Common Moral Priorities and Cultural Diversities

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A NARRATIVE ON UNIVERSAL ETHICS: THE GOOD SAMARITAN

A traveling merchant fell under the robbers, was robbed, badly beaten, and left half-dead. Various people passed the scene thereafter, orthodox theologians, experts in ethics, also a moral and religious stranger in this area around the Jordan river, one of the people from Samaria, a not well educated and respected group among the neighboring cultures and communities. When the others passed the crime scene and saw the helpless victim, none of them stopped to provide first aid and help; their reasons might have been (a) fear of the robbers still around, (b) no feeling of a moral obligation to a stranger, or (c) a discrepancy between ethical theory and factual moral practice. Only the man from Samaria stopped, helped, brought the victim to the next hotel, paid for his care and left.'

In Western civilization this narrative of the 'good Samaritan' is a well known case study in universal ethics, first told by Jesus when asked by his enemies, fundamentalist Jewish theologians in Jerusalem, how he would define principles of neighborly love, compassion, and the ethics of solidarity. We know of similar teachings of humaneness [ren] by authoritative masters in other cultures: The Confucian rule 'do not do to others, what you would not desire yourself' [Analects 12:2] sounds like the Kantian Categorical Imperative. Hindu, Buddhist, Muslim and Jewish cultures have similar traditions of neighborly love and compassion with the poor, the sick, and with those in need. They all call for humaneness as a prime virtue and moral principle beyond and above all theological or philosophical teachings. Confucian ethics, based on a 'Doctrine of the Mean' sets communication on ethics and cooperation in ethics within an orientational framework of harmony to be worked for among humans and to be cultivated in self-cultivation. Self-cultivation in the narrative of the 'good Samaritan' meant the personal internalization and the factual practical application of those principles.

In telling a story rather then accepting the invitation to an intellectual academic debate on theories of solidarity, community and principles of ethics, he briefly sketched out three theses: (1) There is a difference between ideology or academic theory on one side and factual care and practice of solidarity on the other; moral attitudes are not necessary based on explicit ethical theories; some edifices of moral theory even neglect to recognize the moral stranger as a fellow human being of equal human dignity and therefore withheld solidarity and compassion. (2) There are prima facie moral obligations and common moral principles, which are so basic and universally shared by a majority of cultural, ethical and religious traditions, that they may be called universal ethics; as universal ethics they would be a priori evident to each and every person in each and every moral community, independently from that particular moral community's specific ethical convictions or attitudes. Deng Xiao Peng had put this goal-oriented insight of Jesus into the relevance, the use and abuse of theories in a different way: it does not matter whether a cat is black or white, what is important is that the cat catches mice. The arch-authority on anarchism Kropotkin gave his main publication the title 'Mutual Aid' thus underlining a basic common human need for solidarity beyond and even against religious or philosophical teachings and theories.

KANT, NATURAL LAWS AND A-PRIORI EVIDENCE OF UNIVERSAL ETHICS

German enlightment philosopher Kant made an epistemiological distinction between a priori, i.e. what is evident to everyone without prior empirical experience, and a posteriori, i.e. what becomes knowledge only after experiments and various kind of experiences. If we transport that distinction from the field of epistemology and metaphysics to the fields of ethics, culture, and education, we may say, than moral principles, values, and attitudes evident to all reasonable people and shared by individuals and communities independently of their particular system of belief or orientation could be called universal ethics. Kant holds that all humans are born with an inherent respect for the 'sittengesetz', respect for the law of morality. In arguing that all humans, independently from culture or experience, are naturally endowed with properties to distinguish good and evil, virtues and vices, he follows the Western natural law tradition since Aristotle, which taught that the basic norms of ethics are inherently present in nature. But he differs from the natural law tradition in questioning whether a particular custom or morality or the rules of one particular moral community can be argued for by reference to nature and natural laws. St Paul's Christian teaching argued similarly that those who believe in a God would have gotten the message of such a common universal morality by Godly commands, but that others would have the opportunity to recognize the same common and natural moral principles in natural laws.

