

Uncovering Metaethical Assumptions in Bioethical Discourse Across Cultures

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DRAFT. Final version published in *Kennedy Institute of Ethics Journal*. Available: <https://muse.jhu.edu/article/616676>

Abstract: Much of bioethical discourse now takes place across cultures. This does not mean that cross-cultural understanding has increased. Many cross-cultural bioethical discussions are marked by entrenched disagreement about whether and why local practices are justified. In this article, I argue that a major reason for these entrenched disagreements is that problematic metaethical commitments are hidden in these cross-cultural discourses. Using the issue of informed consent in East Asia as an example of one such discourse, I analyze two representative positions in the discussion and identify their metaethical commitments. I suggest that the metaethical assumptions of these positions result from their shared method of ethical justification: moral principlism. I then show why moral principlism is problematic in cross-cultural analyses and propose a more useful method for pursuing ethical justification across cultures.

Bioethics seeks to answer questions and resolve problems that change along with developments in medicine and biology. Ethical justification plays a crucial role in bioethical analysis by clarifying the reasons that support complex judgments about particular actions and general policies.¹ It helps bioethicists to determine what to allow, forbid, support, and minimize. When there is disagreement, it can also aid understanding of competing positions. However, at times, disagreement on particular issues becomes so entrenched that understanding seems impossible. In such circumstances, how might bioethicists proceed?

In answering this question, this paper considers a particularly significant area of disagreement: the informed consent standards for medical practices in different countries. Since many medical procedures are transnational, it is thought that the informed consent standards for these procedures should be universal. However, global dialogue has

¹ I use “moral” and “ethical” interchangeably. I also consider medical ethics to be one area of bioethics.

revealed notable variation in local standards, resulting in questions about which informed consent practices are ethically justified. Recently, a number of conflicting positions have become entrenched, leading some to sense that the ethics of medical decision-making are not universal, but are instead culture or region specific. Thus the debate on informed consent, which began as a cross-cultural misunderstanding about the reasons behind local practices, has become a deep disagreement over the grounds of ethical justification.

In this paper, I examine the arguments of several prominent figures in the medical ethical debate on practices of informed consent in East Asia. I suggest that the manner in which ethical justification has been attempted is responsible for the initial cross-cultural misunderstanding over these practices, and moreover, that reconceiving ethical justification will clarify the grounds of the misunderstanding and dissolve the deep disagreement over universal versus relative ethics in the cross-cultural bioethical debate.

This investigation proceeds as follows. First, I present the background to the discussion, which includes common tensions in cross-cultural bioethics and their tendency to reduce to a metaethical debate between universalism and relativism. Second, I review the discussion on practices of informed consent in East Asia and outline two opposing attempts (those of Akira Akabayashi and Ruiping Fan) to justify these practices ethically. Third, I analyze the metaethical positions and general commitments behind these attempted justifications to show that their assumptions about ethical justification render their arguments unsuccessful. Fourth, I critique Akabayashi and Fan's shared moral generalism in terms of the problems it raises for cross-cultural ethical justification. Finally, I suggest a more useful method for explaining and justifying medical ethical practices across cultures.

I. INTRODUCTION: TENSIONS IN CROSS-CULTURAL BIOETHICS

Bioethics was born out of the cultural and sociological conditions of the United States in the post-World War II era, and in the latter quarter of the 20th century many of its ideals and practices spread overseas. These ideals and practices were unproblematic in European countries that had been struggling with corresponding issues of medical research and experimentation in the context of similar legal and social systems, but the extension of so-called American bioethics to Asia and the Middle East has not been so easy. Cross-cultural bioethical discussions involving these cultures often manifest as collisions of disparate moral perspectives, with each side defending the intuitive correctness of their claims but neither side truly understanding the other.

Scholars of bioethics and the medical humanities have been paying increasing attention to these cross-cultural discussions for two reasons. First, without resolution, disagreement about the justification of supposedly core bioethical practices like informed consent calls into question the ethical justification of all transnational practices over which there is disagreement. For instance, disagreement about how informed consent ought to be justified in a particular context can challenge the justification of all informed consent practices, if justification is understood as universal and not relative (more on this below). To avoid continuing potentially problematic practices and to ensure that ethical justification is not just locally effective, it is thought that these disagreements must be resolved.

Second, these disagreements sometimes indicate not a failure of understanding, but an inconsistency in the field in which the disagreement takes place (just as moral disagreement is a major issue for ethics in general).² Entrenched cross-cultural disagreements have implications for how bioethics as a field is defined and for how we “do” bioethics. If current methods of bioethical analysis are more likely to lead to misunderstanding than understanding between differing viewpoints and cultures, then the methodology of bioethics should be reconsidered.

Of these two reasons for paying attention to bioethical disagreements across cultures, the latter reason is more pressing and is the focus of the present paper. Without clarifying the theoretical background against which such disagreements take place, any attempts at resolution will be superficial. To seek a more effective solution, this paper asks what cross-cultural bioethical disagreement indicates about bioethics as a field – both in terms of scope and methodology.

Several authors have already taken up this question. Their answers fall roughly into two categories. One group has argued that entrenched cross-cultural disagreements indicate that different cultures “disagree about moral premises and rules of evidence” of bioethics, so we can only “live together as moral strangers in the face of irresolvable moral diversity” (Engelhardt 2006, 17). This suggests the absence of a unified global field of bioethics. In the words of one scholar, bioethics is a “cluster concept” that “comes in many not always mutually understandable dialects” (Holm 2006, 10).

Another group, while sensitive to the threats of moral imperialism, has suggested that a common language of bioethics can be found if we “negotiate about the

² See: J.L. Mackie, *Ethics: Inventing Right and Wrong* (1977), 15-49.

‘reasonableness’ of arguments” (Campbell 1999, 189). This common language will allow us to pursue a global bioethics by harmonizing and bridging regional “ethoses” to become “‘holistic’ as opposed to ‘individualistic’” (Sakamoto 1999, 197). This suggests that there is something properly called “global bioethics,” which is more uniform than the amalgamation of viewpoints implied by the term “cluster concept.”

The former camp, skeptical about reaching consensus on specific issues and suspicious of universal bioethical declarations, leans towards moral relativism. By contrast, the latter camp argues that we can indeed speak a common moral language, while respecting local differences in how this common language is expressed. This implies a form of moral universalism. Unfortunately, neither side specifies what these positions entail; their arguments tend to be based on whether they think that agreement across cultures is a realistic goal.

These viewpoints about cross-cultural or global bioethics can be otherwise articulated in terms of two metaethical positions: cultural moral relativism and moral universalism. Both positions agree that moral claims are truth-apt, but they disagree about the scope of moral claims’ truth-value. For moral universalists, true moral claims are universally true. This means that if “lying is wrong” is true, it is true in all cases and for all people (although the grounds of its truth-value are contested, such that the truth of moral claims can depend on the structure of rationality, the word of God, or moral facts in the world that make them true). According to this position, if “lying is wrong” is true, then I should not lie, and nothing will be able to justify lying.

