

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

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ABSTRACT

To elucidate some issues in global biomedical ethics, I consider three problems about alleged moral differences between Eastern and Western cultures. The first is whether Eastern and Western moral traditions are fundamentally different. Concentrating on Japan and the United States, I argue that theses of profound and fundamental East-West differences are implausible since there are many forms of shared morality. The second is whether human rights theory is a Western invention with no firm roots in Eastern moral traditions. I argue 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. I argue that the reverse is true: multiculturalism is a universalistic theory. The argument throughout supports common morality theory.



Global ethics is currently a fashionable notion, but its meaning and scope remain underdeveloped. To address some questions in biomedical ethics, I will investigate three problems about cultural moral differences, concentrating on alleged 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 that 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. (Bai et al. 1987: 18–20)

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 (Bai et al. 1987. See also Shirai 1993).

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?' My problem, I explained, 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 polar viewpoints.

In this paper I will look and see what the situation is today and how we should assess it. I first will devote some time to clarifying a deeply entrenched perspective that I will call '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' (Kimura 1986: 23, see similarly Ishibashi 1996).

I do not deny that there are some differences *in degree* between American and

Japanese societies on these matters. Empirical studies show modest differences, but the view has no merit as an account of differences *in kind*—as if people from the East and the West have fundamentally different principles, beliefs, practices, and conventions in medical institutions. Where others have looked for cultural *differences*, I will emphasize relevant cultural *similarities*.

INFORMED CONSENT: HISTORY, TRADITION, AND LEGEND

I will use the doctrine of informed consent as my principal example of alleged differences, but more often similarities, between Eastern and Western bioethics. This doctrine has for many years, especially in the literature of the 1980s and 1990s, been 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 influential bioethics literature to supposedly distinctive American views of autonomy and individualism. As an 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’ (Gordon 2011: 261).

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 began only around 1972. It had no significant prior history in philosophy, law, medicine, or public policy in the US (Faden and Beauchamp 1986: chapters 3–6). 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 (Katz 1984).

In an empirical study in the US 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 experimen-

tal anti-cancer drug and is currently receiving a placebo (Hagman 1970, Hershey and Bushkoff 1969, Fellner and Marshall 1970, Alfidì 1971). 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 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 both derived from centuries of physician paternalism and cultural deference. American interest in patients' rights and paternalism has occurred only in the last thirty-five years.

EMPIRICAL STUDIES OF JAPANESE BELIEFS ABOUT INFORMED CONSENT

Does the current situation in Japan differ significantly from that in the US, with relation to cultural attitude and medical practice? There are differences, but my working hypothesis is that today no profound cultural differences in consent practices exist between Japan and the US. To assess the current situation, I will consider the findings of several empirical studies on paternalism and informed consent that have been conducted in Japan. These studies elucidate 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 have similar, though not identical, results. I know of no serious scholarly study that contains significantly different findings than those I will report.

The first study was reported by Professor Hiroyuki Hattori and five associates, published in 1991, having been conducted in 1986-87 (Hattori et al. 1991). The data in this study show some striking similarities of attitude and behavior to earlier empirical studies of American physicians. 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: between 56% to 60% of respondents gave 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' (Hattori et al. 1991: 1013). These results are largely consistent with various studies of the behavior of American physicians.

A second study was conducted in 1989 by Professor Yutaka Mizushima and eight associates (Mizushima et al. 1990). This study examined disclosures of a diagnosis of cancer (in Toyama Prefecture), and asked the opinion of physicians, paramedical personnel, and lay persons about Japanese practices of nondisclosure. 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 United States of America, ... more than 90% of MDs reveal the diagnosis of cancer to their patients' The Mizushima study revealed 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% 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 (Morioka 1991). 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 (Asai et al. 1995).

Fourth, a 1997 qualitative study, again by Asai and associates, used focus groups (Asai et al. 1997). 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. The reports of these physicians show deep similarities at the time between US and Japanese physicians in their beliefs and practices.

