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# **Ethno (medical)-Ethics as Contested Knowledge and Practice in Times of Globalization: A Case-Study from China**

## Abstract

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Framing “new ethics” within both Chinese and international characteristics has become a pressing issue, while China’s research and innovation policy encourages a turn towards a knowledge economy and while a number of international/Chinese corporations delocalize industrial production in poorer countries offering cheaper labour. Plural health ideas, practices and medical sciences currently develop within the broader framework of social and economic transformation of the Chinese society. Voices from civil society at large wish also to participate in the debates going on in the official, academic and media spheres. On one side, ethno-(medical) ethics may be contested by most international development actors who strongly support a universalistic view of ethics; on the other side, local/national knowledge through the voices of a number of lay people’s groups, locally-based and trained experts, and official actors gain ground for recognition. Of course positions taken by all these stakeholders towards such knowledge in terms of knowledge production, decision-making, and policy implementation may widely diverge. Issues raised in the 2000s relative to medical ethics, bioethics and the New Health Reform guidelines and implementation, will be discussed. My study is based on data collected using anthropological methodology within the framework of a research project (2006-2011), conducted in partnership between the Peking Union Medical College/Chinese Academy of Medical Sciences, Human and Social Sciences Department, Center for Bioethics (IRD and PUMC/CAMS) in Beijing.

In China, failure in health management from the early 1980s over two decades through a market- oriented reform, has been officially assessed. The reform was recognized by the very powerful Chinese State Council as “basically unsuccessful” through the voice of the Center for Development

Research (The Evaluation and Recommendations of Healthcare Sector Reform, July 2005, retrieved September, 15, 2011: <http://www.drc.gov.cn/report.asp?t=report&y=2005>).

Qiu (2008) highlighted the key achievements and failures of the 1980s reform process and from his analysis, voiced the need for renewed interest in Confucian style values of trust coming from the population at large: a very common complaint was that the art of *ren* (humaneness, beneficence; also known as humanism the Chinese way) had been transformed into the art of making money (Qiu, 2012, p. 18). Interestingly enough, while more than 90% of the population at large acknowledged the failure of the reform by strongly disapproving it, in contrast more than 90% of health-care professionals interrogated were very satisfied with it (He, 2005, quoted by Qiu, 2012, p. 19).

This situation prompted previously contained disapproving voices to express dissatisfaction in the academic arena: a number of medical professionals and social scientists argue that a solution might be to look back to previous medical ethical knowledge throughout Chinese history. Nonetheless medical ethics in the context of culture is a form of local knowledge (Christakis, 1992); subsequently,

653

it is worth further investigation and is capturing the attention of the academic arena at an international level. Further research is urgently needed as UNESCO programmes tackle the pressing and controversial issue of bioethics education, with a focus on Asia (Calderbank, 2008). Open debates and listening to voices from all stakeholders in Asian societies have been limited in the region so far, while basic research and R&D in health sciences have promptly developed, and new (bio)technologies have become gradually available raising new ethical issues.

My paper is organized in three parts: the first part builds on the 2000s health reform; the second one is about ethno-ethnics in China and elsewhere; and the third reports about ongoing discussions in China on a few medical ethics-related issues.

## **China's New Health Reform**

Since the late 2000s, the health reform designed to extend basic health insurance coverage and curb market-oriented health-care, among other goals, has been in progress. A few chronological points with regards to health-care management in China need to be recalled here.

In the 1980s, a first round of reforms characterized by market-led deregulation and massive retrieval of the State in terms of funding and control was gradually implemented. Both urban and rural healthcare systems had experienced drastic changes on the road to economic liberalization. Raising healthcare standards and reducing government financial burden through market competition and rules were generally approved. Even though there was some improvement in terms of operational efficiency and health facility modernization and standardization, one downside with regards to public health was an increased burden on the shoulders of individuals: in 2005 significantly enough more than half of total healthcare expenditure (55.5%) was borne by the people (Jiankangbao, 2005). In the 2000s, Chinese society experienced a new round of reforms called "new health reform" following the assessment of the failed reform and voices raised against the current healthcare system and its dysfunctions: a number of studies and heated debates revealed the importance of trust lying at the heart of patient-healer relationship, which had been badly damaged over the years. This situation signalled a rising societal interest in a widespread quest for better values which often translates into a search into the past. Confucian values and their possible application in medical ethics once again capture public attention in rethinking ethical issues and help to nourish the ongoing discussion.