If there is, indeed, a universal common morality, then specific rules of moral communities have to be questioned whether or not they embody, what in Kant's vision was universal to all humans, respect for human dignity, compassion, and respect for rules and principles that support the respect for human dignity rather than neglecting or even fighting it. Kant's approach to universal ethics has been called formalistic as he does not call for specific human rights or obligations, except for respect for human dignity and for following those rules which, if generalized, would be good rules for everyone and could be accepted by everyone. This formalism has a mission and vision of content: maxims in ethics, moral attitudes, and moral communities and traditions always have to be analyzed and assessed in how far they support or suppress fellow humans and the respect for their dignity, liberty, and security, how far they treat people as ends in themselves not as means to an end.

Solidarity and humaneness with fellow humans in extreme situations of danger, suffering and need definitely are such principles which in fact are - at least in teaching and theory - universally recognized in all moral communities based on respect of human dignity independently of their religious belief, race, gender, social position, or specific personal properties, gifts, or handicaps. When we review the long list of cultural traditions and moral communities, the vast majority of them support the principle of humaneness, especially solidarity with the most vulnerable, the sick, the poor, and the dying, but also the principle of sincerity, the demand for self-cultivation and honesty.

Kantian, Christian and Islamic pretexts for assessing universal ethics are matched by Confucian and other traditions, based on the vision of a natural respect for human dignity, but still in need to find the most adequate, agreeable and harmonious expression of such a vision in a particular situation or moral community. Therefore many cultural traditions need to be highly critical in regard to any particular principle or custom which might not support or even be counterproductive to the recognition of solidarity and compassion. The Taoist said 'The world is a sacred vessel, which must not be tampered with or grabbed after. To tamper with it is to spoil it, and to grasp it is to lose it. In fact, for all things there is a going ahead, and a time to following behind' [Tao Teh Ching:29]. Overbearing theories very likely could tamper with common moral intuitions and harmonious relationships. While paying respect to established rules of conduct and customs, as the history of ideas shows, those custom-based cultures nevertheless are capable to review and abandon old queues and customs which violate rather than support or encourage humaneness and solidarity. Post-enlightment European positions in general have been more critical in analyzing cultural and moral traditions suspected of suppressing fellow humans, thus tending to the other side of extremes. Kant's emancipation model of universal ethics as common morality understood the natural law concept as a 'regulative idea', a vision and a mission, not as a

demonstrated empirical fact of science or anthropology. Taoist understanding of nature and classical European natural law concepts seem to be more acceptable to models derived from interpreting nature in an idealistic way. But both positions share a common understanding that so-called systems of ethics, abstract rules, laws or regulations are written on paper only, and that the attitudes of people and the convincing and educating of respectful moral behavior does not necessarily or directly depend on those maxims, doctrines or regulations, and that those rulings in themselves are powerless, if not embodied into real-life behavior and action.

CULTURAL TRADITIONS PRO AND CONTRA PROFESSIONAL ETHICS

There are different tools in interpreting the worlds of facts and values and different rooms of religious or philosophical orientation. But some prime virtues and principles seem to be the same, even though they are expressed in different terms and referred to in different orientational rooms. Bioethics presents a good case study to show common cross-cultural priorities in values, virtues and ethical principles in some areas and severe and probably unsurmountable differences in others. Medical ethics in particular is quite an easy field for crosscultural studies as the challenges to care for health, to heal or to manage sickness, to alleviate suffering and to accompany those who are frail, confused or dying are not that different among humans of different culture. Traditionally, highest levels of character and virtue together with medical expertise were required from good physicians. No expertise without ethics; no ethics without expertise. Expertise without ethics is blind, unguided, dangerous and should not be applied; ethics without expertise is helpless, powerless, sentimental, dangerous and nonapplicable. According to Aristotle, the master of a craft has to know how to do things, why they are done they way they are done, has to be able to teach the craft and to explain the purpose of the product and its proper use. In Confucian teaching physicians need to combine expertise [ji] and humaneness [ren]; this can be said for all scientific and administrative work in all complex modern technological societies.

Requirements for ethics and the integration of ethics into professional activities and interaction between ethics and expertise in the expert-lay setting mostly were expressed in terms of virtues or maxims, to a lesser degree and only recently by ethics principles. It is rarely one principle alone which needs to govern most situations of moral and technological challenge; it is mostly a set of principles as it is a set of technical aspects that govern a certain process, application, or manufacturing. Therefore situational assessment and education is the most successful in integrating ethics into expertise. For purposes of an overview I differentiate between four genuinely different approaches in the case of bioethics: (a) sets of virtues integrating ethics and expertise, (b) sets of bioethical principles, (c) interactive rules for

stakeholders, (d) open checklists for assessing principles and virtues and determining the course of action.