Cultural moral relativists reject that moral claims are universally truth-apt, and instead argue that their truth-value is relative to particular cultures. For example, if I am

in a situation where I want to tell a lie and I need to know if lying is wrong, then I should appeal to my culture. If in my culture lying is wrong (i.e., if “lying is wrong” is true in my culture), then I should not lie and I will not be able to ethically justify lying.³

Both cultural moral relativism and moral universalism hold that moral judgment and ethical justification proceed by assessing the situation in terms of one or more relevant moral principles. In the case of universalism, moral principles usually take the form of moral rules that demand obedience.⁴ In the case of cultural relativism, moral principles manifest as a culture’s sanction or prohibition, also often phrased as moral rules. Moral universalism and cultural moral relativism as so defined (and as most often discussed in the bioethical literature) are forms of moral generalism, according to which morality is best described as a system of general moral principles.⁵ In any situation, the relevant moral principles must be weighed and balanced. While “lying is wrong” might be the moral principle with the most weight in some circumstances, the moral principle “help those in need” could outweigh “lying is wrong” in different conditions. For example, in the case of cultural relativism, my culture might prohibit lying while also sanctioning compassionate actions, and both these rules might hold in a single situation. Similarly, for the universalist, it might be true that “lying is wrong,” but also that

³ This is not a situationist ethics. Whether or not a lie is permitted depends not on the predominant culture in which I am situated, but on the culture with which I identify. If I am an American in Japan, I can appeal to an “American ethics” as an American or to a “Japanese ethics” as a resident of Japan. This may also raise problems for the relativist position, but these problems will not be dealt with here.

⁴ Moral principles and moral rules are essentially identical, although moral principles tend to be general values or goods while moral rules are usually phrased as more specific imperatives.

⁵ In this paper I use moral generalism to indicate the metaethical position that ethics consists of moral principles, and principlism to indicate the related position that ethical justification must proceed in terms of principles.

“harming others is wrong.” Any process of moral judgment and justification will have to weigh and balance these rules or principles.

There is another possible metaethical position with regard to the question of “global bioethics” that is not currently represented in the debate – this is the view of moral particularism.⁶ Moral particularism is the rejection of moral generalism. For the moral particularist, while all situations have morally relevant features that contribute to the judgment and the justification of what should be done in those situations, these morally relevant features are not moral principles, and their truth-value is neither relative to culture nor universal. Moral particularism thus often holds that moral claims are truth-apt, but understands the relativity of their truth-value more radically. Moral principles, understood as consistent across cases, are rejected altogether. In other words, while “lying is wrong” may be “true” in one case, that is, may count in favor of not lying, it is not necessarily “true” in another case. Its truth-value depends on the interaction of innumerable features of the case, so it cannot really said to be a “moral principle” in any stable sense of the term. In assessing a situation that seems to require lying, rather than proceed via moral principles, the moral particularist will ask what the reasons are for and against lying. What is the situation? To whom will the lie be directed? What are the motivations for the lie? Whether or not the action is “wrong” depends on this set of

⁶ Jonathan Dancy has been the foremost defender of moral particularism; his *Stanford Encyclopedia of Philosophy* entry is useful in defining this position. Also see Norris Lance, *Challenging Moral Particularism*, and Hooker and Little, *Moral Particularism*. Importantly, while Dancy makes moral particularism into an ontological claim, others (Garfield, “Particularity and Principle”) have argued that it is an epistemological one. My concern, however, is different from those of Dancy and Garfield. Rather than discussing what moral particularists think ethics is or how moral particularists think we have ethical knowledge, I focus on how moral particularists think ethical claims can be justified.

reasons holistically, where participation in a culture or belief in a set of moral principles may matter, but are not definitive.

I will have more to say about these positions later. For now, I suggest that one reason for the entrenched nature of cross-cultural bioethical disagreements is that those engaged in these debates assume that generalist moral universalism and moral relativism are the only possible routes to ethical justification. This reveals a further assumption about the *methodology* of bioethics.

Both general discussions and particular debates on cross-cultural bioethics assume that bioethics deals with rules or principles that are either universally or relatively applicable to particular cases. According to this dichotomy, bioethics must either have its own set of universal principles, or be a classificatory term for culturally, nationally, or socially defined principles. Few scholars question whether bioethics must involve ethical principles, or whether ethical justification in bioethics should apply principles to biomedical issues. The principled nature of bioethics – and thus the assumption of a moral generalist framework – is taken for granted. Yet in the face of unyielding debates, these foundational assumptions about bioethical judgment and justification must be questioned. There is also a pragmatic reason for questioning moral generalism in the context of global bioethics. While most philosophical argumentation about generalism and particularism takes place metaethically, practical differences between the two positions are perhaps most clear in the sphere of applied or practical ethics, where these

theories underlie potential solutions to real-world problems and may offer pragmatic, non-theoretical reasons to prefer one over the other.⁷

This paper will not prove which of the three positions is the proper metaethical foundation for bioethical justification. Indeed, the contemporary debate between these positions is lively in metaethics as well. However, commitments to the first two of these metaethical positions are hidden in contemporary debates on cross-cultural bioethical issues, and this is problematic. Metaethicists can separate themselves from practical considerations so as to focus on the arguments for and against these three positions. Cross-cultural bioethicists are more likely to commit to metaethical positions for reasons other than the strength of the arguments. For example, one may defend relativism to protect the distinctiveness of one's culture from moral imperialism, or one may argue for universalism because one thinks that bioethics should not be culturally insulated or "parochial." Such hidden commitments lead to misunderstanding and contribute to the entrenched nature of these cross-cultural disagreements. Identifying the role of these metaethical assumptions in cross-cultural bioethical justification provides the clarification necessary for continued dialogue. The analysis that follows does not attempt a theoretical critique of these metaethical positions, but produces a practical argument for why some of them do not work in cross-cultural bioethics. Whether or not these practical issues suggest deeper theoretical difficulties remains a subject for future work.

⁷ I take the terms "applied ethics" and "practical ethics" to be interchangeable, although there is disagreement over whether the two really amount to the same thing. Applied ethics is often described as the application of abstract ethical theory to real world problems, whereas practical ethics is interpreted as the study or analysis of ethical issues in the particular contexts in which they arise.

II. INFORMED CONSENT ACROSS CULTURES

A well-known example of disagreement in cross-cultural bioethics is the debate on practices of informed consent in East Asian cultures.⁸ In the case of terminal illnesses such as cancer, physicians and families have been more likely to withhold the diagnoses of these illnesses from patients.⁹ For many scholars outside these cultures, these practices are morally problematic, either as blatant violations of patient autonomy or because there seems to be no adequate justification for them.¹⁰

Within these cultures, many find these practices to be intuitively morally acceptable, yet attempts to justify them ethically have led to disagreement about the foundation of their moral acceptability. The failure to resolve these disagreements has contributed to arguments based on the metaethical positions described in section I. Some suggest that a local or generally Asian approach to bioethics is needed, others allege that Asian bioethics is just one version of a unified global bioethics (Akabayashi et al 2008), and yet a third group argues for “a collage of culturally informed perspectives built upon an ever-increasing aggregate of shared experiences” (Castro 1999). To better understand these positions, this section focuses on the method of ethical justification used by two of the foremost East Asian representatives in the informed consent debate. One side leans towards relativism, while the other espouses universalism. It is crucial to understand *why*

⁸ This disagreement has also occurred in the context of Islamic, Middle Eastern, Eastern European, and South American cultures. However, since it has been the most sustained in the East Asian context, I focus on this case here.

⁹ For example, see: Shahidi (2007), Pang (2013), Wang (2012).

¹⁰ The responses by Robert Klitzman, Kenneth Kipnis, Yvette Pearson, and Anita Ho to Akabayashi and Slingsby’s article in the *American Journal of Bioethics* (2006), Vol. 6 (1) are good examples of possible responses from outsider perspectives.

they support these positions and *how* they think their arguments get them to their desired conclusions.