Why did health reform become unavoidable for the Chinese government, so as to be subsequently considered a priority in public policy change? In the 2000s, health had become the first preoccupation of the Chinese population (Micollier, 2011b), as the people's voice, through the widespread use of what appeared to be a new common adage *kanbinggui, kanbing nan* ('indeed how expensive and difficult it is to consult') became so loud that

official actors could no longer ignore it. Many cases demonstrating the vulnerability and lack of trust of ordinary people (laobaixing) had been circulated through all sorts of media, with whole families being ruined by a disease affecting one of its members, and patients not being taken care of because they could not afford the exorbitant fees (Micollier, 2011b; Zhai, 2012). All these examples prompted a widespread discussion followed by a heated debate on trust and its high place as a value among Confucian virtues as shown in our historical sets of medical ethics rules (detailed in Micollier, 2014). A process of revitalization of historical medical ethics in the context of broader cultural repertoire change (increased interest for tradition, patrimony, both material and immaterial, knowledge, social ethics, etc.)

654

is currently at work in China. The 2000s was a period of renewed interest for Chinese traditional and popular knowledge, know-how and practice, with a focus on both material and immaterial patrimony, and on norms and rules, including social ethics for example.

Lack of trust was widely acknowledged and restoring it was urged in both the inter-subjective patient-healer relationship and, on a broader scale, in the population at large and within the health personnel network of relationships, as well as within the larger framework of the health system. Heuristically most contributions from Chinese authors (Qiu, Zhai, Xia, Hou, and Xiao) address these issues in a Special Issue of the International Journal of Bioethics concerning “Ethics-related issues in hospitals. French and Chinese situation compared”, published in 2012.

### **About Ethno-Ethics in China and Elsewhere**

Since the 1970s, four basic principles have laid at the heart of Western bioethics. These became post-second World War II international basic principles, namely autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 1983). In our globalized and multicultural society, since the 1980s, research in social sciences, and more specifically in

anthropology, has brought a new light on the universalistic nature of a number of ethical principles, such as new interpretations about the four principles emanating from the Belmont report and North-American bioethics. The aim of these studies was to inform about the ethno-centric nature of bioethics, cultural diversity in societies, and issues regarding the application elsewhere of a Western-born ethical thought designed for biomedicine, as practiced and interpreted firstly in the West.

Lieban (1990) studied the medical ethics of traditional and popular healers from a comparative perspective, emphasizing the cultural differences but also the similarities beyond cultures, approaching biomedical ethics from an inter-cultural perspective. His account of the Chinese context is based on Unschuld's (1979) work on medical ethics in Imperial China. A key hypothesis is that similarities in medical ethics do exist in various cultural contexts independent of each other. He takes the case of biomedicine and of traditional medicine in imperial China as significant examples. He argues that both contexts share one principle and two important ethical issues: the principle of beneficence and assistance, the relationship between the two values is perceived as contradictory— profit generated by the practice of medicine versus the altruism necessary for the practice; ethical issues concern the relationship between medical ethics and the process of professionalization.

McGréal (1991) investigated innovation and changes in Chinese medical ethics comparing historical principles' sets and post-1979 (Reform Era) sets.

Lieban (1990, p. 233) builds on Beauchamp & Childress (1983) and Veatch (1981): "Beneficence, defined here in broad terms as a duty to promote the welfare of others, is a primary ethical principle of Western biomedicine, with roots that go back to the Hippocratic Oath". However rather than drawing too hasty a conclusion, the notion of beneficence should be looked at more closely: the meaning of the Western notion of beneficence may diverge from the meaning of *ren* (humaneness, humanity) in Chinese. According to Tung (1994, p. 490), reflecting the highest virtue, the character 仁 (*ren*) formed by "two" and "human" indicates that the body-self is part of a larger whole, more precisely of both another human being and/or of the natural

environment. Such a cosmological dimension is not present in the Western notion of beneficence: the relationship of the human being to Nature is obviously very different in each context. In contrast, the principle of social ethics contained in the Chinese term is closer to the Western meaning.

655

Chinese sources quoted by Unschuld (1979, pp. 30, 52, 71) often mention the moral duty of helping others and of assisting sick people.

The first ethical issue concerned the contradiction inherent in medical practice between making a profit and being altruistic: tension between self-interest and philanthropy has been analyzed as the key paradox in medicine (Pellegrino, 1985).

The second ethical issue concerns medical ethics and the professionalization of medical practice. In the context of China (Unschuld, 1979) and in the context of Western civilization (Freidson, 1970), the codes of medical ethics are tools serving a corporation guaranteeing a moral use of medicine and assuming responsibility for medical resources.

Ethno-ethics of medicine still needs to be explored: it “refers to moral tenets and problems of health care as they are conceived and reacted to by members of a society” (Lieban, 1990, p. 236). Even though most studies about medical ethics from an inter-cultural perspective focus on cultural differences, the consensus is compulsory because biomedicine has fully developed into global institutional medicine. However such consensus and subsequently homogeneity through a standardization and institutionalization process is only apparent and superficial. Therefore Kunstadter (1980) argues that behind the scenes introduction of Western medicine and the spreading of its ethics is the main explanatory factor for such apparent homogeneity. Taking the example of India, he shows how traditional ethical systems have been ignored by Westernized medical institutions. However biomedical ethics in non-Western countries inexorably experiences a process of adaptation to the norms and values of non-Western societies.

