

Euthanasia, and the Meaning of Death and Dying: A Confucian Inspiration for Today's Medical Ethics¹

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In his introductory greetings to the International Medical Ethics Conference at the Chungshan Medical College, Taichung, on May 8, 2001, Dr. Huang Kunyen of the National Health Research Institute pointed out, "If we do not know how to die, nature will care for it".

This simple sentence summarizes elegantly what it means for humans to be free, as related to the brutal fact that we are mortals with limited influence on the way we are going to die.

1 Euthanasia or physician-assisted suicide, from The Netherlands to Korea to China

How shall we make it possible for people to die in a meaningful and peaceful way? This question burns all over the world, whenever medicine and nature compete. It is important for us to keep in mind that our dignity is neither limited by our biology nor determined by the range of medical capabilities. We are responsible agents in charge of our own lives and its meaning. The moment of dying is critical for the assessment of each one's entire life. This makes it imperative to be prepared for it at any time. In the old and etymological sense of the term, all actions that aim at providing conditions for a peaceful and happy death relate to the concept of "euthanasia", or "*Anlesi*" (the accepted Chinese translation of the term). Unfortunately, good reasoning and lessons from history inform us that this is the most riskful attempt to mould our fates, or to "assist" someone who lacks the power to either cut or maintain the physical bonds to life by himself.

The Netherlands, a neighbour of Germany well known for its liberal social politics, have recently adopted a law that legalizes active "euthanasia" under certain conditions. This step has raised concerns among bioethicists and prompted heated debates among policy makers and the public in general. This incidence has re-emphasized the problematic situation of how to assess quality of life, especially as related to dying patients. Germany's minister of justice, Hertha Daeubler-Gmelin, criticized the Dutch legislation. She said the emphasis should remain

¹ This paper has been presented first at the International Bioethics Conference on The Ethics of Letting Die, May 8-9, 2001, Chungshan Medical College, Taichung, Taiwan. I am grateful for substantial comments by Paul Unschuld and Nie Jingbao.



on therapy to reduce suffering and questioned the idea of mercy killings, saying it involved "the decision of a third person on the death of a human being."²

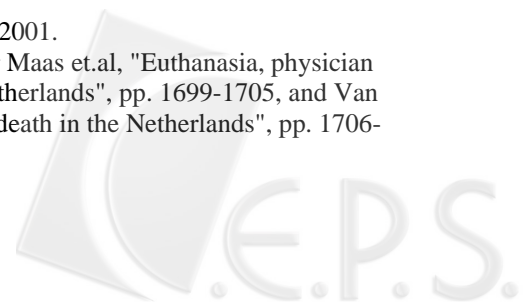
The technical legal standards are meticulously defined. For example, under the new law, a patient would be required to be experiencing irremediable and unbearable suffering, be aware of all other medical options and have sought a second professional opinion. The request would have to be made voluntarily, persistently and independently while the patient is of sound mind. Doctors are not supposed to suggest it as an option. In the future, cases of active euthanasia will not be evaluated by a prosecuting attorney, as in the past, but by an independent commission. The maximum penalty for violation of the regulation is 12 years in prison.

Justice Minister Benk Korthals told the upper house of the Netherlands the bill formalizes the guidelines adopted in 1993 under which doctors have been assisting suicides with tacit approval³. The Dutch believe legalizing doctor-assisted suicide will clear up a fuzzy area of law that has left open the possibility of doctors being prosecuted. "It's a good thing that at a certain moment common practice becomes law," Korthals said. In fact, the law seems to care for the interests of the doctors. This notwithstanding, in the weeks preceding the debate in early April, the upper house received more than 60,000 letters, most of them urging the legislators to vote against the bill. The anti-euthanasia group "Cry for Life" gathered 25,000 signatures on a petition.