(a) Confucian physician Yang Chuan, 1700 years ago using the virtue language and presenting a set of virtues in ethics and expertise requested that, because of the overwhelming responsibility of the physician, we only can trust or rely on such physicians who have the heart of humaneness and compassion, are clever and wise, sincere and honest' [Qiu 1988:285f], i.e. interacting virtues of ethics and expertise. A brief detailed description of the character traits, virtues and professional expertise in knowing and applying correctly the content of medical knowledge by Yang Chuan himself and by a contemporary Chinese ethicist already would provide similar colors and shades of virtues and expertise. Others in Western thought, such as Pellegrino, have developed sets of maxims for the 'virtuous physician' clinging to the traditional virtue theory, including the virtue of striving to highest possible medical and technical expertise [Pellegrino, Thomasma 1988:205].

Kishore summarizes from the Indian Buddhist orientational perspective the following virtues which constitute 'dharma': love, trust, righteousness, compassion, tolerance, fairness, forgiveness, beneficence, sacrifice, and concern for the weak'. Out of these character traits of a truly educated and cultured person derive the moral values of 'justice, equality, autonomy, benignancy, altruism, human solidarity, respect for the dead, respect for other forms of life, and preservation if life' [Kishore 2003].

Michael Tai focusses on a set of five principles 'rooted in Asian culture': 'ahimsa or nonmaleficence, compassion, respect, righteousness, dharma or responsibility'. Dharma, a sanskrit word meaning the pattern and destiny of 'living right' is not only a Buddhist maxim, but also known in Confucian traditions of self-responsibility and specific situational responsibility in the private and professional setting. Mencius said: 'Between father and son, there should be affection, between ruler and minister, there should be righteousness, between husband and wife there should be attention in their separate functions, between old and young, there should be a proper order, and between friends there should be faithfulness' [Mencius 3A:4, Tai 1999]. According to Tai, the other four virtues are well known guidance principles in both, Buddhism and Confucianism as well. The virtues and principles presented by Tai can be very well understood and supported in European tradition, even though they traditionaly have not been the keywords in European reflection and teaching.

(b) Quite different to an virtue-and-expertise approach as the one by Yang Chuan is the recent, 25 years old and now widely used bioethics-principle approach of 'autonomy, nonmaleficence, beneficence, justice' as a set of principles to be obeyed in order to respect the 'patient as a person'. Originally developed as common ethical denominator for allowing human

experimentation and clinical research in a multicultural society without strong reference to personal or professional virtues, these principles intended to guarantee a wide spectrum of public support for human experimentation: informed consent of the research subject replacing the benevolence or humaneness of the physician, the traditional principle of no-harm, finally the principle of justice, e.g. that no vulnerable populations such as prisoners or those who could not give consent were used in potentially risky experiments. From being developed for usage in medical research, these principles later were called Georgetown mantra and became the most commonly used framework for clinical ethics and medical ethics teaching not only in the United States [Beauchanp, Childress 2001] and now calling itself a model of 'common morality', also used conveniently in most international or national medical guidelines.

As these principles focus not primarily on virtues, they only need to be implemented professionally by individuals or by committees in order to fulfill the requirement of being ethical, of treating probands or patients ethically. It is a module developed next to the original process of research or treatment and serving as a quality-control feature for the process itself. The four principles routinely are used for quality control purposes, for reviewing cases, and for education. Being used as ethics principles separately, they are not as in Yang Chuan's model integrated with requirements for highest professional expertise in technical matters, nor do they make explicit requirements for self-cultivating of character traits of experts. In Europe another set of bioethics principles discusses 'autonomy, dignity, integrity, vulnerability' as to be more adequate to the European tradition {Rentdorff 2002]. The sets of virtues discussed by Tai and Kishore, on the other hand, lay emphasis on self-cultivation within the process of personal and professional moral duty.