IIA. First Viewpoint: Akira Akabayashi

One of the most vocal participants in this debate is Akira Akabayashi, a physician and medical ethicist at the University of Tokyo, who in 2006 advanced his idea of the “family-facilitated” approach to informed consent. According to this approach, informed consent is accomplished through a consultation between the family and physician about how best to inform the patient of his or her diagnosis. In some cases, the patient will not be informed at all. Since 2006, Akabayashi has repeatedly defended this approach to informed consent, most recently in the 2014 volume, *The Future of Bioethics*.

Akabayashi alleges that family-facilitated informed consent is based on a form of autonomy that is similar to relational autonomy (Akabayashi and Hayashi 2014, 745).¹¹ This “form of autonomy” better captures the autonomous nature of individuals with an “interdependent self-construal,” as compared with individuals who have an independent self-construction, for whom the traditional understanding of autonomy as individual self-determination is more appropriate.

Akabayashi often uses case studies to clarify the family-facilitated approach. In his 2014 paper, he explains the family-facilitated approach through three case studies.¹²

In each case study, he presents the facts he takes to be relevant: the patient’s age,

¹¹ “Relational Autonomy” has been proposed as an alternative to traditional Western autonomy, sometimes described as “rugged and individualist.” In contrast, relational autonomy emphasizes the importance of embodied experience, interpersonal relationships, and unique context for the development of autonomy (see Mackenzie and Stoljar 2000).

¹² The same cases he considers in articles from 1999 and 2006.

occupation, gender, mental state, relationship with family members, details of the diagnosis, prognosis, and proposed treatment. He describes the scenario in which the diagnosis is told, as well as the reactions of the patient, family, and physician. He then analyzes the roles of the family and physician. Akabayashi's main concern throughout is whether the family-facilitated approach can be understood as consistent with patient autonomy.

Akabayashi conceives of this explanatory work as getting him almost all the way to ethical justification. Interpreting the family-facilitated approach in terms of autonomy allows him to use autonomy as a justification for family-based informed consent. While Akabayashi does not explain why this form of autonomy is valuable, he repeatedly stresses that it is consistent with "the general ethical principle of respect for autonomy in the United States" (Akabayashi and Slingsby 2006, 13), understood as "the minimization of physician paternalism and respect for patient preference" (Akabayashi and Hayashi 2014, 745). Akabayashi's concern to ground the Japanese practice in American/Western autonomy reveals his belief that this principle of autonomy is valid and universal, while his application of this principle to Japan suggests that it is not an unchanging Platonic ideal, but one that can adjust to local considerations. He writes, "we attempt to pay due respect to local cultural values to the extent that they are compatible with the concept of autonomy that underlies the ideal practice of informed consent" (Akabayashi and Hayashi 2014, 747). For him, autonomy is not only a common ethical standard, but further specifies an ideal practice of informed consent against which particular practices can be measured. He stakes his argument on whether or not he can show that the family-

facilitated approach to informed consent is based on an alternative interpretation of the principle of autonomy that is still compatible with the ideal of informed consent.

Akabayashi's justification reveals his motivations. He writes that the goal of his argument is "to reconcile apparently conflicting abstract ideals and local realities without giving either of them absolute status" (Akabayashi and Hayashi 2014, 747). He is committed to respecting local values, while pursuing justification based on abstract ideals, in order to preserve the possibility of dialogue, critique, and revision. He summarizes these goals in what he calls the commensurability of values between cultures despite local specificity of practices, holding that particular practices must be defended in terms of universal principles to avoid being "cultural artifacts" (Akabayashi and Hayashi 2014, 737). This implies that for Akabayashi, disagreements between local practices and universal principles are apparent, and local practices can be justified in terms of an abstract ideal or principle.

In short, Akabayashi values the possibility of dialogue about ethical valuations across cultures, so he does not allow that ethical judgments are predicated on unique cultural values. Rather, ethical justification must have a universal foundation such that individuals in different cultures can engage in dialogue and critique. For Akabayashi, this foundation is a set of common abstract ideals used in moral judgment and justification. While judgment and justification occur in the context of local realities, their content (i.e., Beauchamp and Childress's four principles: autonomy, beneficence, non-maleficence, and justice) and methodology (i.e., application of principles) are universal.

In a lengthy footnote to "Informed Consent Revisited: A Global Perspective" in *The Future of Bioethics*, Akabayashi recognizes the efforts of Ruiping Fan to ground

family-oriented medical practice in Confucian culture as similar to his attempt to accommodate the importance of the family into medical decision-making. Yet he ultimately concludes that Fan's justification, which relies on particular Chinese or East Asian cultural concepts "incommensurable with the Western principle of autonomy" (Akabayashi and Hayashi 2014, 747), differs from his own, which seeks consistency or compatibility with Western autonomy. For Akabayashi, commensurability of ethical concepts across cultures is necessary for successful cross-cultural dialogue, so his defense of the Japanese practice of informed consent in terms of a form of autonomy compatible with Western autonomy achieves two goals: it accounts for the practice in non-culturally relative terms, and it justifies the practice according to non-culturally relative standards.

IIB. Second Viewpoint: Ruiping Fan

Fan's argument is initially very similar to that of Akabayashi. Fan begins from the fact that the Western principle of autonomy, described as self-sovereignty and self-determination, is not realized in medical practice in East Asia. Akabayashi agrees that Western autonomy, strictly defined, does not account for many East Asian medical practices, and they both present the role of the family as an example of this difference. But while Akabayashi defends common abstract ideals across cultures, Fan advocates the relativity of cultural norms.

Fan describes the Western principle of autonomy as embodying "a general priority given to the value of patients' self-determination in the clinical setting" (Fan 1997, 313). Fan suggests that while this principle has been introduced into the East Asian context, it has not been widely accepted, as evidenced by East Asian disclosure practices.

The main reason for this non-acceptance is that East Asia has its own principle of autonomy, which is incommensurable with that of the West.¹³ Fan terms Western autonomy “personal autonomy” and East Asian autonomy “moral autonomy,” and describes them as self-determination and family-determination, respectively.¹⁴

In concrete terms, this plays out in the following ways. In the West: (1) final authority in decision-making belongs to the patient, (2) there is a subjective conception of the good such that a good decision is one that satisfies one’s own desires, preferences, and expectations, and (3) independence is “overwhelmingly important” to Western patients. Fan describes this as self-determination-oriented (Fan 1997, 313-315). By contrast, the East Asian principle of autonomy is family-determination-oriented. As Fan defines it: “Every agent should be able to make his or her decisions and actions harmoniously in cooperation with other relevant persons” and “No harmoniously made decisions and actions should be subjected to controlling constraints by others” (Fan 1997, 316). Based on this definition, in East Asia: (1) the family has the final authority to make decisions, (2) Eastern societies have an objective conception of the good such that a good decision satisfies family preferences and social expectations, and (3) “harmonious dependence” is the value that is overwhelmingly important to East Asian patients (Fan 1997, 315-319). Fan suggests that these features are “common to all East Asian societies,” and while “similar to the behaviors of some Western groups,” “the difference between East Asia and the West is very clear” (Fan 1997, 316).

¹³ In the 2014 book Fan switches from the language of “incommensurability” to “incomparability,” but as with Akabayashi, he seems to mean inconsistency or incompatibility.

