

Common Morality, Human Rights, and Multiculturalism in Japanese and American Bioethics

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ABSTRACT

To address some questions in global biomedical ethics, three problems about cultural moral differences and alleged differences in Eastern and Western cultures are addressed: The first is whether the East has fundamentally different moral traditions from those in the West. Concentrating on Japan and the United States, it is argued that theses of profound and fundamental East-West differences are dubious because of many forms of shared morality. The second is whether human rights theory is a Western invention with no firm traditions in Eastern moral traditions. It is argued that this thesis is unsupported both historically and in contemporary bioethics. The third problem is whether multiculturalist theory casts doubt on claims of universal principles and rights. It is argued that the reverse is true: multiculturalism is a universalistic theory. The argument throughout supports common morality theory.



Global ethics is a currently fashionable notion, but its meaning and scope remain underdeveloped. To address some questions about universal standards in biomedical ethics, I will investigate three problems about alleged cultural moral differences, concentrating on presumed differences in Eastern and Western cultures. The first problem is whether there is merit in the thesis that the East—that is, Asia—has fundamentally different moral traditions from those in the West—that is, Europe and the Americas. I will argue, concentrating on Japan and the United States, that the thesis of *profound* and *fundamental* East-West differences is dubious in light of our many

cultural similarities and forms of shared morality. The second problem is whether human rights should be understood as a Western invention with no firm traditions in Eastern moral and political theory. I will argue that this thesis is unsupported in contemporary bioethics. The third problem is whether the existence of multicultural societies and pluralism of moral viewpoint support the claim that there is no universal morality. I will argue that this claim too is unconvincing.

ALLEGED DIFFERENCES BETWEEN EASTERN AND WESTERN MORAL VALUES

I begin with a quote from an article published in 1987 in the *Hastings Center Report*—an article I have long admired. It was written by Professors Koichi Bai, Yasuko Shirai, and Michiko Ishii, who presented the following thesis:

We must beware of drawing general conclusions as to “Japanese” characteristics on [bioethical] issues. We ought not to assume too readily a uniformity in Japanese culture; nor, needless to say, can we ignore Japanese peculiarity. The key is to observe the situation as it exists.... [I]t is difficult to generalize about the attitude of the Japanese people [on bioethical issues]. Taken collectively, the numerous opinions do not suggest any uniform perspective. Japanese attitudes have not been examined closely because of misinformation and lack of research.

These authors argue, based on the empirical data available to them at the time, that there is a “lack of consensus among the Japanese on the acceptability” of conclusions about relatively new issues in bioethics. They say that this situation creates both “a tension and a link between traditional belief and contemporary practice” (pp. S18-S20).[1, see also 2].

I had read this article prior to a Conference in Japan in the 1990s that Professor Bai and I both attended. I told him then that I had been struggling to understand what I had been told by a number of people from Japan *about* Japan. What they had reported as Japanese moral views in conflict with American views is also widely found in bioethics literature. I was at the time reading the available empirical studies of Japanese practices and beliefs that had been published, especially the studies that compared Japanese beliefs and practices with American beliefs and practices. I asked Professor Bai, “Can you clarify for me how to think about the numerous reports in

the literature that Japanese families and physicians are paternalistic, family-oriented, and opposed to principles in Western ethics such as respect for autonomy, informed consent, and the like.” I told him that my problem was that much of what is reported to be Japanese beliefs and practices did not seem supported by the empirical literature on Japanese beliefs and practices. I could find only fragments of support in the empirical literature, which simply failed to show that Japanese physicians, nurses, and patients are morally at odds with American physicians, nurses, and patients.

Professor Bai had had his eyes locked on his tea cup as I asked my question. In giving a response, he shifted his gaze from the tea cup and fixed his eyes on mine. He said, “Professor Beauchamp, the Japanese people will tell you many things about the Japanese people, but look and see.” He had given an answer to my question in one astute sentence. I knew immediately what he meant, and it struck me that it applies just as well to the United States. Whether one starts with cultural stories and traditional beliefs in the United States, or Japan, or anywhere else, one has to look and see what the beliefs and practices are before one is entitled to claim a specific viewpoint.

