preferences but conditions for any coherent account of moral agency, and that a bioethics unwilling to defend them across cultural lines has simply given up on having normative content at all [9]. On this view, what looks like moral relativism is often just moral cowardice dressed in the language of respect.

The opposing worry, argued at least as persistently, is that universalist bioethics has a track record of mistaking the particular commitments of post-Enlightenment liberal societies -- individual autonomy chief among them -- for features of reason as such, and of using that mistake to license interventions in other societies' medical practices that look, from the receiving end, less like principled advocacy and more like moral imperialism [3]. A frequently cited formulation of the dilemma asks how bioethics can respect cultural diversity without collapsing into a relativism that leaves it unable to criticize anything, and without collapsing in the other direction into an imperialism that leaves it unable to listen to anything [10].

Figure 1. Schematic, illustrative comparison of the four consultation models from Table 1 along two qualitative dimensions -- cultural responsiveness and normative consistency. Positions are conceptual judgments drawn from the literature discussed in the text, not measurements from a single empirical study.



The middle position that much of the recent literature converges on, however awkwardly, distinguishes between a thin set of procedural and protective commitments that hold across contexts -- freedom from deception, from coercion, from exploitation of dependency -- and a much thicker layer of substantive value commitments -- about who should be told a diagnosis, who should decide on a patient's behalf, how death and dying should be discussed -- where genuine and defensible variation exists [11]. This distinction does real work: it lets a consultant insist on procedural protections everywhere while remaining open to real disagreement about substantive outcomes. It does not, however, dissolve every hard case, since a great many disputes in cross-border consultation are precisely about which category a given practice belongs to. Figure 1 renders this tension schematically, plotting the four models introduced above along two illustrative dimensions -- cultural responsiveness and normative consistency -- to show that the trade-off, rather than a genuine solution to it, is what most current institutional arrangements actually deliver.

INFORMED CONSENT AND FAMILY-CENTERED DECISION-MAKING ACROSS CULTURES

Informed consent is the practice where the universalism-relativism debate stops being abstract. The dominant Western model treats the individual patient as the appropriate unit of disclosure and authorization, but empirical and sociological work from settings where medical decision-making is customarily a family matter complicates that model considerably. A recent sociological study of family-oriented informed consent practice in two Chinese megacities found that clinicians and families alike frequently experience the individual-consent model, when it is imposed by policy or by visiting foreign-trained physicians, as actively harmful -- disrupting family cohesion, increasing patient distress by forcing premature disclosure, and

producing consent forms that satisfy a legal requirement without reflecting how the decision was actually made [12].

Interculturalist responses to this evidence generally resist two easy answers. They resist saying that family-centered consent is simply wrong and should give way to individual consent wherever the two conflict, since that risks exactly the imperialism critics warn about. They also resist saying that any locally customary practice around consent is therefore beyond ethical scrutiny, since that risks licensing genuine coercion under a cultural label. The more defensible position argued in this literature holds that the patient's own preference about how much control to delegate to family, disclosed and confirmed rather than assumed from cultural background, is itself the thing informed consent should protect -- which reframes family-centered decision-making not as a departure from autonomy but as one of the things autonomy can legitimately choose [13]. Older commentary in the same vein observed that treating "informed consent" as a single transportable procedure, rather than a family of practices serving the same underlying protective purpose, was itself part of the problem [14]. A broader review of religious and cultural critiques of the standard consent model reaches a similar conclusion from a different angle, arguing that many objections to individual-centered consent are best read not as rejections of autonomy but as disagreements about what autonomous choice looks like when a person's identity is constituted relationally rather than individually [15].

CROSS-BORDER CONSULTATION: TELEMEDICINE, MEDICAL TOURISM, AND JURISDICTIONAL GAPS

Two developments have made cross-border ethics consultation a routine occurrence rather than an occasional curiosity: the growth of telemedicine networks that let a consultant based in one country advise on a case in another, and the growth of medical tourism, which moves patients rather than consultants across the same borders. Telemedicine-based ethics consultation was proposed years ago as a way of extending access to formal ethics support in settings, often rural or under-resourced, that could not otherwise sustain a standing ethics committee, and the model has since been used specifically to connect institutions across national lines [16]. The practice raises a jurisdictional question that most existing ethics-consultation frameworks were not built to answer: whose professional norms, whose legal standards for disclosure and capacity, and whose account of the patient's rights govern a consultation conducted by someone physically located in a different country than the patient.

