

# DEVELOPING MEDICAL ETHICS IN CHINA'S REFORM ERA

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## ABSTRACT

*The paper gives an analytical synopsis of the problem of developing medical ethics in the early half of the 1990s in China, as perceived by Chinese scholars and medical professionals interested in medical ethics. The views captured and analyzed here were expressed in one of the two major journals on medical ethics in China: Chinese Medical Ethics. The economic reform unleashed profound changes in Chinese society, including in the medical field, creating irregularities and improprieties in the profession. Furthermore, the market reform also created new values that were in tension with existing values. In this transitional period, Chinese medical ethicists saw the need to rebuild medical morality for the new era. Using the code of conduct promulgated by the Chinese Ministry of Health in 1989 as a basis, assessment and education aspects of the institutionalization of medical ethics are discussed. In addition to institutional problems of institutionalising ethics, there are philosophical and methodological issues that are not easy to solve. After all, to institutionalize medical ethics is no easy task for a country as old and as big as China. Chinese medical ethicists seem ready to confront these difficulties in their effort to develop medical ethics in Reform China.*

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## INTRODUCTION

The paper discusses the problem of developing medical ethics in the early half of the 1990s in China. The views captured and analyzed here were expressed in one of the two major journals on

medical ethics in China, *Chinese Medical Ethics*.<sup>1</sup> By *developing* medical ethics, I mean what the Chinese medical ethics community often refers to as ‘construction of the medical morality (*jiangou yixue daode*).’ For the Chinese medical ethicists, medical morality refers to the moral beliefs, norms, values, behaviours, decisions, and rules within the medical community regarding how to practice medicine. Stakeholders include medical practitioners, patients, medical professionals, medical administrators, medical researchers, and society at large. Medical morality consists of the morality of how these stakeholders treat and relate to each other, as well as the rights and wrongs relating to such treatment and relationships. The issue of developing medical ethics received its serious attention particularly in the nineties as a result of the “open door” policy (*kai fang zheng ce*) adopted in China in 1979. The economic reform under the open door policy brought in increasingly more market mechanisms to the economy, causing profound changes in Chinese society, including medicine. However, the onslaught of market on socialist medicine unfortunately brought along irregularities and improprieties in the profession, including the overcharging of patients, an exorbitant increase of medical fees, conducting unnecessary diagnosis and operations, and the erosion of the quality of care. Furthermore, the market reform also created new values, which have been in tension with existing values. In this transitional period, Chinese medical ethicists saw the need to rebuild medical morality for the new era.<sup>2</sup>

The paper introduces the development medical ethics by presenting the code of conduct promulgated by the Ministry of Health (*weixhengbu*) in 1989. The program of medical ethics development contains both *assessment* (*pinggu*) and *education* (*jiaoyu*), both of which will be discussed.

<sup>1</sup> *Chinese Medical Ethics (Zhonghua Yixu Lunli)*, Various Issues from 1990 to 1995, published in Chinese in Xian, China. This Journal is chosen as a source because there are very heavy coverage of this debate and discussion in this area. The other journal – *Medicine and Philosophy (Yixue yu Zhexue)* – is another source. But there are great overlaps of views with the first journal insofar as the topic under discussion is concerned. The author chose the first journal as a starting basis for analysis. Key Chinese terms in the paper are also shown by pinyin version in brackets.

<sup>2</sup> R.Z. Qiu. Medical ethics in Developing Countries: A view from China. *Chinese Medical Ethics* 1993; 2: 8–9, 12. R.Z. Qiu & D.J. Jin. Medical Ethics in China: 1991–1993. B. Andrew Lustig ed. *Medical Ethics Year Book*, Volume 4, Dordrecht: Kluwer Academic Publishers, 1995: 339–365.

## MARKET REFORM AND VALUES CHANGE

Since the open-door policy, there has been a gradual change of values directly as a result of the economic reform. Values of the old system were under pressure to change. Values in medicine suffered the same fate. The reform era created intense and extensive value tensions in medicine.<sup>3</sup>

Prior to the reform era, there was a high degree of convergence of personal values and professional values. In the socialist system, medicine's primary goal is to serve and care for the health of the people. Medical professionals took pride in their work and were respected by the people. However, the market reform has severed the convergence of their personal and professional values. In terms of salary and benefits, they were worse off than many of their counterparts in other professions. They felt undervalued and under-recognized. Demoralized and frustrated, they lost their zeal and enthusiasm, and finally, in many cases, their integrity. Such circumstances created an ideal environment for illicit activities to 'compensate' for what they perceived as being their due. For many, pursuing profit was legitimate as a means of fending for themselves. In doing so, many put their own interests before the interests of their patients. The serious lack of funding for medicine further aggravated this problem.