I will start by looking and seeing what the situation is today in literature that studies beliefs, and to some extent practices, in Japan and in North America—and how we should assess similarities and differences in these beliefs. I will also assess an entrenched perspective on cultural differences that I label “the received view.”

THE RECEIVED VIEW

The received view is about morally relevant cultural differences between Japan and the United States. It asserts that Eastern cultures are paternalistic and family-oriented in their moral beliefs and practices, with great deference given to physicians, whereas American and European cultures are nonpaternalistic and anti-authoritarian in their treatment of patients and families. Traditional family values in Japanese society are said to feed this custom: Individuals are expected to be relatively constrained and unassertive, remaining sensitive to the maintenance of fluent relationships that avoid confrontation and self-assertive conduct. This behavior and these cultural expectations are said to contrast sharply with Western emphases on individual rights and individual choice, which, according to the received view, are not admired in Japanese culture. As Professor Rihito Kimura once put it, “Autonomy, an important bioethical principle in the Western social context, is out of keeping with the Japanese cultural tradition” (p. 23).[3, see similarly 4].

In my arguments against this view, I do not deny that there are some differences *in degree* between American and Japanese societies on these matters, just as there are between American and European cultures, where the latter have been said to display more support for principles of solidarity and dignity even to the point of making those values more important in Europe than respect for autonomy and justice. Empirical studies show both modest differences between these cultures, while also showing disagreements within each culture when variables such as differences in time and age are taken into consideration. However, the thesis of basic moral differences *in kind*—as if people from the East and the West have fundamentally different moral principles, beliefs, practices, and conventions in medical institutions—is not empirically supported. Where others have looked for cultural *differences*, I will emphasize relevant cultural *similarities*. My claim is that the available evidence indicates that moral viewpoints in these cultures converge to agreement on basic moral norms and evaluations of moral character, not disagreement.

INFORMED CONSENT: HISTORY, TRADITION, AND LEGEND

I will use the doctrine of informed consent as my principal example of alleged differences that turn out not to be so different in Eastern and Western cultures. This doctrine was for many years, especially in the literature of the 1980s and 1990s, presented as a peculiarly American practice and as a notion poorly suited for an Eastern ethics of relationship in communities and family decision making. It was then, and is still today, closely linked in bioethics literature to supposedly distinctive American views of autonomy and individualism. As a paradigmatic example of this view, consider a September 2011 article by Professor John-Stewart Gordon of the University of Cologne, Germany, who states that, “non-western countries such as China, Japan, and most African countries do not share the idea of individual informed consent in biomedical ethics. Instead, they generally demand that either family—or community—informed consent should be obtained in cases such as life-threatening diseases” (p. 261).[5]

The view that informed consent is an outgrowth from a history of American individualism is a strange historical thesis. The term “informed consent” emerged only in the 1950s, and discussions of the concept as we know it today in the U.S. began only around 1972. It had no significant prior history in philosophy, law, medicine, or public policy in the U. S.[6] The histories of patient-physician interactions in

medicine in Europe and the United States prior to the 1970s are at root paternalistic and antithetical to informed consent. The history is one of tight physician control of information and patient deference to physicians.[7]

In an empirical study in the U. S. published in 1970, 50% of the physicians surveyed thought it *medically* proper, and 30% thought it *ethically* proper, for a physician to perform a mastectomy with no authorization from the patient other than her signature on a blanket consent form required for hospital admission; half of these physicians thought that it is ethically appropriate for a physician not to tell a cancer patient that she has been enrolled in a double-blind clinical trial of an experimental anti-cancer drug and is currently receiving a placebo.[8, 9, 10, 11] Only during the years between 1972 and 1980 did a major shift occur favorable to the view that physicians have a moral and legal duty to obtain an informed consent from patients for many procedures.

Accordingly, I do not accept the received view's claim that American tradition is non-paternalistic, whereas Japanese traditions are deferential to physicians and rest on a paternalistic model of medicine. European and American traditions of medical ethics derive from centuries of physician paternalism and cultural deference. American interest in patients' rights and paternalism is a phenomenon largely of the last thirty-five years of American history.