(c) Following the model of Confucian physician Gong Tingxian of interactive maxims for stakeholders in the care for health, the physician and the patient, I have developed similar rules using the virtue-theory approach within the parameters of modern medicine and contemporary culture. As principles such as compliance and non-compliance or non-harm and beneficence have to be balanced in individual cases and in different scenarios, I present sets of principles to be balanced and evaluated every time anew. For the lay person, I see the maxims of self-determination (autonomy) and compliance in dialectical and differential tension and in need to be balanced, also the goals of quality of life and length of life in as far as certain forms of enjoying life might not be healthy nor contribute to a long life. On the side of the physician, I see the the respect for the autonomy of the patient and the professional obligation to request compliance in need to be balanced in a process of prudent and honest decision making, also the traditional tension between doing the patient good without harm as a side-effect of treatment or medication. No stakeholder can resolve the tensions and probable imbalances between principles,

maxims and goals alone, they have to interact on the basis of trust, of communication-in-trust and cooperation-in-trust, in caring for health as in all other endeavors when experts and lay customers have to cooperate and to communicate goals, means, and procedures [Sass 1994; Sass 2003].

Interaction among stakeholders, between customers and providers in health care, nowadays covers more than just the care for the sick and the frail; predictive and preventive medicine allows for protecting and improving health. This gives the educated and cultivated lay person more power and responsibility in protecting and enhancing health. Peimin Ni quotes Western Han Dynasty health care expert Huang Di Nei Jing as saying: 'the sages do not wait until the sickness is there to cure the sickness, they cure it before it takes place .. if one only waits until the sickness is there and then uses medicine to cure it, that is no different from waiting until one is thirsty and then starting to dig a well'. He also quotes Tang Dynasty Confucian physician Sun Si Miao on public health and health education and preventive medicine: 'a superior doctor takes care of the state, a mediocre doctor takes care of the person, an inferior doctor takes care of the disease'[Ni 1999:31]. Health enhancement and anti-aging, millennium old dreams of humankind, can be achieved to a certain degree and at various costs and risks today. Enhancement issues together with those of lay health care ethics have not yet become a prime focus in contemporary bioethics. Dormant cultural traditions in lay health education and competence and physician's obligations to advice and assist in health care protection and, if possible, enhancement have not yet been re-activated. Limits to anti-aging and enhancement will need to be discussed using classical models of the 'golden rule' of avoiding extremes, and following the 'doctrine of the mean', dormant in Western and Asian cultures as well [<www.health-literacy.org>].

Individuals will react differently to the challenge of health protection, health enhancement and anti-aging. In general, as far as the professions of the healing arts and medicine are concerned, there seems to be the need either for a culture of fiduciary relationship around a partnership or stakeholder relation between physicians, nurses, patients, healthy and sick people and their families, or a partnership-stakeholder relationship within which in extreme cases retreating to more paternalistic/ maternalistic models of care for the suffering and helpless is called for by the virtue of compassion.

In summary, different cultures have come to use different terms, virtues, principles or modes of interaction in integrating ethics into expertise or in communication and cooperation between stakeholders: Humaneness, compassion, cleverness, wisdom, sincerity, honesty (Yang Chuan); Nonmaleficence, compassion, respect, righteousness, responsibility (Tai); Autonomy, nonmaleficence, beneficence, justice (Beauchamp, Childress); Autonomy, dignity, integrity, vulnerability (Rentdorff); Self-determination versus compliance, quality of life versus length of

life, health care competence, trust for the lay/patient, nonmaleficence versus beneficence, professional responsibility versus respect for autonomy, expertise, trust for the health care expert (Sass).

It would be worthwhile for non-European traditions to develop programs in teaching and reviewing medical ethics based on their own cultural heritage rather than importing sets of principles from other traditions. American principlism and virtue theory basically are offsprings of the European tradition, while Asian orientational tools and rooms rest on the combination of Buddhism, Confucianism, Taoism or combinations and modifications of them. Case studies and clinical-ethical grand rounds using more than one set of principles of reference might show important aspects of similar and different attitudes in professional cultures and cultures in transition.

Common sense in teaching professional ethics suggests to use the systems of reference traditionally prevalent in specific cultures or professional traditions. There is and always was, however, the need to critically review traditions and fight repressive developments which use tradition against emancipation, liberty, personal freedom and responsibility. These days we see in particular a debate between the fiduciary responsibility, often dominating and very paternalistic, and the communication-in-trust and cooperation-in-trust partnership relationship between expert and lay people. Different culturally supported systems of reference actually might promote an active critical and self-critical process of communication and cooperation among different professional settings.