Health care, which once was regarded as state-provided *basic goods* of the people in China, was now seen as a *commodity* (*shang-pin*), to be purchased at a cost in the marketplace.<sup>4</sup> As a result of such a value change (*jiazhi gaibian*), medical professionals used *profit* (*lirun*) as a basis for health care delivery, with perceived dire consequences. For example:

- It distorted the proper physician-patient relationships. The relationship of the physician and patient was transformed into a market relationship of material exchange from one of care.
- It created a lot of waste as a result of the misallocation of resources, and created a mismatch of resource allocation and end-use.
- It created differential income groups within the various units of the hospitals and amongst different hospitals.

<sup>3</sup> Regarding the causes of the many moral problems emerged in medicine during the early stage of the reform, there was a high level of convergence of views among authors regarding the impact of reform on the medical profession. See esp. Zhen, M.S. Value Orientation of Medical Morality. *Chinese Medical Ethics* 1992; 25: 3–6.

<sup>4</sup> Gu, et al. Comments. *Chinese Medical Ethics* 1992; 22: 11–13.

- It created the incorrect impression on people that the quality of the medical care depended on the amount of fees charged.
- The marketization of the medical services ran contrary to need-based socialist health care (*shehui zhuyi yiliao*) principle.
- The marketization of medicine hampered the development of health care system below the county level. The villages could not afford to buy medical equipments, which were becoming more expensive.

Overall, the profit-motivated or market-driven medical practices were widely seen as a violation of the socialist moral principle. The market-driven practices forced many medical people to seek profit-maximization at the expense of the quality of the health care for the patients. Middle-aged and senior medical people were particularly susceptible to this profit temptation. As a result, many of them were no longer able to be the role models of medical morality, as they had been in pre-reform years. Furthermore, the interests of persons and groups became more important than those of the state and society. The market drive also created the conflict between the preventive side and the remedial side of medicine as each was perceived to have unequal market values. Many people saw these phenomena as indicative of the moral demise of the profession.

To arrest this moral decline, many called for a wholesale re-evaluation and reform of values. Universal values, including humanitarianism and benevolence, among other values should be reaffirmed and developed further in order to meet the needs of the people in the transforming economy. New values should be identified and developed to suit the new environment. Proper balance should be given to both collective interests and individual interests. Some called for the reconfirmation of the socialist principles and values. The general consensus was that the values introduced should be *realistic* and *practicable*. Pluralism and diversity should be tolerated and encouraged. The transformation of values should be done in conjunction with other social policies. Integrative, multidimensional, multiple-values should be the guiding principles for the value reform. In sum, the successful morality construction in medicine would not be possible without a proper transformation of values in society at large.

In addition to the value reevaluation and reform, norms and guidelines should be formulated and implemented to promote and develop medical ethics in the medical profession. Ways and strategies of medical ethics development were proposed in the literature.

## DEVELOPMENT OF MEDICAL ETHICS: MORAL ASSESSMENT

The Chinese medical ethicists saw the development of medical ethics as being comprised of two parts: *assessment* and *education* of medical ethics. Medical ethics assessment or audit is an exercise to assess or evaluate the professional conduct of medical personnel against the norms of medical morality. It is generally hoped that the institution of the medico-ethical assessment or audit with its effective implementation, can help to promote and develop biomedical ethics, and minimize unethical conduct.<sup>5</sup>

Medical ethics assessment and education were seen as being complementary aspects of a single process. Ethical assessment without the correlated education and training would not be fair and sustainable. Education and training should be accompanied by a fair and effective assessment to maximize its effect. Both the assessment and education of medico-ethical development were to be carried out under the framework set by the Code of Conduct (*xingwei shouze*) promulgated by the Ministry of Health in 1989, which spelt out the basic guidelines for professional ethics in the medical profession.<sup>6</sup>

1. Rescue the dying and heal the wounded; carry out socialist humanitarianism; always keep the patient's interest in mind; treat the disease and relieve the suffering of the patient by every possible means.
2. Respect the patient's personality and rights; treat patients as equals without discrimination on the basis of nationality, sex, position, social status, or financial means.
3. Serve the patient conscientiously; deport oneself in a dignified manner; speak to the patient in a refined manner; be amiable; take care of the patient with compassion, concern, and solicitude.
4. Be honest in performing one's duties; conscientiously observe disciplines and laws; do not seek one's own selfish interests through medical practice.
5. Respect the patient's confidentiality; do not say or do anything that may harm the patient's condition.
6. Learn from one another and respect each other; approach relationships with colleagues and co-workers in an appropriate manner.