EMPIRICAL STUDIES OF JAPANESE BELIEFS ABOUT INFORMED CONSENT

Is the situation significantly different today in Japan, by contrast to the U. S., either as a matter of cultural attitude or medical practice? There are differences, but my working hypothesis is that today no profound cultural differences in consent practices exist between Japan and the U.S. To assess the current situation, I will consider the findings of several empirical studies about paternalism and informed consent that have been conducted in Japan about the opinions of Japanese physicians, nurses, patients, and families. Over three dozen such studies have been conducted in Japan since the early 1980s. I will mention only a representative sample conducted or reported over the course of 20 years from 1986 to 2006. These studies reach similar, though not identical, conclusions. I know of no scholarly study that contains significantly different findings than those I will mention.

The first study was reported by Professor Hiroyuki Hattori and five associates,

published in 1991, having been conducted in 1986-87. The data in this study show some striking similarities of attitude and behavior to earlier empirical studies of American physicians.[12] This questionnaire survey reached the following conclusions: Japanese physicians are willing to give their patients information adequate to obtain an informed consent, but many physicians retain discretion to judge how much information should be provided. In every category tested, over 50% of Japanese physicians stated that they morally *should* make adequate disclosures and receive an informed consent. One interesting response came in answering the question, "How do you explain high-risk diagnostic procedures to the patient?" Across medical students and physicians in university and other hospitals in Japan a consistent result appeared of from 56% to 60% who give the answer, "We explain the incidence and the severity of the risk, and if the patient seems to be bewildered by the information, we explain them to the relatives" (p. 1013).[12] These results are largely consistent with various studies of the behavior of American physicians.

A second study, conducted in 1989 by Professor Yutaka Mizushima and eight associates. This study examined disclosures of a diagnosis of cancer (in Toyama Prefecture), and asked the opinion of physicians, para-medical personnel, and lay persons about Japanese practices of nondisclosure.[13] One goal of the study was to critically examine the widespread belief that, "In Japan, more than 90% of medical doctors hide the actual diagnosis of cancer from patients. On the contrary, in the Unites States of America, . . . more than 90% of MDs reveal the diagnosis of cancer to their patients." The Mizushima study brought to light a very different picture of Japan than the 90%/90% hypothesis suggested. In response to the question, "Do you think we *should* reveal the diagnosis of cancer to patients who have requested it?", 69.2% answered "yes," 12.7% indicated they were not sure, and only 17.7% answered "no." Similarly, to the question, "Would you wish to be told the diagnosis of cancer if you had cancer?", only 13.2% of these physicians answered "no." This rate of "nos" is not surprising in light of another Japanese study that had shown nondisclosures and deception to have been steadily declining in Japan throughout the 1980s.[14] They declined still further in the 1990s.

In a third study, in 1995, Atsushi Asai and associates published a questionnaire study about terminally ill patients that was administered to both Japanese and Japanese-American physicians. The most intriguing feature of this study is that significantly fewer Japanese physicians would want for themselves the very same interventions that they recommend to their patients. For example, 74% would recommend

blood transfusions for gastrointestinal bleeding to their patients, but only 29% would want these transfusions for themselves.[15]

Fourth, a 1997 qualitative study, again by Asai and associates, used focus groups. [16] A number of physicians reported that they regularly disclose a diagnosis of cancer to a patient and also give an accurate prognosis and explanation of the effectiveness of available treatments. Many physicians reported that they make recommendations to patients about life-sustaining interventions, which the patients are free to reject. The study showed a considerable diversity of opinion among Japanese physicians about disclosure, about making decisions together with patients, about whether to always respect and follow a patient's decision, about withdrawing life-support once started, and about obligations generated by advance directives. As I read this study, the reports of these physicians show deep similarities at the time between U. S. and Japanese physicians in their beliefs and practices.

A fifth study is a 2005 questionnaire study on the subject of "negotiating end-of-life decision making" for incurably ill patients with metastatic gastric cancer, conducted by Baback Gabbay, Shinji Matsumura, et al.[17] This comparative study of resident physicians in both Japan and the United States was conducted at two U. S. sites and five Japanese sites. The widest variation these researchers found is that 94% of Japanese residents try to include both the patient *and* the family when disclosing the diagnosis and prognosis, whereas only about 54% of American residents routinely include the family. Also, Japanese residents generally prefer discussions with the family *first*, and Japanese residents reported in much higher numbers (76%) than Americans (18%), that they had sometimes *deceived* patients at the request of families.