A German physician's association, the "Hartmannbund" attacked the law as being a step back into a mentality of euthanasia and super-human image of physicians, reminding of medical atrocities under Nazi rule, under the disguise of mercy-killing. The physician should accompany a dying patient, "standing by him and holding his hand", but in no way may assist to die. According to critiques from the churches and the conservatives, every year about 4000 people are estimated to have died under active euthanasia, since 1994, in The Netherlands. Moreover, hundreds of severely handicapped people and coma patients have allegedly been killed without anyone's asking for consent. The Secretary General of the German Hospice Foundation, Eugen Brysch, called for realizing the right to dying with dignity. He pointed out that a viable concept of death bed care must include pain therapy as well as psycho-social care. As a matter of fact, the very definition of *palliative medicine* includes much more than pain therapy, namely the concept of bio-psycho-socio an spiritual care enveloping the patient as a whole human being. It also includes more actors than just physicians and patients. Being a multidisciplinary approach, palliative medicine assembles nurses as well as social workers, psychologists, priests, etc., in order to provide as a team the best possible treatment, according

² Cf. *The New York Times*, "Dutch Senate Debates Euthanasia Bill", April 10, 2001.

³ Cf. two articles in the *New England Journal of Medicine* 335 (1996). Van der Maas et.al, "Euthanasia, physician assisted suicide and other medical practices involving the end of life in the Netherlands", pp. 1699-1705, and Van der Wal et.al., "Evaluation of the notification procedure for physician assisted death in the Netherlands", pp. 1706-1711.



to the patients' needs as a non-reduced human being. This approach offers comprehensive care, not limited to the relief of pain and other physical symptoms, but also aiming to provide all physical, emotional, mental and spiritual comfort. It has been argued that the neglect of such a comprehensive range of attention to patients in the medicine and health care might contribute to a bias in favour of euthanasia.⁴

This debate is likely to be continued in Europe, where many monitoring individuals and organisations have announced that they will scrutinize all forthcoming cases critically. How is this signal received in other places over the world? I suggest to take a look at South Korea first, being an Asian pluralist democracy with a largely traditional and paternalistic medical system.

The AP news agency reported on April 13, "'Mercy killings' are illegal in South Korea but the Korean Medical Association, a lobby for 70,000 doctors, has drafted a new ethics code that would give doctors more discretion in determining the fate of patients suffering from unbearable pain with no hope to live. Without a clear legal definition of mercy killing in South Korea, doctors have been uneasy when they treat patients who they believe are terminal and suffering unbearably with only a few days to live."

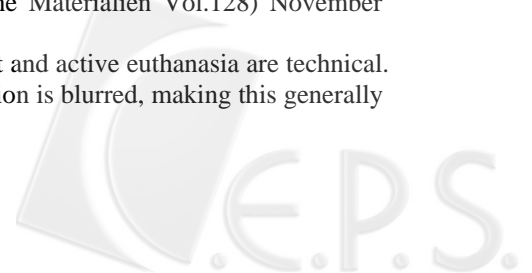
In a widely publicized case in 1998, a doctor in Seoul was sentenced to 2 1/2 years in prison for allowing a terminally ill patient to go home and die without further treatment at the request of his wife. If adopted, the new ethics code would allow doctors to discontinue treatment on terminally ill patients on their own judgment or when they are asked to do so in writing by the patients' families. It would also enable doctors to refuse demands for treatment by patients' families if they believe it's medically needless⁵.

It is obvious that the chief concern of this legal initiative, just as in The Netherlands, affects the interest of the doctors to have greater confidence to be on the safe side of the law.

In mainland China, euthanasia (*anlesi*), as active killing of the patient upon request is illegal. However, passive euthanasia, and the withdrawal of treatment is widespread, and the real practice is not well documented. Along with the development of biomedical sciences and the rise of living standards, the average lifespan of people will be further prolonged in the coming years. The group of the aged in the population will grow, especially as related to the overall population, wherein, as a result of the family planning policy, the proportion of the economically productive generations is decreasing. As a side effect, the incidence of cancers, heart and brain vascular disorders as well as chronic diseases can be foreseen to grow beyond the

⁴ I gratefully acknowledge Michael Zenz for reminding me of the comprehensively "covering" nature of palliative medicine. Cf. Buchanan ML and Tolle SW, "Pain Relief for Dying Persons: Dealing with Physicians' Fears and Concerns", *Journal for Clinical Ethics* 6 (1995): 53-61; Michael Zenz and Franz-Josef Ilhardt, *Ethik in der Schmerztherapie*, Bochum (Zentrum für Medizinische Ethik, Medizinethische Materialien Vol.128) November 2000.