<sup>5</sup> J. Guan. Assessment of Medical Ethics. *Chinese Medical Ethics* 1992; 2: 20–22.

<sup>6</sup> Ministry of Health, 'Ethical Codes for Medical Personnel' R.Z. Qiu & D.J. Jin. *Medical Ethics in China: 1989–1991*. B. Andrew Lustig Ed. *Medical Ethics Year Book*, Volume 2, Dordrecht: Kluwer Academic Publishers, 1992: 372–373.

7. Be rigorous and dependable in work; be vigorous in spirit and eager to make progress; be committed to continued professional growth; continuously renew one's knowledge and increase one's technical competence

In effect, the Code of Conduct provided a broad normative framework for doctor-patient relationships, relationships between hospitals, medical personnel, and society. There were reportedly three levels of morality demanded of different personnel: namely low, middle and high levels of morality. However, it is difficult to determine what the specific norms for a certain level of moral performance may be. The code could also be seen as a set of *mega-norms* for guiding medico-ethical conduct and practices. However, because of its generality, it needed to be adapted to local situations in order to be operationally effective. More specific provisions needed to be worked out under these general guidelines. Some ethicists suggested that quantifiable performance indicators be formulated to give a more accurate and objective measure of staff's ethical performance.

#### THE CRITERIA OF ASSESSING MORALITY

Within the medical ethics community, it was generally accepted that there should be criteria for assessing the morality of the medical professionals and/or the health department or unit. The following three criteria were proposed:<sup>7</sup>

1. The conduct of the professional and/or the health department or unit should contribute to the treatment and eradication of the patient's disease.
2. The conduct of the professional and/or the health department or unit should be beneficial to the health of the society at large, including the protection and improvement of the human living conditions.
3. The conduct and/or the health department or unit should be beneficial to the medical practice and the development of medical science.

While remedial medicine could bring benefits to the patients by the relieving of pain and the curing of the disease, the benefit of preventive medicine to patients and society at large should also be given equal recognition. Activities that are seen as being

<sup>7</sup> M. Gao. Rethinking Several Theoretical Problems of Medical-moral Evaluation. *Chinese Medical Ethics* 1992; 5: 11–12.

beneficial to preventive medicine should also be counted in the assessment exercise.

A proper balance should be made between patient's interests and societal interests, between interests of the near future with long-term interests.

To use *motive (intention)* or *consequence* of a medical act for moral assessment was also suggested. One should ask whether using either motive or consequence alone could give a fair assessment of the conduct. There are four possibilities: (a) good intention(s) with good consequence(s); (b) good intention(s) with bad consequence(s); (c) bad intention(s) with good consequence(s); and (d) bad intention(s) and bad consequence(s).

While cases (a) and (d) are unproblematic in terms of passing a moral judgement; cases (b) and (c) require a detailed analysis before a fair moral assessment can be done. One cannot judge a medical conduct as morally bad simply by assessing its consequences, as the consequences may be the result of inexperience or unanticipated effects. However, using good consequences of an act as the only basis for judging it as being morally praiseworthy may not be fair either. This is because the act may be the result of pure luck or a morally suspect motive. On the other hand, good motives or intentions may also lead to harmful consequences. So, for cases (b) and (c), more specifics of the situation have to be examined in an assessment. However, there is always a tension between using the motive or the consequence of an act as the basis of assigning moral praise and blame. This tension only reflects the perpetual tension between the two competing moral doctrines: deontology and consequentialism.

Apart from the criteria of assessment, questions of the role of assessment in the construction of medical morality, assessment methods, and how to use the assessment results were raised.

The role of the assessment was seen as a means of achieving several goals: education and empowerment, sanction and monitoring, and providing a basis for possible reward and punishment.

Three methods of assessment were proposed: *client-patient assessment (bingren pinggu)*; *peer assessment (tongshi pinggu)* and *self assessment (ziwo pinggu)*. However, it was pointed out that the self-assessment was not given the attention that it deserved. Some argued that self-assessment could give a more effective measure for moral assessment. The inner moral self of the medical staff determined his world view, moral beliefs, which would be manifested in the person's senses of justice, of right and wrong, of responsibilities, of guilt and honour, of self worth, and of conscience. They formed the stable core of the belief structure, which

would shape his moral outlook and guide his actions. They were also reflected in the person's sense of professional conscience with regard to his patients, peers, society, his own profession and human kind. Social moral norms and professional norms must be 'internalized' in order to be effective. A person must 'own' his own moral principles and norms. This is what Kant calls moral autonomy, as distinguished from moral heterogeneity.