These findings might seem to support the received view of a significant cultural difference in the family's role. However, a strong cultural-difference interpretation of this study would be a mistake. First, the fact that 54% of American physicians follow the apparent Japanese cultural pattern of including the family hardly shows that Japanese are family-oriented whereas Americans are autonomy-oriented. Although a much higher percentage of Japanese physicians reported deceiving their patients at the families' requests, a large number of Japanese physicians in this study expressed serious remorse, guilt, and moral uncertainty about their own moral judgments and behaviors when asked their ethical assessment of their deceptive conduct. Only 5% to 8% of Japanese medical residents were confident that their approaches to disclosure were the best way to handle the situation. Put another way, 92% to 95% of these Japanese physicians expressed some level of uncertainty about their moral duties of

disclosure. 45% of Japanese residents and 61% of American residents reported that they felt guilty either “all of the time” or “most of the time” when concealing a diagnosis. Both American and Japanese physicians, in comparable numbers, reported high levels of uncertainty about the proper ethics of the disclosure situations in which they find themselves.

In the end, the single biggest difference between Japanese medical residents and American medical residents, based on this study, is that 44% of Japanese residents would prefer to disclose a diagnosis of cancer to the family first, whereas only 2% of American residents would prefer that practice. Although this difference may seem large, *only* 44% of Japanese residents prefer this approach, well short of a majority, and this 44% figure goes down to 23% when the disclosure to the family is of *both* a diagnosis *and* a prognosis. At this point we see only a relatively small difference between the practices in Japan and the U.S. Gabbay, Matsumura, et al, in addition, point out that several studies conducted in Japan indicate that Japanese cancer patients are now directly expressing to their physicians a desire for disclosure, even though their families often do not express the same desire.

These investigators cite approvingly a sixth study by N. Horikawa, et al about how rapid the changes have been in Japan regarding the disclosure of a diagnosis of cancer to adult patients. The Horikawa study found that in 1993 disclosure of a diagnosis of cancer was made by physicians to only 27% of their Japanese patients, whereas five years later, in 1998, disclosure of the diagnosis of cancer increased to 71%. These investigators state flatly that the higher level of disclosure in 1998 is to be explained by the growing social importance of informed consent.[18, 19] This rate of change in the Japanese medical context seems to almost completely close what had until the late 1990s been the biggest gap in disclosure and consent practices between American and Japanese physicians.

A seventh study, by Yasuhiko Miura and associates, reported in 2006, contains results about how well Japanese families and physicians understand what patients actually want.[20] Using a questionnaire, they studied 450 dialysis patients in 15 hospitals in Japan. They found that only 47% of patients believed that their families could correctly report what they would want in the way of life-sustaining treatments; and only 31% believed that their physician could do so. As it turned out, about 68% of families made correct predictions of what the patients’ preferences would be. Physicians were slightly less accurate in reporting what their patients would want. Investigators point out that the ability of both families and physicians to accurately predict patient pref-

erences is only slightly above chance. These investigators note that their conclusions generally agree with the results of similar studies in the United States.

Finally, I mention a 2006 analysis of “Informed Consent Revisited: Japan and the U.S.,” by Akira Akabayashi and Brian Slingsby—a view expanded on in their recent book with Satoshi Kodama.^[21] They assert that informed consent is now an “imperative aspect of clinical medicine worldwide” and that “nondisclosure is no longer practiced regularly.” They analyze the history and meaning of “informed consent” in Japan, noting the importance of recently issued “Professional Ethics Guidelines for Physicians” of the Japan Medical Association, which asserts that “physicians have an ethical obligation to inform patients” and to “fully disclose all relevant information,” even though physicians have some “leeway not to inform patients directly.” They note similarities in the U. S. and Japan in the system as it now exists and maintain that any differences in cultures are “far less important than the need to understand each patient and family.”

The six studies and the seventh commentary that I mentioned in this section show the shallowness of the received view about cultural differences, at least when it comes to the imperative of receiving an informed consent. Both the U. S. and Japanese medical cultures have been in a process of progressive change over the course of the last 25 to 35 years, and both have been chipping away at past paternalistic practices.^[22, 23, 18] The idea that there is a deep divide in medical ethics of consent and paternalism between East and West should now die a quiet death.