¹⁴ Fan’s choice of terminology here is not consistent with Western philosophy of autonomy, and so seems to be either a new usage or one unique to the Confucian context.

Setting aside worries about cultural essentialism, Fan's argument uses the Western bioethical model of conceptualization and ethical justification to ethically justify valued local practices to a Western audience. He argues that the East Asian principle of autonomy functions just like the Western principle of autonomy – it is the sole reason for, and justification of, “practices of truth-telling, informed consent and advanced directives” (Fan 1997, 319). In addition, the approaches to medical decision-making dictated by the two principles both reject physician paternalism. Thus the concrete motivations for the two principles are also the same.

Fan assumes that morality must consist of systems of principles, rules, and rights that are culturally and theoretically distinct. He uses the language of autonomy to describe the principle that applies in China, while holding that the content of ethical principles differs between Western bioethics and East Asian societies. He maintains that individual self-determination and family determination are incomparable principles; this means there is no universal common morality, because the principles that make up common morality are not universally shared (though they may have the same terminology, e.g., “autonomy”).

Fan thus accepts half of the picture of ethical justification used by Akabayashi – that ethical justification depends on principles, rules, and rights to define what is sanctioned and what is prohibited – but not the other half, which stipulates a common system of principles across all cultures and traditions. For Fan, a moral judgment's objective truth depends on whether it accords with moral principles dictated by a certain culture or tradition. In the context of cross-cultural disagreement, he concludes that ethical principles are relative to the cultures in which they are found.

Both Fan and Akabayashi assert that informed consent can be conducted with the family alone, and that it is sometimes ethically justifiable not to inform patients of their diagnoses. Akabayashi justifies family-facilitated informed consent by appealing to “a form of autonomy” commensurable with the absolute principle of autonomy, part of the universal set of moral principles. Fan justifies family-determined informed consent based on a principle of autonomy appropriate for the Chinese Confucian context and incommensurable with Western autonomy. Akabayashi and Fan reach the same general conclusion and understand ethical justification in the same way: it is the application of abstract ethical principles to concrete cases based on “the Western bioethical model.” They share the assumption that bioethics deals with principles applied to particular cases, while disagreeing about the ground of these principles due to their respective commitments to universal dialogue and cultural distinctiveness. In the following section, I clarify how these general commitments affect the normative force of their arguments.

III. CLARIFYING THE TWO POSITIONS

The shared goal of Akabayashi’s and Fan’s arguments is to justify their cultures’ practices. Both assume that ethical justification must proceed through the use of principles and both rely on Tom Beauchamp and James Childress’s *Principles of Medical Ethics* for their methodology. Akabayashi and Fan refer to Beauchamp and Childress repeatedly and rarely cite positions that challenge the methodology of *Principles of Medical Ethics*. However, Beauchamp and Childress’s four-principles approach to bioethics should not be accepted as the standard in the field without critical reevaluation.

I contend that while Beauchamp and Childress' defense of the informed consent standard according to the principle of respect for autonomy is used in bioethical discourse with nearly canonical frequency, this defense makes it difficult to advocate alternative forms of informed consent (such as the family-facilitated approach) for any other reason than respect for autonomy. The Beauchamp and Childress defense closes off non-autonomy based justifications in the following ways:

(1) It ties informed consent to respect for autonomy both historically and conceptually. For example, "Virtually all prominent medical and research codes and institutional rules of ethics now hold that physicians and investigators must obtain the informed consent of patients...prior to a substantial intervention...Since the mid-1970s the primary justification advanced for requirements of informed consent has been to protect autonomous choice...We think that respect for autonomy does provide the primary justification for rules, policies, and practices of informed consent" (Beauchamp and Childress 2013, 121).

(2) It uses the language of "exception," "lie," or "nondisclosure" for any non-autonomy based alternative to informed consent. For example, "This lie infringed the principle of respect for autonomy by denying the patient information he may have needed to determine his future courses of action. Although the matter is controversial, such a lie might be justified by a principle of beneficence if certain major benefits will flow to the patient" (Beauchamp and Childress 2013, 108), and "This physician's temporary act of nondisclosure is morally justified, although beneficence has, temporarily, received priority over respect for autonomy" (Beauchamp and Childress 2013, 223).

(3) It only allows these non-autonomy based alternatives in cases where the patient has been found to be incapable of making autonomous decisions or where the informed consent process would harm the patients' autonomous capabilities. For example, "Physicians have traditionally held that disclosing certain kinds of information can cause harm to patients under their care and that medical ethics obligates them not to cause such harm" (Beauchamp and Childress 2013, 216), and "A physician may invoke the therapeutic privilege only if he or she has sufficient reason to believe that disclosure would render the patient incompetent to consent to our refuse the treatment" (Beauchamp and Childress 2013, 128).

In this context, the only available options for defending a family-facilitated model of informed consent are: (A) to redefine the historical or conceptual connection between autonomy and informed consent, (B) to allow that beneficence or non-maleficence based informed consent is merely an exception to the standard autonomy-based informed consent, or (C) to restrict such informed consent to cases where the patient is not autonomous. Yet, in their discussion of family-facilitated informed consent, Beauchamp and Childress seem to tie options B and C together:

Some physicians take the view that the family can help the physician to determine whether the patient is autonomous and capable of receiving information about serious risk. Although well-intended and in some cases acceptable, this approach runs the risk of begging a critical question: By what right does a physician initially disclose information to a family without the patient's acceptance of this arrangement? Families provide important care and support for many patients, but an autonomous patient has the right to veto familial involvement altogether.

Lacking careful justification, it is unethical for a physician to first disclose information to a patient's family without the patient's authorization (Beauchamp and Childress 2013, 304).

In this passage Beauchamp and Childress suggest that, if the physician thinks that she ought to follow option (B) and not disclose the diagnosis to the patient due to beneficence or nonmaleficence, she may discuss the patient's situation with the family *in some cases*. Yet they then assert that option (B) only works if the physician knows that the patient is not autonomous – option (B) thus becomes option (C). Since she does not know whether the patient is autonomous (that is ostensibly what her discussion with the family would be about), the physician cannot disclose to the family, because to do so would violate the patient's autonomy. This seems to close off dialogue about the viability of options (B) and (C) – the physician cannot know whether the patient is not autonomous without consulting with the family, and she cannot consult with the family if the patient is autonomous. Beauchamp and Childress may intend to leave open the possibility that the physician can have a discussion with the family about whether the patient is autonomous for reasons of beneficence or nonmaleficence; it is just the discussion of the diagnosis that is proscribed. However, it is at least ambiguous whether or not this is the case, and when combined with the strong historical and conceptual ties to autonomy and the weighted language of an “exception” or “lie” describing any situation not governed by autonomy, it becomes nearly impossible to defend a family-facilitated approach to informed consent *without* taking on autonomy.¹⁵

¹⁵ This language is weighted because, while Beauchamp and Childress suggest that a lie or nondisclosure could be allowed *in some cases*, they assume that in general these actions are immoral and can only be justified by special, outside considerations. This

Therefore, to attempt a principlist defense of the family-facilitated approach to informed consent, Akabayashi and Fan must either accept Beauchamp and Childress's principle of respect for autonomy or reject this principle and redefine autonomy to encompass familial relations in East Asia. Here their commitments to universal discourse and local practices resurface. Despite their shared methodology, Akabayashi and Fan rank global dialogue and traditional cultural practices differently. While each finds value in their local practices *and* in rational discourse across cultures, Akabayashi is committed to global discourse through universal principles and Fan defends local traditions through relative principles. Their primary commitments to either the global or the local dictate whether they lean towards moral universalism or moral relativism. Their only two options are a universal principle of autonomy or a relative principle of autonomy; Akabayashi chooses the former, and Fan, the latter.