MEDICAL AND MEDICAL-ETHICAL QUESTIONNAIRES

An alternative to sets of rules, principles or virtues are culturally checklist or medical-ethical questionnaires, which do not make value judgments or prescribe the use of one or the other bioethics principle. The only parameter they provide are the questions, i.e. the tools available of potential use and the dimensions and features of the room in which they put those questions. The selection and arrangement of questions, of course, is already a predetermination of the issues to be addressed, but to a much lower degree determining the probable outcome of the analysis, evaluation, and predetermination of action [Sass, Viefhues 1992].

table 1

BOCHUM WORKING PAPER FOR MEDICAL ETHICAL PRACTICE

1. MEDICAL TECHNICAL DIAGNOSIS
    a. general medical facts and reflections
    b. special medical facts and reflections

c. medical challenge: competence, knowledge, risk

2. MEDICAL ETHICAL DIAGNOSIS

a. patient's welllbeing and wellfeeling

b. patient's self-determination

c. professional responsibility: risk and conflict management

3. CASE MANAGEMENT

a. identify the optimal course of action

b. identify specific obligations of parties involved

c. discuss arguments against your decision, keep the patient involved

4. DIFFERENTIATING SPECIAL SCENARIO QUESTIONNAIRES

a. identify and assess specific moral issues

b. micro-allocate and mix-allocate principles

c. create, amend and revise special scenario checklists

The 'Bochum Questionnaire' under medical-ethical diagnosis asks: l.Health and well-being of the patient: What kind of harm can arise as a result of single alternative methods of treatment? (Worsening of the patient's well-being, pain, shortening of life? Physical or mental degeneration of the patient? Fear?).- 2.Self-determination of the patient: What is known about the patient's values? How does the patient construe intensive or palliative care, or resuscitation? Is the patient well informed about the diagnosis, prognosis, and the various methods of treatment? Is it possible to include the patient in the treatment plan? How far can the physician leave it up to the patient to decide? Who else could make a decision on behalf of a patient? Does the patient agree with the therapy?.- 3 Medical responsibility: Are there any conflicts between the ethical judgment of the physician, the patient, the staff, or the family? Is it possible to reduce or to reconcile such conflicts by employing a special treatment option? How ean one guarantee that the following principles will be applied: (l) the mutual trust between patient and physician; (2) the principle of truthfulness and credibility; and (3) medical confidentiality? What relevant facts are unknown? Are the ethical terms and their relation to each other sufficient and clear?.-
Summary: What kind of treatment would be optimal given the medical-ethical considerations?

Under "Treatment of the Case' we ask: What kind of options (alternative possible solutions) can be provided in the face of a possible conflict between medical-scientific and medical-ethical consequences? Which of the aforementioned scientific and ethical criteria are affected by these alternative options?.- Which options would be appropriate for the good of the patient? Who could or should be consulted as an advisor? Is referral of the case necessary for

medical or ethical reasons?.- What are the concrete obligations of the physician with regard to the chosen treatment? What are the obligations of patients, staff, family, and health care institutions?.- Are there arguments against this decision? How does one respond to these arguments? Is the decision open to ethical consensus? For whom? Why? Was the decision discussed with the patient and did he/she agree? Should the decision be revised?.- Summary: What decision was made in the face of the connection between the medical-scientific and the medical-ethical consequence and the intended balancing of goods? How can one summarize exactly the medical-ethical decision and the balancing of goods?'

It is clear, that such an open questionnaire is aware of issues of paternalism, familianism, informed consent, the essential role of trust, communication, compliance and cooperation, and the critical review of medical and moral options. But no predetermination is made how strongly the principle of autonomy or truth-telling should play a role in decision making or who should be the prime decision maker among the stakeholders. We had been heavily criticized by followers of the strict use of the Georgetown mantra approach to even ask 'is it possible to include the patient in the treatment plan?' or 'how far can the physician leave it up to the patient to decide?'. We do not make up our mind in regard to patient's autonomy before we see the patient and communicate with her; our only predetermination was and is to carefully evaluate the issue of self-determination versus paternalism and give self-determination every chance. Arguing about theories and principles is one thing, the application of principles and virtues in any single case 'for the patient's good' is another thing. Such an open questionnaire, eventhough predetermined by a certain cultural tradition (in this case, by an enlightened preference to let the patient decide if at all possible), concentrates on 'the good of the patient' achieved by an integrated effort of compassion [ren] and competence [ji].