It might be maintained that the goal of “looking and seeing” what Japanese beliefs and practices are might not be well served by the attention given in this section to empirical studies using questionnaires and the like. These instruments might motivate both patients and physicians to say what they think they are expected to say. I do not deny that there are methodological limits to these studies, but their convergence is important and cannot be dismissed.

HUMAN RIGHTS AND COMMON MORALITY

I will hereafter assume that there is little, if any, credibility in the received view of differences in bioethics. I move on now to ask whether there is good reason to think there is a substantial, globally shared agreement over moral matters—and, if there is not, then whether there should be. I am shifting from a paradigm case of shared belief to the far more general subject of universal morality, or common mo-

rality, first considering what we today conceive as human rights. Again I will argue against a view that has been prevalent in the literature. This view is related to the received view, but now I focus on the claim that beliefs in human-rights are western inventions uncongenial to eastern moral and political views. I concentrate on human rights because this category occupies the most prominent place today in discussions of universal morality.

The literatures of philosophy, political science, and bioethics often discuss problems of human rights through the lens of “human rights theory” or “political theory.” My concentration here is not on such theory but on the underlying cultural values in moral traditions that gave rise to the discussions that have occurred at least since the seventeenth century in human rights theory. The fact that these values may not have been designated “human rights” is unimportant to the argument.

SEN’S ACCOUNT OF RIGHTS AND EAST-WEST DIFFERENCES

I begin with an argument presented by Amartya Sen in a lecture on “Human Rights and Asian Values.” [24, pp. 10, 13, 17, 27, 30] Since Sen is from India, his moral outlook presumably descends from an Eastern culture. But Sen rejects the way Eastern views are often presented, especially when it comes to issues of freedom and human rights. Sen points out that the idea of “Asia as a unit” with a set of Asian values about freedom that are different from those of the West has no historical grounding. He notes that 60 percent of the people in the world live in Asia, with virtually nothing to solidify them as a uniform moral culture—or to distance them as a culture segregated from Europe, for that matter. Sen argues that “There are no quintessential values that apply to this immensely large and heterogeneous population, that *differentiate* Asians as a group from people in the rest of the world.” He finds that the major constituent components of basic ideas of liberty, especially political liberty, are present in both Eastern and Western traditions.

Even if the concept of human rights and human rights theory are relatively new to *all* parts of the world, as they are, the values that gave rise to these conceptions need not be new. Sen’s claim, as I understand him, is that the thesis that the values underlying human rights theory are friendly to Western tradition and alien to Eastern tradition is “hard to make any sense of.” I completely agree with him.

In speaking of freedom and authority in the East and the West, Sen need not be taken to mean that individual autonomy is prized *to the same extent* in the East as in

the West. Perhaps many populations in the East prioritize community and authority over individual autonomy to a *higher degree* than do many populations in the West. But this thesis does not entail that Eastern populations deprecate or reject either individual autonomy or political liberty. Sen's claim is that, as a moral matter, liberty rights are not antithetical to Eastern traditions of freedom and that claims of human rights are not less important in one place by comparison to another.

UNIVERSAL MORALITY: ITS BROAD SCOPE

The point of human rights language is to provide standards that transcend norms and practices in particular cultures that conflict with human rights, but universal morality—the common morality shared by all morally committed persons—is composed of much more than what we today designate as human rights. These “rights” are merely one way of carving out the territory of universal morality. We also share universal morality's *rules*, *virtues*, and *ideals*. I will now briefly examine these three categories of rules, virtues, and ideals.

UNIVERSAL RULES OF OBLIGATION

I start with a few examples of what I will call rules of obligation in the common morality: These rules require not killing, not causing pain or suffering to others, preventing evil or harm from occurring, rescuing persons in danger, telling the truth, nurturing the young and dependent, keeping one's promises, not stealing, not punishing the innocent, and obeying the law. These rules of obligation have been justified in various ways in various philosophical theories, but I will not treat problems of *justification* here. These cross-cultural norms are implemented in different ways in different communities, but the general norms themselves are not culturally contested in any community of persons committed to morality.