Akabayashi must explain how a practice, apparently different from Beauchamp and Childress's informed consent, actually follows from the same universal principle of autonomy. Likewise, Fan must account for why a practice that is called informed consent and that deals with medical decision-making is based on a different principle just because it takes place in China's Confucian cultural context.

Akabayashi writes that his "method can provide a starting place for practical solutions that avoid the pitfalls of parochial ethnocentrism and arrogant universalism" (Akabayashi and Hayashi 2014, 747). To avoid these pitfalls, family-facilitated autonomy must be commensurable, compatible, or consistent with individual autonomy. This

precludes the possibility that a non-autonomy based policy of nondisclosure could ethically be justified across cases on equal footing with autonomy-based informed consent policies. Non-autonomy justifications are at best exceptions to the rule, and at worst a strictly hypothetical possibility.

requires a theory of autonomy that can capture the East Asian practice of informed consent *along with* the American practice. Akabayashi first turns to relational autonomy, a theory that incorporates relationships into the development and maintenance of autonomy. However, as Akabayashi recognizes, the theory of relational autonomy does not permit the family to be told the diagnosis first without the patient's explicit consent (although it does more comprehensively address the connection between patient autonomy and family concerns).¹⁶ Accordingly, relational autonomy cannot stand in as Akabayashi's theory of autonomy because it cannot account for East Asian practices. Akabayashi then appeals to Onora O'Neill's conception of "principled autonomy," where he takes the crucial point to be the absence of coercion (Akabayashi and Hayashi 2014, 771). However, it is hard to assess whether the appropriate safeguards for ruling out coercion are in place without further analysis of medical decision-making in Japan, as many of the respondents to his 2006 article argue. So principled autonomy cannot be Akabayashi's theory of autonomy either, since its application is unclear in the Japanese context. In the end, Akabayashi has no universal theory of autonomy by which to justify his claims.

Fan's argument encounters similar setbacks. His goal is to prove that Chinese/Confucian and Western moral principles are fundamentally different. He suggests that the concept employed in China is "moral autonomy," which he describes as respect for the "moral will" rather than respect for an individual's arbitrary will, where the moral will is grounded in the proper way of Heaven. The "normal way of Heaven" is "the proper, virtuous mutual care and interdependence of family members" (Fan 2014,

¹⁶ See Anita Ho's response to Akabayashi: Ho, "Whose Interest is it Anyway?"

764). The moral will, in accordance with the normal way of Heaven, is akin to a familial or communal will in that the will exists at the family unit or community level. Granting decisional authority solely to the patient is deviation from this normal way. The goal is for all decision-making procedures to follow this way of Heaven, and such procedures are ethically justified if they fit this ideal.

However, while family harmony is a laudable ideal, it is hard to see why real-life situations that can only approximate this ideal should be judged according to this standard.¹⁷ Even if Confucian culture downplays an individual's authority to make decisions that will affect the family and expects the family to function as a shared decision-making unit, not all families within Confucian cultures will function in this way. Some family members may prefer personal autonomy. To accommodate this variation, Fan suggests that patients who prefer personal autonomy should state this clearly in advance so they can receive the first-person approach to informed consent. All other situations will be assumed to follow moral autonomy. Yet, what happens if a patient prefers personal autonomy, but their family prefers moral autonomy? Is the patient's preference a deviation from the normal way of heaven or an individual choice that must be respected? Here Fan's deference to individual preference may collapse into individual autonomy, such that family decision-making also depends on patient choice.

As with Akabayashi, Fan's argument is too abstract to prove the existence of a unique principle of autonomy in Confucian culture. Without inquiring into how decision-making within the family is facilitated and how to resolve conflicts, Fan's proposal falls short. In difficult cases, he must resort to personal autonomy, because at least it is clear

¹⁷ This problem is not unique to the principle of family harmony, but is faced by all such "ideal" standards.

how this principle applies in actual cases. His principle of moral autonomy fails to function as a guide to action; it is merely a descriptive ideal.

Neither Akabayashi nor Fan successfully justifies East Asian informed consent. This is not because the practices they describe violate respect for autonomy, as many critics have suggested. Nor is it because they have misinterpreted the theory of moral generalism or because the theory of moral generalism is necessarily flawed. Rather, the failure of these two arguments highlights a practical problem with how bioethical discourse is pursued across cultures. Akabayashi and Fan both assume that ethical justification must be attempted according to a moral generalist methodology – principlism. This assumption is not unique to Akabayashi and Fan. Many non-Western bioethicists take the principlism of *Principles of Biomedical Ethics* to be the accepted method of bioethical justification.¹⁸ However, this assumption narrows attempted justifications: (1) it focuses the justification on the definition of ethical principles rather than a detailed description of the practices in question, and (2) it requires an explanation of the chosen principles in terms of either moral universalism or moral relativism.

In the case of Akabayashi and Fan, they both seek to make their countries' practices of informed consent understood in terms of a principle of autonomy, which requires that they (1) explain the content of the principle and (2) justify their use of the principle by accounting for how their countries' practices fall under the scope of the principle. For Akabayashi, the relevant principle is a form of the universal principle of autonomy, the content of which is the obligation to prevent paternalism and respect patient preferences. For Fan, the relevant principle is a relative form of autonomy called

¹⁸ Alternatively, they may think it is the only method that will make their practices understandable to a Western audience.

“moral autonomy,” the content of which is family-determination. They make their arguments in terms of these principles *alone* and do not consider other potentially relevant moral properties. As a result, outsiders to these cultures cannot determine whether these practices should be allowed or forbidden, and insiders become distracted by a seemingly irresolvable opposition between universal and relative principles.

One might counter that the failures of Akabayashi’s and Fan’s arguments should not be blamed on moral principlism because they incorrectly use principlist methodology. Indeed, applying principles correctly requires careful judgment, and principlists suggest that if a given case seems out of step with preexisting principles, then those preexisting principles should be altered. According to this suggestion, it is possible that East Asian informed consent practices indicate that a change to the principle of autonomy is necessary.¹⁹ In fact, revision to the principle of autonomy is exactly the argumentative route taken by both Akabayashi and Fan – Akabayashi seeks out alternative conceptions of autonomy, and Fan defines a Confucian form of autonomy. Yet while revision to principles is theoretically possible, it seldom occurs in practice. Indeed, as shown in the assessment of Beauchamp and Childress’ autonomy-informed consent paradigm at beginning of this section, if practices that seem to violate the given principles are not immediately rejected as violations of autonomy, then they are perceived as exceptions to general rules (e.g., as cases in which beneficence is more significant than autonomy), rather than as opportunities to rethink these general rules. Despite principlism’s theoretical allowance for some variant of reflective equilibrium, the fact that principles

¹⁹ I would like to thank an anonymous reviewer for *The Kennedy Institute of Ethics Journal* for making this point.

are rarely revised in the face of diverse and dynamic practices should give us pause.²⁰

This does not necessarily indicate a problem inherent in the idea of ethical principles, but rather an issue that arises as a result of moral generalists' use of principlist methodology.