⁵ In practice, the borderline between refusing treatment, withdrawing treatment and active euthanasia are technical. From an ethical view, focusing on the ethical maxims of an agent, this distinction is blurred, making this generally a case of concern for active euthanasia.



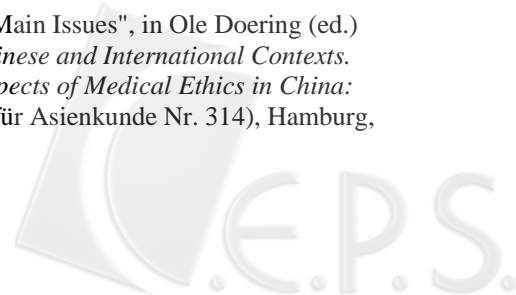
limits sustainable by the currently drafted system of health care and social insurance. Eventually, this development will in general multiply the occurring of situations of economic crisis for seriously ill and terminal patients and intensify the social and economic pressure on patients and their families, generating the related psychological and psycho-somatic indications on a large scale. Incidences of withdrawal or refusal of treatment, which are reported widely in China, will increase in numbers, because the main reason for it is not that people in general care less about the well being of dying patients but that treatment can not be afforded. This makes euthanasia a most relevant topic for practical reflections about the meaning of death and dying.

Qiu Renzong has explained, "euthanasia has been the first topic of Bioethics in academic journals as well as in mass media. In 1988 the First National Conference on Euthanasia was held in Shanghai. Especially the *Hanzhong case* stimulated a nation-wide debate on euthanasia in China. In 1986 a female patient X suffered from the late stage of cirrhosis, with severe bedsores and had fallen into coma. Her son and the youngest daughter asked the doctor to do euthanasia to her without consulting their two sisters. The patient died from an injection of chlorpromazine. Her other two daughters sued the doctor for murder and the doctor was arrested under suspicion of murder. In 1991, the Middle Court declared the doctor not guilty, though he committed a crime, but it had been insignificant. Because the patient's death had been caused by the disease, the doctor's action had only hastened it, and *his motive was to relieve the patient from suffering*. Thousands of people were engaged in the debate on the *Hanzhong Case*. About 80% of them favored euthanasia, but 20% spoke out against it.

In 1991 a case of voluntary euthanasia was published in the *Beijing Daily* in which a terminal cancer female patient insisted on her request for euthanasia, and died by an injection, with the consent of her husband and child. This was approved by all medical professionals in the Department of Cancer of a hospital in Beijing City. Nobody sued the physician; instead, the patient's determination and bravery was praised. In 1994, however, there were some cases in which the request of euthanasia by a terminal cancer patient was rejected by physicians, and the patient asked family members to kill her or him, by using a pillow to suffocate the patient or using poison to kill the patient. All those who took this action were arrested and sentenced as murderers to three years in prison."⁶

In the discussion in China the concept of euthanasia was not made very clear. Beijing bioethicist Zhai Xiaomei has suggested that an action such as *anlesi* requires that the patient is in terminal state and with unbearable, intractable pain and suffering; euthanasia should be insistently requested by the patient; the agent who takes the action should be a medical

⁶ Slightly abridged from his report, "Medical Ethics in China: Status Quo and Main Issues", in Ole Doering (ed.) *Chinese Scientists and Responsibility: Ethical issues of Human Genetics in Chinese and International Contexts. Proceedings of the 'First International and Interdisciplinary Symposium on Aspects of Medical Ethics in China: Initiating the Debate', Hamburg, April 9-12, 1998*, (Mitteilungen des Instituts für Asienkunde Nr. 314), Hamburg, 1999: 24-32: 25.



professional; and the means of euthanasia should be painless and dignified as far as possible⁷. This definition resembles the one adopted by Dutch law and favoured by the Korean physicians. Still the different social, political and economic situation of China is crucial for the real practice of any relevant law or guideline. Qiu reports, "Some people are anxious to legalize euthanasia, but some argue that it is not the right time to legalize it, and that what is needed is to decriminalize it in certain circumstances."⁸