UNIVERSAL VIRTUES

Common morality also contains standards that are moral character traits, or virtues. Here are some examples: honesty; integrity; nonmalevolence; conscientiousness; trustworthiness; fidelity; gratitude; truthfulness; lovingness; and kindness. These human traits are universally admired (pp. 33—34, 46—50),^[25] and a person is

deficient in moral character if he or she lacks one or more of these traits. Negative traits opposite the virtues are *vices*—for example, malevolence, dishonesty, lack of integrity, cruelty, etc. These character traits are substantial moral defects, universally so recognized by persons committed to morality.

UNIVERSAL IDEALS

The final of my three examples of the common morality (in addition to rights) is moral ideals, such as charitable goals, community service, maximum dedication to one's job, and service to the poor. These aspirations are not *required* of persons, but they are universally *admired* and *praised* in persons who act on them (pp. 20—26, 76—77).[26] Four examples are exceptional forgiveness; exceptional generosity; exceptional compassion; and exceptional thoughtfulness.

Some diversity of judgment will arise in interpreting and implementing all of the norms I have used as examples. My claim is only that these norms are shared across cultures and are universally recognized by morally committed persons.

THE UNIVERSALITY OF PRINCIPLES OF RESEARCH ETHICS

I will now extend this discussion of rights, rules, virtues, and ideals to what I take to be a fact about *recent developments* in biomedical research ethics where a base of values spread from one part of the globe to what is, in effect, a universal presence. Forty years ago, or even thirty years ago, there was no recognized universal research ethics of the sort that has become familiar to us in recent years. There was then scarcely any research ethics. Today we can see a vast similarity, in virtually every developed nation, in moral codes, declarations, laws, and regulations governing research with human subjects. There are understandable and justifiable differences from country to country, but the differences pale in comparison to the sea of similarity in the moral and legal norms governing how biomedical research can and cannot be conducted.

Many principles are globally accepted, and violations of them are universally condemned. Examples include:

Disclose all material information to subjects of research.

Obtain a voluntary, informed consent to medical interventions.

Maintain secure safeguards for keeping personal information about subjects private and confidential.

Receive surrogate consent from a legally authorized representative for incompetent subjects.

Ethics review committees must scrutinize and approve research protocols.

Research cannot be conducted unless its risks and intended benefits are reasonably balanced; and risks must be reduced to avoid excessive risk.

Special justification is required if proposed research subjects are vulnerable persons.

Several global organizations and many governments have subscribed to these norms in guidelines, codes, or regulations, but the force and authority of the norms is not contingent on particular laws or agreements. These norms are human rights of research subjects and they are in each case correlative to duties of researchers and sponsors. (See, as one of many examples, the World Medical Association's *Declaration of Helsinki*.^[27])

Having now explored the categories of rights, principles, virtues, and ideals, I could go on to several other domains of universal morality, but this project is too much of an undertaking for this paper. In making the claims I have advanced about global moral beliefs I do not deny that historical context and political circumstance have had a major role in the way these values have been transmitted across the centuries. Research ethics is a good example. I have not tried to explore such an historical point of view, as it too requires more than can be attempted in this paper.

MULTICULTURALISM

In conclusion, I turn to the related subject of multiculturalism, which I interpret as a form of human rights theory. However, many writers see matters very differently. They maintain that the idea of a universal, or common, morality does not appreciate the "multicultural world" that we now experience. They hold that multiculturalism and secular pluralism have delivered a post-modern world in which our robust past beliefs in the universality of moral precepts are no longer sustained. For example, H. Tristram Engelhardt and Kevin Wildes maintain that a "theoretically intractable

secular moral pluralism” pervades the modern world, rendering it unamenable to any form of common morality. From this perspective, one cannot say anything about what constitutes proper physician-patient relationships, what human rights might mean, or what constitutes virtue and character—except from within a commitment to the moral framework of a particular moral community.[28, 29] This theory too makes no sense to me.