INTEGRATING PROFESSIONAL ETHICS AND EXPERTISE

Principles and virtues will develop their positive or negative input as they are implemented in the situation or, as Thomas Aquinas, one of the fathers of continental European philosophy said 'actiones humanae secundum circumstantias sunt bone vel male' [S.Th.8I,II,qu18,3]. The use of a certain ethics principle as a tool for evaluation and action might be essential in one situation while it might be totally inappropriate in another one. A four-step analysis-and-evaluation development procedure developed for consulting purposes in ethics quality control can as well be used in education as well as in single-case medical decision making in a cross-cultural setting:

table 2:

ACTION-ORIENTED INTEGRATED TECHNOLOGY AND VALUE ASSESSMENT

1. PROBLEM IDENTIFICATION
   - a. collect technical (medical) data
   - b. collect significant human data
   - c. identify value elements
   - d. discuss relations between technical and moral issues

2. DEVELOP ALTERNATIVE SCENARIOS FOR ACTION
   - a. establish reasonable possibilities for each scenario
   - b. identify stakeholders
   - c. identify principles uncertainties
   - d. discuss ethical and technical risk and uncertainty

3. PRESENT A SET OF ALTERNATIVE SCENARIOS
   - a. discuss uncertainty in each scenario prognosis
   - b. assess technical and moral benefits and risks
   - c. discuss assessments with stakeholders
   - d. evaluate differences in benefit-risk balances

4. FORMULATE A JUSTIFICATION FOR YOUR SELECTION
   - a. specify your reasons for selected course of action
   - b. include stakeholders in reviewing decisions
   - c. understand ethical shortcomings of justification
   - d. anticipate and discuss objections to your selection

Such an analytical and evaluative method of differential ethics can be used in all kinds of technology assessment and application assessment, definitely also in family medicine and primary health care, in developing policy options for public policy, in scenario evaluation schemes in situations of professional activity, and in anticipatory assessment of new technology and of introducing new technology into medical, social and cultural contexts. Ethical assessment is intertwined with technology assessment and situational challenges are given priority over the application of theories. Principles and rules supported by one or the other theory are used to develop different courses of possible action and the most suited one for the specific general scenario or individual case is selected competitively. Only when principles or virtues will contradict each other due to different worldviews or theories, then theories have to become

involved and have to undergo a critical checkup by stakeholders and among stakeholders. The Confucian 'Doctrine of the Mean', a very early stakeholders model, puts emphasis on the need of stakeholders to be open to criticism and self-criticism, resulting in the self-cultivation of stakeholders and in best possible harmonious solutions and procedures.

Also, ethical terminology has to be as precise as the technical terminology, to be fine-tuned and made applicable to the situational challenge. General ethical principles such as autonomy, humaneness, compassion, justice, trust, responsibility, and family ethics have to be micro-allocated and mix-allocated into specific cases and scenarios. General ethical principles can be understood as value commodities, which will become useful only in semi-finished or finished versions. Semi-finished moral principles are mid-level principles such as codes of professional conduct (semi-finished form of responsibility), free speech (semi-finished form of autonomy); amalgamated value products include humaneness (ren) of the physician (compassion plus expertise), informed contract or consent (professional responsibility plus client autonomy), the patient's best interest (nil nocere plus bonum facere], most guidelines, regulations, legal, organizational, technical and political instruments and procedures represent a specific mix of principles. In scenario analysis, we deal with the scenario adequate mix and balance of semifinished value components, which we may call maxims. Value end products appear in single case situations of adequate micro- and mix-application of mid-level principles; they form the fabric of case assessment and patient care ethics in medicine, of good client-provider relations in professional services. We may disagree on the 'commodity' level, but such an disagreement might be totally irrelevant for consensus formation or at least trust based cooperation formation on the 'end product' level.