The actual impact of Confucian morality on the problems of euthanasia is frequently discussed by scholars on the mainland. The discussion seems to reflect the unsettled stage of the debate. Here are two interesting voices. Beijing historian of medical ethics, Zhang Daqing says, "It should be noted that some scholars mistakenly regard the Confucian teachings of the superiority of righteousness over life, and of the Gentleman's will to be rather killed than to accept being dishonored, and of the preference of a worthy death over a worthless life, as arguments supporting euthanasia. These Confucian concepts refer to social and political areas of life, but not to the question of the individual's life in situations of disease or old age. Confucians maintain that death is something unwanted. Therefore, no action that helps someone to die is regarded as a virtuous action. The concept of filial piety and the inviolability of the body, (since life is owed to the parents), have made a deep impression on China's cultural tradition. Hence all Chinese are negatively biased against euthanasia for their elderly."⁹

Shanghai philosopher Shen Mingxian, on the other hand, has argued that, in fact, Confucianism supports euthanasia on the grounds of focusing on the "good death" as a function of the "good life". "If we put euthanasia in the category of the good death, is it possible that Chinese people will more easily accept the idea of euthanasia? It requires us to make more effort, in the fields of academy and propaganda."¹⁰

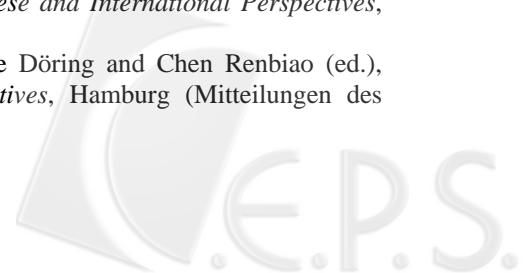
In an attempt to enlighten the debate, Li Lu from Hangzhou has pointed out that, "We are confronted with a comprehensive ethical problem relevant to our outlook on death, ethics, and medical values, which does not appear in the case of the terminal care. Developing the cause of terminal care cannot take the place of exploration of euthanasia for of medical science, socio-cultural, and legal reasons. Also terminal care cannot solve problems that are related to euthanasia regarding life quality in social medicine, and the reasonable utilization of resources in health economics, and cannot decide whether patients approaching life-end should choose death or senseless survival with mental and physical suffering. Even the best hospice can not remove the extreme pain suffered by dying patients. Scientific and reasonable euthanasia is the

⁷ Cf. Zhai Xiaomei, *Anlesi: Lunli he Gainian Wenti* (Euthanasia: Ethical and Conceptual Issues), Ph.D. thesis, Beijing 1998.

⁸ Qiu, a.a.o.: 26. It is interesting that the distinction between legalizing and decriminalizing has become a topic in Germany's way to deal with matters of potentially high moral controversy.

⁹ Cf. Zhang Daqing, " *Medicine as Virtuous Conduct: Assessing the Tradition of Chinese Medical Ethics*", in Ole Döring and Chen Renbiao (ed.), *Advances in Chinese Medical Ethics. Chinese and International Perspectives*, Hamburg (Mitteilungen des Instituts für Asienkunde) 2001 (in print)

¹⁰ Cf. Shen Mingxian, "Euthanasia and Chinese Traditional Culture", in Ole Döring and Chen Renbiao (ed.), *Advances in Chinese Medical Ethics. Chinese and International Perspectives*, Hamburg (Mitteilungen des Instituts für Asienkunde) 2001 (in print)



most important link in satisfying dying patients' wishes, approaching death without pity or pain, improving our valuation of death and the quality of life's end. (...) As for many dying people and their relatives, death is not the beginning of suffering but the beginning of freedom from suffering. The greatest pain dying patients and their relatives suffer is the never-ending stalling of death. In addition, were the chief attention to be paid to the relatives in terminal care, what should we do when confronted with the relatives of those who die of emergencies or accidents, who theoretically should have been consoled and paid attention to, since they are filled with great sorrow for the sudden death of their family members, without any mental and psychological preparation. However, this particular group is still being neglected in terminal care. Indeed, in the field of medicine at life's end there are still a number of problems waiting to be solved, both theoretical and practical."¹¹

2. A Confucian approach

A Confucian approach to issues of medical ethics can be significant for contemporary debates inasmuch as it does not essentially depend on outdated concepts and realities of social and moral life. For example, if we depict Confucianism as essentially based on the patriarchal family clan with as primary social and economic functions, it is going to be very difficult to contextualize it in a setting of modern societies, with their disintegrating nuclear families, market economic rationality and plurality of subcultures. This social trend is obvious in the current socio-economic transformation on the Chinese mainland, and applies to Taiwan since even longer.