If biomedical perspectives conflict with local norms and values, serious ethical issues emerge which need to be discussed and negotiated in context. From the field of health education to research and development sectors, biomedicine is always adjusted in context: such a localization process generates discussion and tensions regarding ideas (knowledge at work and its production) and practice (clinical, care, healing aspects, research) including of course in the field of ethics (On such process, see among other works, Gobatto & Lafaye, 2007; Micollier, 2007; Micollier, 2011a).

### **Discussions in 2000s China: A Few Examples** (Text based on Micollier, 2014)

The Chinese situation will be informed with a number of the issues of informed consent, confidentiality, family role and with a focus on the patient-healer relationship. The modalities and management of this relationship lie at the heart of medical ethics considerations.

As is the case in many countries, family decision making is the normative way of dealing with health and illness in China. This has been recognized and recommended within the framework of the national medical ethics scheme. When a family member is affected by a distressful situation, all members perceive themselves as sick and the most vulnerable member is the one who effectively puts the others at risk: from this insider's view, the observer can understand why the decision is often not individual and is made collectively. This attitude questions the value of confidentiality and the role of the individual in the consent procedure. Confidentiality along with privacy are fundamental values in the West relative to individual decision making and a clear line is drawn between the private and public sphere. I will recall here that the emergence of a standardized procedure for informed content and the very idea of informed consent brings us back to the roots of contemporary/Western bioethics, namely the Nuremberg Code, the 1970s Belmont report and North-American rules.



Another issue concerns international normative rules that have not been sufficiently contextualized: informed consent is required for any treatment intervention and tragic cases like the one cited by the sociologist Xia (2012, p. 78) are not rare: a pregnant woman had lost her life due to lack of health information and sufficient awareness on the part of her husband who refused to sign the informed consent. This situation happened in Beijing in 2007.

Among others voices, Zhai (2012) argues: while medicine had become a big business, the goals and management of medical services need to be changed to restore people's trust in what has turned into a highly damaged patient-healer relationship. Cases of aggression, attacks targeting health-care personnel, of personnel wearing helmets to protect themselves, has become common in the 2000s (cases' examples by Xia, 2012, pp. 78-79). Xia gathered official data from surveys conducted in the 2000s in Shanghai, Beijing and in Hunan Province showing a consistently badly damaged therapeutic relationship: the number of incidents, medical malpractice, medical disputes, and medical staff being orally insulted or physically beaten, increased dramatically. Results from the Fourth National Health Service Survey completed in 2008 indicated that more than one in five of the medical staff surveyed had endured oral insults, almost one per cent violence and close to six per cent threats, either orally or through mailed letters (Xia, 2012, p. 79).

Xia, Zhai, Qiu and Hou & Xiao all focused on an increased/newly emerged "unbalanced position of negotiation" (Xia, 2012), or on the asymmetric power relationship (Zhai, 2012) between doctors and patients as a key factor explaining why the relationship had undergone such a dramatic change. Interestingly enough, this point is what the Nuremberg Code (1947) elaborated by a post-World War II US Military Court aimed to initially change, namely that reducing the power imbalance between medical staff, institutions, and the patient suggests, in a more egalitarian power-relation model, increasing the decision-making power of the patient who is intrinsically recognized as vulnerable. This is how and why the procedure of informed consent, "une capacité légale totale à consentir" (a complete legal capacity to consent), was created and from then on strongly recommended. "Complete legal capacity" of the individual means that the two parties are

equal: subsequently in order to facilitate the analysis of risks and benefits for the individual concerned, sufficient and detailed information concerning the medical service should be provided (Ambroselli, 1994, p. 106).

Following a Foucauldian reading (Foucault, 1976), in the end the whole process for the benefit of the patient, the population at large, and more specifically vulnerable groups of people, would consist in decreasing the “bio-political” power of the medical actors acting acquired through a form of “governmentality” on bodies and individuals, a subtle way of taking control on persons and groups.

East-West exchanges in terms of knowledge production are being reshaped. Applied to the field of health and medicine, Asian ideas and practices are disseminating at a global scale through a whole range of healing practices, among actors and institutions, within the framework of ‘integrated’ and ‘integrating’ health care systems. These latter bring other medical traditions into biomedicine: more specifically in the fields of preventive medicine, occupational and rehabilitation medicine, well-being and corporal practices, pain management and palliative care. Let us note however that ethno-ethics and ethical governance from elsewhere, namely not rooted in the post-colonial order, are still scarcely taken into account in this transforming process.

In the end, significantly enough, such process may produce ‘post-Western’ bodies of knowledge and practice in a number of fields investigated and therefore contribute to transform societies at a global scale.

657

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658

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659