The tendency to focus on defining principles to the exclusion of explaining concrete cases is not just a problem for Akabayashi and Fan. Principlism relies on assumptions about the structure and significance of ethical thinking that are not reflectively acknowledged within the methodology itself. Principlists' allowance of flexibility in the order, balance, and definition of principles – whether through reflective equilibrium, coherentism, or some alternative – does not correct for a fundamental imbalance in principlist methodology. This imbalance favors abstract, supposedly universal ethical theories to the detriment of contextual, unique ethical concepts and ideas. The main issue is not that principles are inflexible, but that principlism focuses the ethical discussion on theory rather than complex practices. This is especially problematic in ethical discourse across diverse cultures, where general principles cannot be the intuitive action-guides they function as in discourse between parties with similar cultural backgrounds. Principlism's proclivity for theory drives scholars from cultures whose practices do not fit the assumed universal framework to expend considerable effort fitting their practice into this framework or risk the charge of immorality. In the process, much of the context that could have justified their practices is lost, and misunderstanding and disagreement ensue. The only practices exempt from misunderstanding are those within the dominant culture in which the principlist theory arose.

²⁰ The fact that Beauchamp and Childress' four principles have been liberally applied to divergent practices in diverse cultures but have not themselves changed substantially in the twenty-some years since they were first proposed supports this claim.

In short, the assumption that principlism is the established method of ethical justification in bioethics is a major underlying reason for bioethical disagreement across cultures. Entrenched disagreement about whether local practices are ethical indicates neither that ethics is reducible to culture nor that explanations of these practices in terms of universal principles have been insufficient. Rather, ethical justification requires more than principles in the first place. In the following sections, I expand on how principlism frustrates cross-cultural understanding and gives rise to the universalism versus relativism divide.

IV. PROBLEMS WITH PRINCIPLISM ACROSS CULTURES

Principlism is one method of ethical justification by which moral claims are defended in terms of moral principles. A decision or action is justified if it can be shown to fall under a given principle's scope of application. This is a top-down method of ethical justification, in which justification occurs at the most abstract level of analysis. In *Principles of Biomedical Ethics*, Beauchamp and Childress write that an ethical judgment such as "You should not lie to Mr. Stanford" is justified according to this method because we are able to derive the rule, "You should not lie to patients" from the general principle "You should respect the autonomy of patients" (Beauchamp and Childress 2013, 392). In other words, principlist ethical justification begins with a judgment, and, instead of asking why the judgment would be or was made in practical terms, accounts for it in terms of a general rule and an even more general principle.

This method of ethical justification focuses only on the aspects of the judgment that relate directly to the principle thought to cover the judgment. Other reasons that may

account for the judgment are likely to be disregarded because they do not fall within the scope of the principle. As Beauchamp and Childress themselves note, these reasons include traditional practices, institutional rules, and case judgments, as well as factual beliefs about the world, cultural expectations, judgments of likely outcome, and precedents. This list might also include subjective factors, such as the emotional states and intimate relationships of those involved. While Beauchamp and Childress' principlist methodology theoretically incorporates these factors into ethical justification by specifying and balancing moral principles and rules (Beauchamp and Childress 2013, 392, 404-410), practically this rarely occurs, as seen in their justification of informed consent practices in section III.

This practical tendency of principlism to exclude supposedly irrelevant situational factors in favor of those that fall under a principle not only impairs the argument for ethical justification, but also risks cross-cultural misunderstanding by those for whom the principle is not so intuitive. Within a given culture, many details of a case remain unspoken because they are part of the presumed background to the discussion. In different cultures, what is salient and what is unspoken may vary. For example, to an American citizen the connection between informed consent and autonomy may be salient, while the patients' rights movement and mistrust of physician paternalism might be unspoken. To a Japanese citizen, on the other hand, there could be salient connections between "informed consent," transliterated as *infōmudo konsento*, and American ethical standards, while concerns about burdening one's family and increasing rates of medical malpractice could be unspoken. Both the salient and the unspoken affect the ethical analysis of a given practice.

Without clarifying the presumptions, conceptual schemes, and forms of understanding that affect decisions and judgments in local contexts, agreement about whether a given principle applies to a particular situation is unlikely. Just as the understanding of informed consent in the U.S. depends on a range of legal, social, historical, and cultural factors unique to American life, so the understanding of informed consent in Japan depends on similarly complex factors. This does not mean that practices outside of one's own culture cannot be understood, but it does mean that understanding requires ample consideration of these practical factors. Uncovering unspoken aspects of practices is no small feat. Accounting for cases in terms of principles may seem simpler, but it is likely to exclude relevant considerations of how and why judgments are made. This engenders cross-cultural disagreement about ethical justification and misunderstanding about the motivations and reasons for the judgment, especially if the form and content of the principle is not agreed upon. But this is not the only way that principlism is problematic.

Principlist justification also readily leads to the opposition between universalism and relativism, because it requires not only that we justify actions in terms of principles, but also that we account for the principles themselves in terms of a higher-order, logical framework. Principlist ethical justification invokes ethical theory as a final justification – otherwise the chosen principle will explain, but not justify, the judgment in question. It is very easy to come up with a principle that explains one's judgment, but it is difficult to show that the principle itself is normative. In other words, demonstrating that one can find a relevant principle is not the same as demonstrating the significance of that principle for living a moral life or making an ethical decision. As Beauchamp and

Childress recognize, the top-down model of ethical justification creates a “never-ending demand for final justification... proof that some principles occupy this [self-justifying] status...is an arduous demand that current ethical theory cannot meet... it would appear, on the assumptions of this [the principlist] approach, that there are no justified principles or judgments” (Beauchamp and Childress 2013, 393).²¹

Nevertheless, Beauchamp and Childress seem to understand principles as belonging to a universal or general moral structure. According to *Principles of Biomedical Ethics*, principles are part of the common morality, which contains “moral norms that are abstract, universal, or content thin” (Beauchamp and Childress 2013, 4). The common morality is a complex of universally valid norms that can also be described as standards of action or rules of obligation. Some of these standards include: tell the truth, do not steal, keep your promises, and obey just laws. The common morality includes features besides these rules, such as character traits (virtues), human rights, and moral ideals. While this common morality is not ahistorical or a priori but has been learned and transmitted, Beauchamp and Childress suggest that it is also universal and authoritative in all communities (Beauchamp and Childress 2013, 5). This is because it is developed from ordinary, shared moral beliefs that all people pre-theoretically hold (Beauchamp and Childress 2013, 411).

Beauchamp and Childress offer no empirical evidence for their claim that the common morality is universally shared, although they do suggest a possible methodology for investigating it. Yet their proposed study assumes what it is trying to prove. It limits participants to those who understand morality as consisting of norms and already

²¹ Beauchamp and Childress themselves solve this problem by tethering principles to the “common morality.”

subscribe to one of the moral norms they describe in *Principles of Biomedical Ethics* (Beauchamp and Childress 2013, 416-417).²² Beauchamp and Childress themselves assume that a “moral point of view” must take the form of universal action-guiding norms or rules. It is not clear why this must be the case, especially if we become familiar with the ethical philosophies of different cultures, which do not universally espouse rule-based morality.²³ I cannot make a full argument against common morality here, but in the next section I suggest a few reasons why we should be suspicious of its claims in the cross-cultural context and how we might counter it while not sacrificing a sense of “ethics in common.”²⁴

Without proof of worldwide ethical consensus, choice of ethical theory is based on intuitive ethical motivations. In the cases of Akabayashi and Fan, Akabayashi justifies his form of the principle of autonomy by tethering it to Western theories of autonomy, which he presumes to be theoretically secure. Fan, on the other hand, justifies his principle of moral autonomy within the Confucian worldview, arguing that moral autonomy is a justified principle within Confucian ethical theory, but is incompatible with similar principles in Western ethical theory. The requirement that the principles themselves be justified by moral theory forces Akabayashi and Fan to defend universalism and relativism, respectively. Importantly, the choice of an ethical theory here is arbitrary – no further justification of the choice of a theory is possible. Within

²² Some of the opponents to common morality (according to the Beauchamp and Childress definition) include Rebecca Kukla, Carson Strong, Bernard Gert, and Charles M. Culver.