For the purpose of this paper, I claim that it is consistent to interpret the Confucian Classics (especially the *Lunyu*, *Mengzi* and *Xunzi*) as describing the clan/family (*Jia*) as being an important, yet not isolated part of human society. As it is laid out in the *Daxue*, the family is the first inter-personal compartment of moral experience which prepares everyone for the basic moral understanding of his duties and entitlements in social life. However, it is not a kind of super-human subject in terms of accountability and responsibility in ethics and law.

The moral mission of Confucianism is reaching out far beyond the constraints of an ingroup-morality (or a mere family-morality), by virtue of its procedural concept of a continuous enlargement of the range of moral experience and reflection. This process continues over space (including all people everywhere, even in "barbarian lands") and time (including concern for the prosperity of future generations). It is grounded, on the other hand, on the concept of the reason-capacity and the moral sense of each individual's heart-and-mind (*Xin*). To borrow an analogy from Meng Zi, it would be a needless "mutilation" of this philosophy to regard ethics and morality, in a Confucian sense, as essentially a family ethic, and it would also

¹¹ Li Lu, "Breakaway from the Medical Misunderstanding of Approaching Life's End ", in *Bioethics in Asia*; Norio Fujiki and Darryl R. J. Macer (ed.), Christchurch (Eubios Ethics Institute) 1998: 126-129



be hermeneutically flawed.¹² To the contrary, Confucianism is a universal way to depart from one's self-inflicted (moral) infancy, transcending the moral restrictions of any social sub-group.

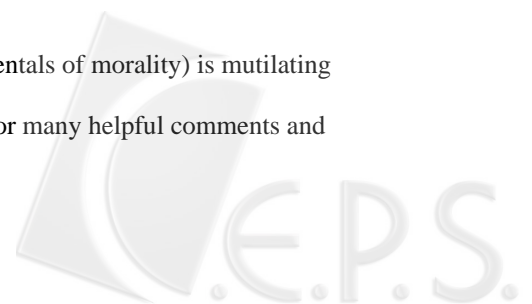
2.1 Who is entitled to interpret Confucianism?¹³

The question of this subtitle has been put forward during the discussion of my paper. As it appears to relate to a fundamental hermeneutical problem I would like to spend a few lines on responding to it. The current lack of appreciation of Confucian ethics in Taiwan and mainland China has its roots in a long history of dogmatic politics and ideologies in the name of Confucius, rendering the Classic a socio-religious icon of conservatism and notoriously culminating in the campaigns to pull down the "Confucius shop". It reminds me to some degree of the situation of a general scepticism against the "Christian" morals and ethics in my native country. It was a common sentiment, shared by many intellectuals, to point out the moral corruption of the churches who failed to interfere with atrocities, from "the holy inquisition" to Nazi terror, or even supported them. In Germany, especially during the 1970s, arguments that related to "Christianity" would likely be evoke feelings associated with backwardness, cultural sclerosis, ignorance of science and progress, conservative moralism and political bias. This reaction was obviously provoked by long term behaviour patterns of Christian institutions, especially of the churches. Traditionally, the churches had claimed an absolute legitimacy in interpreting the words and the spirit of Christianity. Over time, this practice established confusion between ethical interpretation and theological dogmatism, the former being embedded in the richness of social culture, whereas the latter is the business of only a few specialized scholars. On the other hand, as part of our real culture, many Christians laymen and independent thinkers have accounted for their own original assessment of Christian teachings, revisiting old texts and developing them in the light of new secular realities and problems, with less emphasis on dogmatic agreement with the authorities. This has fed into a general public discourse which eventually generated a more timely diversity of social mores. According to my humble view, there may be the same option for Confucian, not because it would be dignified by the ages but because it can stimulate and help the current debate about medical ethics.