In a society where collectivistic values and interests have been strong, the development of individual autonomy, in medicine or otherwise, is no easy task. The challenge is to develop a balance between collective values and individual values so that the person has the moral space to develop his own autonomy.

One writer proposed some ethical indicators for the physicians' handling of out-patients.<sup>8</sup> The ethical indicators consisted of some micro-criteria at the clinical level. One author proposed to connect medial ethical assessment with medical malpractice.<sup>9</sup> The detailed analysis of the cases of medical malpractice could give insight into why mistakes were committed, which could provide a good basis for preventing them. In the ethical assessment of malpractice cases, attention should be given to the relationships between motive and consequences of a conduct.

#### DEVELOPMENT OF MEDICAL ETHICS: EDUCATION AND TRAINING

Chinese medical ethicists agreed that moral assessment without a parallel education program would not be effective. Therefore, it should go hand in hand with the proper education of medical ethics in the medical community. The development of biomedical morality should include the proper education of all staff, especially the leadership and management of the medical and health care sector. A special education unit under the offices of the Hospital Director and party secretary should be established. The second tier of leadership should include unit heads of the divisions and branches of the hospital, with party secretaries taking the lead. Together with the unit heads of teaching and research offices, they would form review groups to handle the implementation of the program.<sup>10</sup>

<sup>8</sup> D.J. Kung. The Idea and Practice of Medico-ethical Assessment for Out-patient Physicians. *Chinese Medical Ethics* 1993; 2: 34-35.

<sup>9</sup> P. Deng. Medico-ethical Assessment of Medical Mal-practices and its Significance. *Chinese Medical Ethics* 1993; 2: 36-37.

<sup>10</sup> J.M. Yao. Medical Ethics Assessment Contributes to All Levels of Hospital Management. *Chinese Medical Ethics* 1993; 2: 13-14.

Some authors endorsed the principle of *autonomy* (*zizhu*) as a goal in educating the medical profession. Some even went so far as to say that medical morality itself should be autonomous. Hence the realization of medical morality should basically rely on the self-control and self-regulation of the medical staff themselves. Buttressing this autonomy with the outside sanctions, the improvement of moral performance of medical person could be guaranteed. Some argued that moral education should sit at the core of quality management of hospitals.<sup>11</sup>

Some suggested that there should be moral norms for medical management staff. In Tianjin, a concerned group proposed a draft set of ethical norms for medical management. The basic norms include observing the socialist principle, the collectivistic principle, the principle of serving the people, principle of democracy, integrity, a sense of responsibility, and willing to learn and value education, hardworking and thrift, impartiality etc.<sup>12</sup>

The education program should be developed and promoted in stages. In the initial stage, all staff should study the guidelines under the leadership of the Hospital authorities and party secretaries. The second stage would involve an assessment, which could take several forms: self assessment, social assessment, and organization assessment. If there were discrepancies between the different assessments, the senior team would adjudicate. It was proposed good performers of the hospitals and their branches should be identified. The assessment would be a bottom-up exercise. There would be a proportional distribution of the numbers of good performers among branch and hospital level: 6% at the branch level, and 1% for hospital for a more balanced distribution. To prevent over-awarding good performers to heads of branches or to head nurses, it was stipulated that the number of awarded junior physicians and nurses should not be less than one third of the total. Finally, there would be reviews at the end of an assessment exercise and amendment for improvement of the system would be done if required.

The question of how to deal with the results of the assessment was addressed. Some proposed to include the assessment result in the staff's personal file, which could serve as a basis for future promotion consideration, and performance-related pay-rise, as well as consideration for overseas studies. Those who were at the

<sup>11</sup> C. Li. Reeducating Medical Workers on Medical Ethics can Guarantee Quality Management in Hospitals. *Chinese Medical Ethics* 1992; 5: 20–21.

<sup>12</sup> Comments. *Chinese Medical Ethics* 1992; 2: 27.

bottom of the assessment would be deprived of the opportunity of promotion and overseas study.