It is also dangerous in what it defends. Among the human rights that today should be most vigorously defended are rights against the oppression of minorities, women, children, and other targeted groups. When complaints about violations of rights arise, governments or other controlling groups often use the excuse that they are treating women and children in accordance with *their* cultural and religious traditions. The premise that cultures have a right to protect their traditional values, beliefs, and rituals is unacceptable when used to prevent women from educational opportunities, to exploit human subjects in research without appropriate consent, to foster oppressive child labor conditions, or to discriminate against minorities and disenfranchised populations. These practices are basic human rights violations.

THE UNIVERSALITY IN THE THEORY OF MULTICULTURALISM

Many of today’s exponents of the view that there are no universal norms have misrepresented the commitments and objectives of multiculturalist ethical theory. Multiculturalism is the theory that respect is owed to cultural traditions because morality demands this respect.[30] Multiculturalists accept the principle that group traditions, institutions, perspectives, and practices should be respected and should not be violated as long as the members of the group do not themselves violate the standards of the common morality. The objective of multiculturalism is to provide a theory of the norms that universally should guide the protection of vulnerable cultural groups when threatened with marginalization or oppression caused by one or more dominant cultures.[31, 32] Multiculturalism from this perspective has a human-rights dimension.

CULTURAL DIVERSITY

These comments do not undercut the importance and legitimacy of cultural diversity. A multiculturalist account protects diversity. From the fact that we are re-

quired to tolerate and protect different cultural traditions, different religious views, and the like, it does not follow that *all* convictions and practices must be tolerated and protected. Some basic norms govern everyone's conduct, whereas some norms hold exclusively for particular groups.

CONCLUSION

I have argued that it is easy to overlook similarities in cultures because of various cultural differences that capture our attention. Whatever our differences, the U. S., Europe, and Japan share a great deal in common, and no differences in our cultural histories now present major barriers to accord on basic values in bioethics. My perspective has been universalistic from the first section on shared values such as informed consent requirements to the final two sections on human rights and multiculturalism. In these last two sections it became apparent that multiculturalist theory is a form of human rights theory. In the first section the conclusion reached was, in effect, that the right to give an informed consent to a medical intervention is a human right, even if rights language is not used.

These themes have great interest for contemporary bioethics, because there continues to be a shift in the direction of a globally shared bioethics. I have highlighted both clinical ethics and research ethics as examples of the gradual shift to a global bioethics. My hypothesis is that we are well down the path of a process that is still today leveling previous differences through cultural exchange and learning. I am not maintaining that a moral imperialism is being imposed universally by the most powerful nations so that learning is unidirectional from west to east. I mean that we have much to learn from each other that we can share. For example, at the current time in the U. S. we are learning to modify our practices of "community engagement" to protect the interests of participants in research and to create a better set of responsive relationships while engaging in research with human subjects. In this conception, distinctive social, cultural, political, and economic contexts of research participants will be taken into consideration and rules and practices negotiated. U. S. investigators and writers in bioethics have much to learn on this subject from other nations with a history of keenly sensitive practices.

I project that a dialogue and leveling of this sort will continue to occur in bioeth-

ics and public policy, hopefully erasing all differences of actual practice that prevent human rights from being firmly in place.

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REFERENCES

- 1 Bai K, Shirai Y, Ishii M. In Japan, consensus has limits. *Hastings Center Report* 1987;17:S18-S20.
- 2 Shirai Y. Japanese attitudes toward assisted procreation. *Journal of Law, Medicine, and Ethics* 1993;21:43-53.
- 3 Kimura R. In Japan, Parents participate but doctors decide. *Hastings Center Report* 1986;16:22-23.
- 4 Ishibashi A. Four concepts that distinguish pediatric oncology care in Japan from that in the United States: telling the diagnosis, length of hospitalization, home care, and support systems. *Journal of Pediatric Oncology Nursing* 1996;13:226-32.
- 5 Gordon J-S. Global ethics and principlism. *Kennedy Institute of Ethics Journal* 2011;21:251-76.
- 6 Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press 1986. Chapters 3-6.
- 7 Katz J. *The Silent World of Doctor and Patient*. New York: Free Press 1984.
- 8 Hagman DG. The medical patient's right to know: report on a medicallegalethical, empirical study. *UCLA Law Review* 1970;17:758816.
- 9 Hershey N, and Bushkoff SH. *Informed Consent Study*. Pittsburgh, PA: Aspen Systems Corporation 1969.
- 10 Fellner CH, and Marshall JR. The myth of informed consent. *American Journal of Psychiatry* 1970;126:124550.
- 11 Alfdi RJ. Informed consent: a study of patient reaction. *JAMA: Journal of the American Medical Association* 1971;216:132529.
- 12 Hattori H, Salzberg SM, Kiang WP, Fujimiya T, Tejima Y, and Furuno J. The patient's right to information in Japan--legal rules and doctor's opinions. *Social Science and Medicine* 1991;32:1007-1016.
- 13 Mizushima Y, et al. A survey regarding the disclosure of the diagnosis of cancer in Toyama Prefecture, Japan. *Japanese Journal of Medicine* 1990;29:146-155.
- 14 Morioka Y. Informed consent and truth telling to cancer patients. *Gastroenterologia Japonica* 1991;26:789-92.
- 15 Asai A, Fukuhara S, and Lo B. Attitudes of Japanese and Japanese-American physicians towards life-sustaining treatment. *Lancet* 1995;346:356-59.