A fifth study, conducted in 2005, involved a questionnaire on the subject of 'negotiating end-of-life decision making' for incurably ill patients with metastatic gastric cancer, conducted by Baback Gabbay, Shinji Matsumura, and others (Gabbay et al. 2005). This comparative study of resident physicians in both Japan and the United States was conducted at two US 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 that there is a significant cultural difference between Japan and the US 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, the 44% of Japanese residents preferring this approach is well short of a majority, and this 44% falls 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 US. The authors, 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 and colleagues 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 (Horikawa et al. 1999, Horikawa et al. 2000). 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 (Miura et al. 2006). 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 preferences is only slightly above chance. These investigators note that their conclusions generally agree with the results of similar studies in the United States.

Finally, a 2006 analysis of informed consent by Akira Akabayashi and Brian Slingsby, expanded on in their recent book with Satoshi Kodama, asserts that informed consent is now an 'imperative aspect of clinical medicine worldwide' (Akabayashi and Slingsby 2006: 9) and that 'nondisclosure is no longer practiced regularly' (p. 11).

They analyse 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 assert that ‘physicians have an ethical obligation to inform patients’ (p. 10) and to ‘fully disclose all relevant information’ (p. 10), even though physicians have some ‘leeway not to inform patients directly’ (p. 10). 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’ (p. 12).

The six studies and a seventh commentary that I have mentioned in this section show the shallowness of the received view about cultural differences, at least when it comes to the imperative of obtaining an informed consent. Both US 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 (Ninomiya 1978, Novack et al. 1979, Horikawa et al. 2000). 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.

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, whether there should be. I am shifting to the subject of universal morality, or common morality, first considering human rights. Again I will argue against a view that has been prevalent in the literature. This time it is the claim that human rights theory is a Western invention uncongenial to Eastern moral and political theory. I focus on human rights because this category occupies the most prominent place today in discussions of universal morality.

SEN’S THEORY OF RIGHTS AND EAST-WEST DIFFERENCES

I begin with an argument presented by Amartya Sen in a lecture on *Human Rights and Asian Values* (Sen 1997). 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 though the idea of human rights as having a prominent role in moral and political theory is relatively new to *all* parts of the world. He finds the claim that these ideas are friendly to Western tradition and alien to Eastern tradition ‘hard to make any sense of’ (Sen 1997: 10, 13, 17, 27, 30). I completely agree with him.

In speaking of freedom and authority in the East and the West, Sen does not mean that individual autonomy is prized *to the same extent* in the East as in the West. It could be that 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 human rights. That is, ‘rights’ is merely one category 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, non-malevolence, conscientiousness, trustworthiness, fidelity, gratitude, truthfulness, lovingness, and kindness. These human traits are universally admired (Nussbaum 1988: 33–34, 46–50), and a person is deficient in moral character if he or she lacks one or more of these traits. Negative traits opposed to 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 (Gert 2007: 20–26, 76–77). 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. 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 codes, 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, Part B of the World Medical Association's *Declaration of Helsinki* (World Medical Association 2008).)

Having now explored the categories of rights, principles, virtues, ideals, and I could go on to several other domains of universal morality, but this project is too much of an undertaking for this paper.

MULTICULTURALISM

In conclusion, I turn to the related subject of multiculturalism. Many writers today 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 (Engelhardt and Wildes 1994, Engelhardt 1996). This theory 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.

THE UNIVERSALITY IN THE THEORY OF MULTICULTURALISM

Many of today’s exponents of the view that there are no universal norms also misrepresent the commitments and objectives of multiculturalist ethical theory. Multiculturalism is the theory that respect is owed to cultural traditions because morality demands this respect (Siegel 1999). 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 vul-

nerable cultural groups when threatened with marginalization or oppression caused by one or more dominant cultures (Taylor 1992, Fullinwider 1996). Multiculturalism from this perspective is a form of human-rights theory.

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 required 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 US, Europe, and Japan share a great deal in common, and no differences in our cultural histories now present major barriers to accord in bioethics.

I have implicitly suggested that we have gradually moved into a globally shared bioethics, and I have highlighted both clinical ethics and research ethics as examples. 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 do not mean to suggest 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, currently in the US 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. US investigators have much to learn on this subject from other nations with a history of more sensitive practices.

I project that a dialogue and leveling of this sort will continue to occur in bioethics and public policy, hopefully erasing all differences of practice that might prevent human rights from being firmly in place.

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