1. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation: benefit or harm? *JAMA.* 1995;274:826-829.
2. Levin JS. Religion and health: is there an association, is it valid, and is it causal? *Soc Sci Med.* 1994;38:1475-1482.
3. Kapp MB. Living and dying in the Jewish way: secular rights and religious duties. *Death Stud.* 1993;17:267-276.
4. Levin JS, Vanderpool HY. Is religion therapeutically significant for hypertension? *Soc Sci Med.* 1989;29:69-78.
5. Burkett GL. Culture, illness, and the biopsychosocial model. *Fam Med.* 1991;23:287-291.

In Reply.— We thank Drs Pantilat and Fenyvesi for their interest in our article. Timing of discussions concerning patient preferences to be informed about their illnesses is important, and Pantilat's suggestion about this matter seems reasonable. We also agree with Fenyvesi that a trusting physician-patient relationship is the best basis for ethical decision making. Every patient is unique, but we believe it is possible to improve communication about end-of-life decisions by making clinicians sensitive to their own cultural background, their patients' background, and the conflicts that may occur when different cultures come together.

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In Reply.—Dr Fitzgibbons makes several points that trouble us and require clarification. Our article describes a "cultural gap" between Western biomedical providers and our Navajo informants regarding the discussion of negative information, and we conclude that treating all Navajo patients by Western standards is ethically troublesome. However, we do not say that "bad outcomes can be avoided by not speaking of them." In the Navajo view, bad things result from a variety of mechanisms, only one of which is speaking about them. While we do not advise physicians to completely avoid discussions of "sickness, injury, and death" with Navajo patients, we do relay the views of our informants who find explicit and direct discussion of these issues troublesome (a view, by the way, that is not foreign to the Western tradition[1]). As Dr Kazal points out, creative, caring clinicians can together with their patients often devise "culturally sensitive" strategies for bridging cultural gaps.

Dr Fitzgibbons is mistaken in assuming that all Navajo patients who have consented to hospitalization will be untroubled by advance care planning discussions. In fact, 95% of the informants we asked about advance care planning had been cared for in traditional Western biomedical hospitals and clinics. Navajo and non-Navajo patients alike can maintain values and perspectives different from the health care practitioners and institutions caring for them.

We would never suggest that all members of a particular ethnic or social group think or should be treated the same way. We are careful in our article to address this explicitly; clearly, not all Navajos will identify with the views expressed by these 34 informants. Clinicians should gather information about their patients and the local community, engaging each patient with as few untested assumptions as possible.

Nowhere do we suggest that non-Navajos should make decisions for Navajos. Instead, our study raises questions about rigid adherence to a narrow, formalistic interpretation of informed consent that reflects a Western view of personhood. Traditional Navajos' involvement of family members in decision making reflects a Navajo view of personhood, one of "collective interdependence."[2]

The findings of our study invite careful examination of two other issues raised by Fitzgibbons determining "the facts" of a case and "why our profession exists." Are these topics the exclusive purview of medical providers and institutions, or in some meaningful way should patients' authority be acknowledged and their participation in these considerations facilitated so that what health care professionals do and how they do it benefits patients in ways that they can appreciate?

We agree with Dr Pastorek that some of the issues raised by our study point beyond the Navajo informants interviewed, and that the patient's "religious and cultural milieu" should always be considered.

Finally, our article is not simply about the Navajo informants interviewed. It is also about examining the dominant principles and perspectives in Western bioethics, which are neither acultural nor transcultural[3]; rather, they have their own social, cultural, and historical grounding, and consequently, inherent limitations in a pluralistic society.

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1. Reiser JS. Words as scalpels: transmitting evidence in the clinical dialogue. *Ann Intern Med.* 1980;92:837-842.
2. Gostin LO. Informed consent, cultural sensitivity, and respect for persons. *JAMA.* 1995;274:844-845.
3. Fox RC, Swazey RC. Medical morality is not bioethics: medical ethics in China and the United States. *Perspect Biol Med.* 1984;27:336-360.

In Reply.—Scholars in health law and bioethics focus intensely on the right of patients to make autonomous decisions about their medical treatment. This is thought to require full disclosure of truthful information to assist the patient in the process of informed consent. Legal and ethical approval of the principle of autonomy has been so consistent that full and truthful information disclosure is broadly accepted as the standard of practice in medical care. Patients cannot genuinely arrive at meaningful choices about their health care unless they are apprised of all material benefits, adverse effects, and risks, including an informed assessment of their prognosis with and without treatment. Patients are faced with decisions that intimately and powerfully affect their lives. Medicine demonstrates its respect for persons by illuminating patients' decisions with information, not by making decisions for them.

The fact that autonomous decision making usually demands full information does not mean that disclosure is universally respectful of patients. Dr Fitzgibbons' insistence on requiring disclosure in every case irrespective of the patient's culture, religion, or beliefs forces all human beings into a single mold cast by Western traditions. Deep respect for individuals is never demonstrated by faithful observance of what we believe is best for the person, but by consideration of what they request. As Drs Pantilat and Kazal articulately explain, a genuine desire to understand patients is the best way for medicine to illuminate patient decisions without disrespecting their cultures. Medicine can assist patient decisions in many nontraditional ways, consistent with the patient's cultural values by, for example, using the third person plural or discussing matters with the family. Often a simple direct question eliciting the patient's desires demonstrates consideration of his or her beliefs. This ethical view, cited by Dr Fenyvesi, is reflected in the Council of Europe's guidelines that "the wishes of individuals not to be . . . informed shall be observed." For instance, a person's desire not to be informed of a dire unavoidable prognosis may be reasonable in any culture. I have also suggested that an independent ethical review could "facilitate deeper understanding of the patient's culture, custom, and language."[1]

I am not advocating a return to paternalism, defined as the physician making decisions for patients; cultural sensitivity in ethical discourse should not be a disguise for abandonment of hard-won rights of informed consent. While I agree with Dr Pastorek that religious and cultural milieu is important in physician and patient dialogue, I am concerned with his suggestion of extending the discretion not to disclose to a larger segment of American society. Any deviation from the legal and ethical duty to disclose must be narrowly defined and justified rigorously by reference to values.