²³ These are not just particular moral codes, an explanation that dismisses their philosophical contributions. Even among rule-based moral systems, not all require universality.

²⁴ Two debates on common morality take place in the *Journal of Medicine and Philosophy* 25.3 and the *Cambridge Quarterly of Healthcare Ethics* 23.

principlist ethical justification, there is no final reason why universalism or relativism is justified; the two positions are left in a deadlock.

In order to ameliorate entrenched disagreement and escape the universalism versus relativism dichotomy, cross-cultural ethical justification should seek to avoid the pitfalls of principlism described in this section. These include: (1) accounting for cases and practices solely in terms of principles to the exclusion of other morally relevant factors and (2) relying on moral theory to provide the final justification for principles. I discuss this in more detail in the next section, where I address how ethical justification can avoid the universalism versus relativism divide and mitigate entrenched disagreement and persistent misunderstanding.

V. CROSS-CULTURAL BIOETHICAL JUSTIFICATION

Principlist justification is essential to neither ethics nor bioethics, although it pervades both in the Western discourse. Concerns about relying on principlist methodology across cultures are also not new. In a 1984 paper, Renee Fox critiques American bioethicists visiting hospitals in China who assume that the “best way of moral thought” is to begin with a general moral theory or moral concepts and proceeding via logical reasoning (Fox 1984, 355). She observes that “this way of thought... tends towards dichotomous distinctions and bipolar choices... Even the field’s own self-defining conception of what is and is not a moral problem is formulated in a bipolar, either/or fashion.” Fox notes that in bioethics, the application of theory to real situations often manifests as thought experiments, rather than detailed, in situ, empirical investigation. She suggests that this is because “ordered, cerebral armchair inquiry”

generates formalistic data, which “more closely fit the norms of bioethical logic and rationality than information gathered from firsthand research.” She argues that bioethics must investigate these real-life situations, because “these very suppositions of bioethical thought contribute to its inadvertent propensity to reflect and systematically support conventional, relatively conservative American concepts, values, and beliefs” (Fox 1984, 355-356). In other words, for bioethics to function across cultures and contexts, we must question the assumptions of bioethics’ moral epistemology. This means asking whether the content of bioethics is best expressed in terms of principles, and whether the method of bioethics ought to be the application of these principles to particular cases.

George Khushf has also argued that the global bioethics discourse assumes that bioethics must: “involve some minimal but overarching principles or structure, which provide a common basis for moral discourse... downplay deep metaphysical and theoretical differences [and abstract from] the rich textures and forms of life that give content to ethical systems” (Khushf 2003, 123). Khushf identifies this set of assumptions with principlism, and suggests that this type of “constructivist minimalism” leads to an irresolvable tension between so-called Eastern and Western principles. I agree with Khushf that principlism is problematic for cross-cultural analysis, and I think we can do better in the following two ways.

First, ethical justification should begin by explaining the rich background of local practices and specific cases. The experiences, motivations, and emotions of those involved in local practices should be described before any higher-order, logical ethical justification is attempted. Even in principlism, it is impossible to identify relevant principles before knowing the details of the case. While no description of a case or a

practice can determine its evaluation (an “is” cannot determine an “ought,” as David Hume suggested), any evaluation or normative assessment requires this factual background. Before understanding the situation in which a judgment is made, we cannot determine which factors are morally relevant. Leaving out this crucial step results in misunderstanding and poorly constructed arguments. As Daniel P. Sulmasy and Jeremy Sugarman emphasize, “Good ethics depends upon good facts. Failure to understand the facts of a situation thoroughly will clearly lead to perils in moral decision-making” (Sulmasy and Sugarman 2001, 11). A successful ethical justification of a judgment or a practice requires that the facts be understood. Careful clarification of these facts will go a long way towards making particular practices understandable across cultures.

This is not to say that Akabayashi and Fan misunderstand the relationship between the patient and the family in medical decision-making in East Asia. Akabayashi, for example, notes the mental states and relationships of those involved in specific cases and describes aspects of the conceptual framework in Japan that might be unknown to a foreign audience, including the importance of interdependence, the idea of *omakase* (reliance on others for guidance or decisions), and the use of non-verbal communication. However, he interprets these aspects’ relevance to ethical justification almost completely in terms of autonomy, even though they suggest the significance of relationality and mutual support. Given the narrow perspective of principlist ethical analysis, it is possible that he omits other considerations as well.

In his response to Akabayashi, Carl Becker cautions that using an abstract principle to justify a practice can blind one to other significant factors, writing that “*if* Japanese-style decision-making leads to danger or damage, then it should be reexamined,

not because it is weak on autonomy, but rather because of other harms it may cause” (Becker 2014, 752). Becker is concerned with factors that Akabayashi excludes, including how to tell if a non-verbal nod expresses consent, how a physician can know that a patient has a trusting relationship with their family members, and what to do if the family does not agree on a decision (all too frequent in unanticipated medical situations). A focus on only those reasons that relate to a principle can obscure other ethically relevant reasons for and against the practice.

Second, ethical justification should rely on more than just abstract principles as good reasons. Anita Ho writes that “what makes Akabayashi and Hayashi’s family-facilitated approach particularly convincing is that it recognizes the clinical realities and relational complexities that patients face in grim health-care situations” (Ho 2014, 760). She suggests that understanding the practice as “a form of autonomy” or as sufficiently close to the “ideal” of informed consent does not suffice for Akabayashi’s ethical justification; rather, she proposes that if his ethical justification is successful, it is due to his examination of the details and his assessment of what count as good reasons to those engaged in the practice. What is valuable, then, is precisely what is absent from many theoretical accounts of autonomy: concrete particulars. Akabayashi’s appeal to the principle of autonomy is at best a distraction and at worst damaging to the practice.

This is not to say that principles cannot be good reasons, but rather that their role in ethical justification is not as central and their definition is not as certain as principlists suppose. Practically, principles function better as guidelines, values, or goods than as rules strictly dictating conduct. Rebecca Kukla makes this point in her recent article “Living with Pirates: Common Morality and Embodied Practice.” Displaying

Wittgensteinian commitments, Kukla doubts that a common basis for morality can be discursively explained, given that different expressions will “vary in their clarity and connotations to different audiences.” She also suggests that, given the right explanation,

Almost any behavior can be understood as consistent with commitment to almost any rule, given that we allow that people will acknowledge different exceptions to the rules, apply them differently, and resolve conflicts between them differently. We cannot, therefore, read whether someone accepts a rule off of whether her particular actions accord with it, nor off of whether she agrees with a particular formulation of it. Thus it is unclear how to distinguish, even in theory, between disagreements over whether a principle should be accepted and disagreements over how to interpret and apply that principle. So the hypothesis that there are universally accepted rules is not only hard to test but perhaps ill-defined (Kukla 2014, 80-81).