Medical tourism sharpens the same problem from the other direction. A patient who travels abroad for a procedure unavailable, unaffordable, or illegal at home

enters a system whose norms around consent, follow-up care, and the disclosure of risk may differ substantially from those of their home jurisdiction, and continuity of ethical oversight across the transition back home is often minimal [17]. Commentary on the ethics of international medical travel has increasingly framed the central problem less as any single scandal and more as a structural gap: no institution, and no single professional body, has clear jurisdiction over the ethical quality of the whole care pathway once it crosses a border, which leaves cultural-competence questions to be resolved ad hoc, case by case, by whichever clinician happens to be present at each stage [18]. Early analyses of the underlying business model already anticipated that telemedicine and medical tourism would grow together rather than as separate phenomena, which has proven broadly correct and has only widened the jurisdictional gap the ethics literature is still trying to close [19].

TRAINING STANDARDS AND THE LIMITS OF COMPETENCE FRAMEWORKS

If cross-border consultation is now routine, the training that prepares consultants for it remains uneven. Reviews of what makes clinical ethics consultation services effective more generally have long identified formal training and ongoing case-based supervision as the strongest predictors of consultation quality, but relatively few programs build cross-cultural competence into that training as a core requirement rather than an elective add-on [5]. Global health education programs have made more progress on this front than ethics consultation training specifically, partly because global health as a field confronted the power and legitimacy questions inherent in cross-border work earlier and more directly [8].

International guidance has begun to catch up. The World Health Organization's 2025 draft guidance on clinical ethics, circulated for public consultation, explicitly addresses the need for ethics support structures that can function across differing legal and cultural contexts, without prescribing a single institutional model as universally appropriate [20]. Whether guidance of this kind translates into consistent training remains an open question, and the practical literature on cultural consultation continues to caution against over-reliance on any fixed curriculum, since the skill involved is fundamentally one of situated judgment rather than rule-following [2]. A useful illustration of what that judgment looks like in practice comes from commentary describing cases where an ostensibly neutral principle -- respect for patient autonomy -- was itself put "on trial" by a family's insistence on a different decision-making structure, forcing the consultant to decide in real time which commitments were negotiable and which were not [21]. Broader cross-cultural frameworks proposed within bioethics as a field, rather than within consultation practice specifically, have tried to

generalize from cases like this into portable principles, with mixed success [22].

CONCLUSION

Cross-border ethics consultation does not resolve the tension between cultural competence and moral relativism so much as force a consultant to hold both concerns simultaneously, case after case, without the comfort of a formula that decides in advance which one wins. The most defensible position in the current literature treats a thin layer of procedural protections -- against coercion, deception, and exploitation of dependency -- as non-negotiable across cultural lines, while leaving substantial room for genuine variation in the thicker, more substantive commitments around disclosure, family authority, and end-of-life decision-making. That distinction is doing real work in the informed-consent literature discussed above, but it does not by itself tell a consultant, mid-case, which category a disputed practice belongs to, and training programs have only recently begun building the situated judgment that answering this question in real time actually requires. As telemedicine and medical tourism continue to move both consultants and patients across borders faster than institutional and legal frameworks can follow, closing that training gap looks less like an optional refinement to ethics consultation and more like a condition for the practice remaining ethically serious at all.

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Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Zsafia Nielsen conceived the paper, drafted the introduction and the sections on cultural competence and moral theory, and coordinated the overall argument. Sigrid Halvorsen developed the sections on informed consent and family-centered decision-making and conducted the literature synthesis underlying Table 1. Chiara Moreau drafted the sections on cross-border and telemedicine consultation and training standards, and prepared the figure. All authors reviewed and approved the final manuscript.

Ethics Statement

As a literature-based analysis and commentary, this

article did not involve new data collection from human or animal subjects and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed in the preparation of this article. All sources discussed are cited in the reference list and are publicly available through their respective publishers.

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