These articles and letters in *JAMA* have opened a conversation about how best to respect the culture, religion, and values of patients. The conversation is valuable to assist medicine in finding better ways to show regard and consideration for each individual patient, and the family and community in which he or she is embedded. That conversation ought not to open the door to decisions made for, not by, patients because the physician knows best about the desires and needs of competent patients.

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[1] Gostin LO. Informed consent, cultural sensitivity, and respect for persons. *JAMA*. 1995;274:844-845.

Cholesterol and Coronary Heart Disease Mortality in Elderly Patients

To the Editor.—In the Editorial by Drs Denke and Winker,[1] there is the unfortunate implication that our article[2] from the New Haven, Conn, site of the Established Populations for Epidemiologic Studies of the Elderly (EPESE) was published prematurely and should not have preceded a multicenter analysis. The comments reveal a misunderstanding of the nature of the EPESE collaboration and the special features of this observational study.

Unlike many multicenter trials, the EPESE sites are a confederation of studies with distinct sampling designs and features. Although the EPESE was a collaboration contract program, individual sites had the option to publish results separately, where unique data were available. For this reason, single-site publications from EPESE far outnumber the pooled analyses.

There are unique features of the New Haven site that led us to pursue our analysis separately. New Haven is the only site in which diagnoses of hospitalized acute myocardial infarction and unstable angina have been confirmed by medical records review. Although the multisite article used coronary heart disease (CHD) mortality as the major end point, the secondary analyses on new CHD events relied on Health Care Financing Administration data for the ascertainment of the diagnosis, a particularly unreliable source when secondary diagnosis codes are used. It was our belief in the importance of carefully standardized medical record review to validate these outcomes that led us to publish our single-site analysis.

We wish to dispel any notion that our article was an attempt to get a quick publication prior to the release of the multisite data. Our unique end points have been collected since 1983, and the analysis for this article began in 1992. We discussed our project in a variety of forums and presented it formally at the 1993 American Heart Association annual meeting. We went through three rounds of rigorous peer review at *JAMA* prior to the publication in November 1994. An ongoing multisite analysis of cardiovascular risk factors was focused on serum lipids in response to our publication,[3] and two of our coauthors were collaborators on the second publication.

The most important issue for the readers of *JAMA* is that the findings of the two studies with respect to total serum cholesterol are similar. Neither analysis demonstrated a significant association between total cholesterol levels and the rate of new CHD, CHD mortality, or all-cause mortality. In sex-specific analyses, neither study showed a significant association between cholesterol level and outcome in men. However, in contrast to the New Haven analysis, the multisite report suggested that there may be an association between cholesterol and CHD mortality (but not all-cause mortality or new CHD) in women.

A difference between the two analyses is the finding with respect to high-density lipoprotein cholesterol (HDL-C). In our article, we reported a trend of an association between HDL-C and CHD mortality; this association was stronger and statistically significant in the multisite analysis. The relevance of these findings for prevention and therapeutic interventions in older people is not clear at this time. What is clear is that there is a great need for more investigation of the appropriate policy for the preventive care of the rapidly growing elderly population.

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[1] Denke MA, Winker MA. Cholesterol and coronary heart disease in older adults: no easy answers. *JAMA*. 1995;274:575-577.
[2] Krumholz HM, Seeman TE, Merrill SS, et al. Lack of association between cholesterol and coronary heart disease mortality and morbidity and all-cause mortality in persons older than 70 years. *JAMA*. 1994;272:1335-1340.
[3] Corti M-C, Guralnik JM, Salive ME, et al. HDL cholesterol predicts coronary heart disease mortality in older persons. *JAMA*. 1995;274:539-544.

In Reply.—We appreciate the comments of Dr Krumholz and colleagues and agree that the methods used at each independent site of EPESE were not identical. We also appreciate that the measures used in the study were relatively standard: measurements of lipid levels presumably were comparable across sites, and the measurements of outcomes, while not standardized for secondary analyses, were consistent in terms of mortality, the primary end point of the combined site analysis.[1] The verification of myocardial infarction and unstable angina with chart review at the New Haven site[2] would not explain the differences in mortality rates between New Haven and the other sites.

We also appreciate that the New Haven cohort had "unique sample characteristics and health status characteristics,"[3] with the "lowest CHD mortality . . . but the highest death rate from non-CHD cardiovascular disease."[1] While this may have been a reason to publish the results separately, the unique nature of the population should have been highlighted in the original article. In fact, the authors later described their cohort as "truly representative of the elderly population in contemporary urban society."[4] If the authors believed the New Haven cohort to be more representative of the elderly population overall than the other sites, the reason is not clear from either article.[1,2]

Rather than suggesting that the article by Krumholz et al was an attempt to "get a quick publication," we suggested that the questionable association between serum lipids and cardiovascular mortality in the elderly deserved a careful evaluation with attention to power and sample size. Although the original EPESE design did not require investigators to