According to Kukla, moral principles, expressed as rules, are not helpful as a universal basis for morality. We can tell neither from others’ actions, nor from their words, whether they understand themselves as acting according to that rule. For example, while two people may agree with the norm “tell the truth,” they may interpret what this norm requires differently and decide on different paths of action in a similar situation. For person A, telling the truth might mean telling someone all the known facts, while for person B, telling the truth might mean revealing one’s innermost feelings. Conversely, person B may perform an action that person A understands as “telling the truth,” without person B accepting this norm as the justification for the action.

This indicates that our understanding of moral principles, if there are any, must be context dependent. Margaret Olivia Little makes precisely this argument in the context of Wittgenstein's discussion of rule-following.²⁵ She suggests that moral properties can function holistically, such that moral considerations have bearing in certain contexts due to the whole range of natural considerations that make up that context (Little 2001, 167). Different moral considerations will arise out of different contexts. Because these moral considerations function holistically, they are impossible to isolate from their contexts or codify into a set of moral rules. For instance, the moral generalist might say that "tell the truth" is a universal moral rule such that telling the truth is always good and always allowable. Yet we can think of cases in which the situation dictates that one ought not to tell the truth, such as if an abusive husband comes in search of his wife whom you are harboring. The moral particularist will argue that "tell the truth" is not unique in this way – all statements of what one ought to do, or ought to allow, prohibit, or sanction, are dependent on contextual considerations.

This is not to say that there is no foundation for moral judgment – we do not fall into relativism, but avoid the universalism versus relativism opposition altogether. This opposition arises only in the case of moral generalism. If morality is defined in terms of moral principles or rules, then there must be an underlying structure – a reliable constant – dictating the content of these principles. This content can be universally or relatively defined, but it is required for the principles to have any identifiable meaning.

In contrast, moral particularism allows that there is a common aspect to morality, but it is not morality's content. What is common is the bare activity of moral judgment,

²⁵ See Wittgenstein's *Philosophical Investigations* for this argument.

moral action, and moral justification. Morality entails trying to be a good person, a good family, or a good society, and reflectively assessing whether or not that goal was achieved. The content of what it means to be good, and what we think we need to do to become good, will always be up for debate. Indeed, culture plays a major role not only in the development of shared values but also in the evolution of how we think about and practice values. This evolution is constantly progressing – there is no view from nowhere.

Yet as Rebecca Kukla observes, even without agreeing on what it means to be good, even without a shared absolute theory, we are remarkably adept at interacting with other people in non-problematic ways – we can understand others’ emotions and motives, we can make promises and convey gratitude, and we can respect others’ differences (Kukla 2014, 81). A claim of disinterest in being good is itself made a background of other people for whom this is a concern, and who will attempt to convince us otherwise. Accordingly, the common part of morality more properly refers to a shared moral life, not a common moral language. This shared moral life consists of “an endlessly complex yet remarkably stable web of embodied normative responses, coping techniques, perceptual skills, communicative rituals, ways of making public our desires and needs, etc., rather than propositional content” (Kukla 2014, 101).

In short, the fact that we can and do have a dialogue with each other across cultures indicates that we are engaged in the same project. We are not relativistically isolated along cultural lines – just as individuals within a given culture can disagree, so can agreement across cultures be achieved. This is not to say that we must always agree, but that we can at least have a conversation about why we disagree. When cross-cultural dialogue breaks down, we can try to understand and assess each others’ processes of

moral reasoning through the critical reasoning skills we share, including “local normative standards, conceptual analysis, reflective equilibrium, ideals of coherence and practicability, empirical evidence about the good and bad effects of particular practices, and so forth” (Kukla 2014, 83). This is true in ethics and bioethics, just as it is in all cross-cultural conversations.

One might express concern that, without a moral principle or moral ideal transcending context, moral particularism inadequately explains how critique and moral change are possible.²⁶ However, the critical reasoning skills identified by Kukla can serve precisely this function, making moral particularism better able to accommodate the significance of critique and moral change than theories based on moral principles or ideals. According to moral particularism, responding to concerns about whether a given practice is ethically justified entails providing a critical picture of the practice on multiple levels: institutional standards, relevant concepts, social expectations, empirical data, and so on. The practice is not measured against an ideal or principle, but is judged in terms of its specific purposes, meanings, and expectations. For example, in the case of East Asian informed consent, we might ask what practical reasons physicians in East Asia have for informing families before patients: are there adverse effects if patients are informed directly? Do patients expect and desire physicians to consult with their families before themselves? Do patients obtain information about their condition through alternative means/from other professionals than informed consent from physicians? If the answers to these questions are not in keeping with what East Asian informed consent purports to accomplish, then it is correct to critique and reevaluate the practice.

²⁶ I thank another anonymous reviewer for *The Kennedy Institute of Ethics Journal* for this point.

As long as we recognize that different considerations count as good reasons in different cases, we will be less likely to propose that an action is good because everyone should do it, or because everyone belonging to a certain group or culture already does it. Rather, we will ask why a given reason is believed to be a good reason in the circumstances. Reasons such as “the family ought to be valued” or “individual autonomy ought to be respected” will not be sufficient for a moral particularist justification, because neither reason critically engages with an actual practice in context. A set of reasons such as “Japanese physicians know their patients personally, know whether patients expect them to include the family in decision-making, have communication training with families, and Japanese patients have a higher likelihood of adverse psychosocial effects following disclosure of a terminal diagnosis” would better approximate a particularist justification of some Japanese physicians’ informed consent practices, although more detailed consideration would be necessary. However, this does provide a general sketch of what a moral particularist justification might look like and what types of questions should be asked in ethical justification across cultures.

Understanding ethical justification in terms of the moral particularism described in this section avoids opposition between universalism and relativism and clarifies the complex of reasons underlying particular decisions and practices. Had Akabayashi and Fan more thoroughly examined the different reasons for East Asian practices of informed consent, including those outside the scope of the principle of autonomy, they would have increased cross-cultural understanding of these practices while avoiding the competing positions of universalism and relativism.

VI. CONCLUSION

Misunderstanding of local practices and the debate between universalism and relativism within cross-cultural bioethics trace back to the reliance on principlist ethical justifications from a moral generalist perspective. While ethical justification cannot ignore principles (or better, “rules of thumb”), it should neither be assumed that ethical justification depends solely on principles nor that they can be defined independent of contextual considerations. Making these assumptions in the cross-cultural context only perpetuates unhelpful dichotomies, increases misunderstanding, and frustrates resolution.

Gaining clarity on what works in ethical justification helps to avoid such disagreements in the future, so that cross-cultural ethical dialogue can be more productively pursued. In this paper, I have suggested two ways that such cross-cultural bioethical justification can be improved: (1) by describing the particular, practical factors of concrete cases, including the attitudes and perceptions of those involved, and (2) by considering how these practical factors might be morally relevant. Such steps will clarify, if not overcome, cross-cultural disagreements, allowing us to attempt ethical justification of diverse practices. What is *common* in the cross-cultural bioethical discussion is not a set of moral principles or a moral language, but a concern with bioethical questions in the context of our shared moral life. Indeed, there is global interest in ensuring that we judge and act ethically in the midst of rapid advances in biomedical technology and the shifting nature of the physician-patient relationship.

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