### A CASE FROM JIANGSU PROVINCE

There was a report of a successful medical ethics development program launched in Salt City, Jiangsu Province in 1991. The program, which was named 'the Bethune Cup', focused on developing the *moral autonomy* of the medical staff as the major goal of education. Instead of passively reacting to this need, staff took a more active role in self moral assessment and development, resulting in a more *activist* and enlightened moral consciousness and sense of responsibility. Units in the health departments set up internal monitoring and assessment groups to continue to monitor the performance of staff. Suggestion boxes and hotlines were set up to collect information and suggestions from the end-users, monitoring cards were distributed to patients, and '*Moral Norms of Medical Personnel*' and other normative directives were posted conspicuously on the walls of outpatient wards for all to see; and the fees of medications and drugs as well as major services were publicized. These were some of the policies to make the management of hospitals, clinics, and health units more open and transparent, opening up to more social monitoring and control. Some units set up *ethics officers* (*lunli renyuan*) to monitor their staff, many set up medical ethics files with the related reward and punishment, including promotion, pay rise, bonuses and staff development. The guiding principle of the program is self-control and self-management.

Like other provinces, there was an attempt to quantify the performance of the medical staff. There were performance indicators against which marks would be assigned. Though the system was not perfect, it could at least help to differentiate the good from the bad. And it also helped to give the staff a relatively clear idea of how to act.

A follow-up survey of the effectiveness of the Bethune Cup (date of survey unspecified) indicated 84.6% of the people surveyed were satisfied with the services provided by the medical professions.<sup>13</sup>

<sup>13</sup> Report. *Chinese Medical Ethics* 1992; 2: 25.

## HOW TO MAKE EDUCATION EFFECTIVE AND SUSTAINABLE?

It is generally agreed that in order to make the institutionalization of biomedical morality sustainable, various factors need to be taken into account. These include strong leadership with vision, commitment, and understanding, the strengthening of moral education, establishing a viable medical ethics appraisal system, the establishment of a fair and effective reward-punishment system, strengthening the monitoring of medical ethics of staff and enhancing research in medical ethics.

Chinese scholars believed that moral education should not only be confined to hospital staff, but should include staff in the administrative bureaucracy of the Health Ministry as well. The Ministry staff are mainly responsible for enforcing the laws and monitoring tasks, but they also need moral training. Others suggested introducing a set of virtues for law enforcement officers and administrator: loyalty, integrity, self-discipline, and devotion to serve the people. Some form of virtue teaching should be developed. There were also suggestions to integrate the *education of ideals* (*lixiang jiaoyu*) with the medical ethical education in order to make the latter viable. The medical ethical education should not be narrowly conceived and taught as career or professional education, but as a broader life moral education.

Recently, a proposal to set up *ethics committees* (*lunli weiyuanhui*) in hospitals has been seriously discussed. Such a proposal, if implemented, could strengthen medical ethics at the institutional level.

## CONCLUSION

To institutionalize medical ethics in China is a daunting task. What has been discussed are mainly institutional problems, there are philosophical issues, which this paper has no space to address. Philosophically, medical ethicists have to resolve the antinomies of universalism and relativism, obligation-based verses right-based ethics, individual interests verses collective interests, and utilitarianism verses humanitarianism, among others, which have been receiving attention since the reform began. The current medical ethics discourses have increasingly been couched in western moral concepts, like rights, confidentiality, privacy, informed consent, justice, and other virtue-related values. Whether these values and concepts can truly be integrated in the moral deliberations and practices of the medical community, and to

what extent, remains to be seen. On the other hand, traditional moral values, and medical ethics have been receiving attention by medical ethicists who want to adapt these traditional values to the modern situation. Whether Chinese ethics can be blended with western ethics is an issue that no serious medical ethicists can afford to neglect in the cross-cultural assimilation of values.

On the methodological front, the methods of assessment raise issues of objectivity, reliability, and fairness, each of which has a certain degree of complexity that practitioners have to wrestle with. The problem of formulating and designing appropriate performance indicators for measuring performance involves the classic problem of measurement. One difficult issue is the commensurability of different performance indicators. The second is the problem of how to design a common scale of measurement for all these different indicators. There is also the problem of quantifying the performance indicators. Are all performance indicators susceptible to quantification? Are there indicators that are difficult to quantify, yet provide valuable information for the assessment? Though quantification has its operational attractiveness, can this merit be suitably exploited without falling into the trap of misplaced rigor?

These are difficult questions to address. After all, to develop and institutionalize medical ethics is no easy task. Chinese medical ethicists seem ready to confront these difficulties in their effort to develop medical ethics in modern China.

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