CULTURAL DIVERSITY AND INDIVIDUAL CONSCIENCE

Discrepancies within legal systems and ethical deficiencies in moral traditions and communities are nothing new, nor is the fact that different communities have preferred terminological or orientational tools based on their specific cultural tradition Nevertheless, most moral communities of world religions and other systems of belief seem to be preconditioned to support the visions and mission of universal ethics. As far as bioethics and clinical ethics are closely related to physical suffering and pain, to survival and health as the bases for other goods, values, and virtues, codes of professional conducts and lay person's expectations in all cultures throughout history, medical ethics contains a core of principles in professional and lay ethics and in virtues, which is quite stable and not depending on cultural differences or the fashion fads of cultural preferences or political priorities. Taoist reasoning would provide strong arguments for supporting and allowing harmony and individual and communal life while fighting or avoiding

disorder, harm, or various forms of imbalance. Buddhist thinking centers around avoiding suffering and giving and supporting life with a minimum of suffering, if possible. Jewish, Christian, and Muslim traditions of care, love, and protection from harm also request the respect of human dignity and human and civil rights.

However, there are many controversial issues dealt with differently in different traditions and controversial among citizens of pluralistic societies. Issues of abortion, euthanasia, basics and limits of care for others, many issues in social justice are controversial and will be controversial. As conflicts in evaluating these and other issues deeply related to very personal visions and interpretations of culture, dignity, and tradition, uniform solutions should not be enforced as they will only suppress the dignity of the individual conscience, vision and system of belief. When consensus in theories cannot be achieved, then consensus need to be achieved on how to proceed in the presence of dissent. Consensus on procedural matters becomes even more important as the people of different cultural traditions have to work together globally and as more and more societies become multicultural loosing traditional patterns of ideational coherence [Sass 1998].

An old European principle, the principle of subsidiarity, has been reintroduced into modern social theory and ethics and could very well be used in bioethics and other areas of applied ethics. As moral and political controversies and ethical conflicts in part are rooted in the dignity and the right of individual choice, uniform solutions would suppress individual dignity and vision and one should leave complex decisions on good and evil to smaller moral communities, i.e. family and neighborhood, only thereafter with decreasing authority to act as moral agents to societies, politicians, and judges. Subsidiarity [Vatican 1931], first developed as a principle for direct and individual care of the socially needy by individuals and moral communities and targeted against totalitarian welfare programs, in its universalized version can be expressed his way: Whenever and as long as philosophers, ethicists, theologians, politicians, church and state bureaucrats, physicians, groups in society, and educated citizens disagree on principles of ethics, they must agree on respecting the dignity of individual moral choice and responsibility.

European cultural traditions, honoring human dignity in the respect for the individual's conscience, are not only based in the Age of Reason concept of self-determination and self-responsibility, but also in religious teaching calling for following one's conscience, as a recent Roman-Catholic encyclical confirms: 'Like the natural law itself and all practical knowledge, the judgment of conscience also has an imperative character: man must act in accordance with it. If man acts against this judgment or, in a case where he lacks certainty about the rightness and goodness of a determined act, he stands condemned by his own conscience, the

proximate norm of personal morality' [Vatican 1993: art.60). Except for the sexist language, the wide majority of cultures and ethical traditions could agree to this statement. Religious, communal, political, or cultural pressure in the name of universal ethics, except in the most evident and rare cases, would be counterproductive to recognize and to support human dignity and rights. Not everything beyond universal and basic common morality needs to be arranged uniformly, in particular if personal visions and values differ and respect and compassion for the dignity of other people's beliefs, principles, virtues and visions would be hurt rather than supported by uniform solutions and rules. The Buddhist concept of personal dharma and the Confucian understanding of different obligations in different interpersonal roles are quite close to the principle of subsidiarity.

It was Spinoza, who in 1670 observed that peace and the fabric of society would not fall apart if individual freedom and liberty would be granted, rather on the contrary, that peace, respect for persons and all other treasured values of a society rich in cultural and ethical values will fall apart if individual freedom is not granted. Common moral priorities can be formulated in the presence of cultural diversity, indeed, but some complex moral issues should be left to personal responsibility in respect for the dignity of the individual conscience. Cross-cultural ethics is a visionary enterprise and a great mission, which will fail, if the dignity of fellow-human's conscience, their vulnerability, and the principles of communication-in-trust, cooperation-in-trust, discoursivity and tolerance do not form the core principles. Efforts in education, in cultural and trans-cultural communication and cooperation, visions of cross-cultural ethics, declarations on human rights, legal systems of civil right, institutions of education, science and technology, access to work, care, culture and social interaction, these are the vessels and houses we build for the support, respect and promotion of human dignity and rights, but problematic and a challenge is the way we use these products. 'We make a vessel from a lump of clay; it is the empty space within this vessel, that makes it useful', says the Tao Teh Ching [no 11].

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