- 16 Asai A, et al. Medical decisions concerning the end of life: A Discussion with Japanese Physicians. *Journal of Medical Ethics* 1997;23:323-27.
- 17 Gabbay BB, et al. Negotiating end-of-life decision making: a comparison of Japanese and U. S. residents' approaches. *Academic Medicine* 2005;80:617-21.
- 18 Horikawa N, Yamazaki T, Sagawa, M, and Nagata, T. Changes in disclosure of information to cancer patients in a general hospital in Japan. *General Hospital Psychiatry* 2000;22:37-42.
- 19 Horikawa N, Yamazaki T, Sagawa M, and Nagata T. The disclosure of Information to Cancer Patients and its relationship to their mental state in a consultation-liaison psychiatry setting in Japan. *General Hospital Psychiatry* 1999;21:368-73.
- 20 Miura Y, et al. Families' and physicians' predictions of dialysis patients' preferences regarding life-sustaining treatments in Japan. *American Journal of Kidney Diseases* 2006;47:122-30.
- 21 Akabayashi A, Slingsby BT. Informed consent revisited: Japan and the U.S. *American Journal of Bioethics* 2006;6:9-14.
- 22 Ninomiya R. Contemporary Japan: medical ethics and legal medicine. In: *Encyclopedia of Bioethics*, ed. Warren Reich, Vol. 3. New York: Free Press 1978:926-930.
- 23 Novack DH, et al. Changes in physicians' attitudes toward telling the cancer patient. *Journal of the American Medical Association* 1979;241:897-900.
- 24 Sen A. *Human Rights and Asian Values*. New York: Carnegie Council 1997.
- 25 Nussbaum M. Non-relative virtues: an Aristotelian approach. In: *Ethical Theory, Character, and Virtue*, ed. Peter French et al. Notre Dame, Ind.: University of Notre Dame Press 1988:32—53.
- 26 Gert, B. *Common Morality: Deciding What to Do*. New York: Oxford University Press 2007.
- 27 The World Medical Association. *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*, Part B, Basic Principles for all Medical Research, 2008 revision; first adopted 1964.
- 28 Engelhardt HT Jr, and Wildes KW. The four principles of health care ethics and post-modernity: why a libertarian interpretation is unavoidable. In: *Principles of Health Care Ethics*, ed. Raanan Gillon and Ann Lloyd. London: John Wylie & Sons 1994:135-47.
- 29 Engelhardt HT. *The Foundations of Bioethics*, second edition. New York: Oxford University Press 1996.
- 30 Siegel H. Multiculturalism and the possibility of transcultural educational and philosophical ideals. *Philosophy* 1999;74:387-409.
- 31 Taylor C, Gutmann A, Rockefeller SC, Walzer M, Wolf S. In: *Multiculturalism and the Politics of Recognition*. ed. Amy Gutmann. Princeton, NJ: Princeton University Press 1992.

³² Fullinwider RK, Gutmann A, Taylor C, In: Fullinwider, ed. *Public Education in a Multicultural Society: Policy, Theory, Critique*. Cambridge: Cambridge University Press, Cambridge Studies in Philosophy and Public Policy 1996.