I am happy to acknowledge that here I am offering a particular interpretation of sources from the Confucian canon. This implies that, first I do not believe that it is helpful to hinge on a given interpretation or common understanding of Confucianism, be it orthodox or narrated in terms of a common traditional apperception. Second, my interpretation does not represent the entire range and depth of relevant concepts and approaches in Chinese tradition, but offers an attempt to a meaningful reconstruction of its systematic reasoning in the light of medical ethics. Third, I recognize that there exist different real practices of "Confucian morality" in Chinese society, with an obvious bias in favour of justification of ingroup morality and paternalistic, if

¹² c.f. Mengzi 2 A 6, "He who claims not to be able (to understand the fundamentals of morality) is mutilating himself."

¹³ This passage reflects upon the discussion of my presentation. I am grateful for many helpful comments and clarifying statements from the audience.



not to say authoritarian interests, which obviously contradicts the substance of my own reading. This foundation of social morality reflects some patterns, which have dominated the official Confucian exegesis, especially since the times of Southern Song dynasty, and it provides little illumination of our current problems.

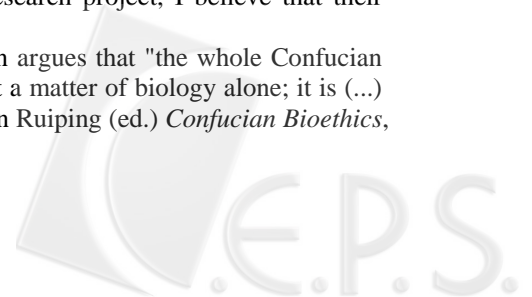
There is no reason to doubt that, regularly, students "do not like Confucianism", as explained by Nie Jingbao with reference to mainland's education and public opinion¹⁴. If theirs was the only way to employ the Chinese tradition we should better let it be. It would be misleading and a waste of time and resources in medical ethics to reiterate answers which have been insufficient in the past to approach the advanced conundrums of our days. The major purpose of my proposed interpretation is to decode these passages in terms of a meaningful narrative, consistent in the account of the text as well as accessible for the contemporary reader. This does not contradict the philological and historical approach, which necessarily follows a certain interpretative scheme as well¹⁵. This is a strictly hermeneutic approach, with a particular practical focus. It does tolerate different interpretations, and it is not limited due to the oddities of Chinese language and culture. More to the point, this approach invites, requires and logically presupposes different interpretations as part of the human project to make sense of ourselves.

Confucius and Mencius speak a language of the past, they are in principle not closer in time and culture to present China than to any other place on earth. Our bridge to their lessons is built from the materials of philological accuracy, hermeneutic empathy and reasonable argument. It requires the complex skills of exegetic sciences. Therefore, everyone who is able to make the ancient sources speak to us in a meaningful way and who is prepared to lay out his related methods and theoretical presuppositions is entitled to refer to Confucianism¹⁶. This is

¹⁴ In a letter to the author, Nie comments, "The most important intellectual reasons may be the anti-traditionalist cultural orientation in 20th- century China. Moreover, social and political criticism cannot be achieved freely, but must be under the disguise of cultural criticism. In other words, traditions, Confucianism included, are actually a scapegoat."

¹⁵ I am glad to be able to refer to the fundamental groundwork accomplished by Heiner Roetz in his outstanding and exhaustive philosophical, philological and hermeneutic reconstruction of pre-Qin Confucianism as meaningful sources for contemporary ethical discourse; c.f. *The Confucian Ethics of the Axial Age*, New York (SUNY Press) 1993; "The 'Dignity within Oneself': Chinese Tradition and Human Rights", in: Karl-Heinz Pohl, Hg., *Chinese Thought in a Global Context. A Dialogue Between Chinese and Western Philosophical Approaches*, Leiden: Brill, 1999: 236-262. Lee Minghui has offered a basic philosophical reconstruction of early Confucian ethics as compatible with fundamental liberalism and enlightenment; cf. his *Rujia yu Kangde*, Taipei (Lianjing) 1990. Lee Shui-chuen has submitted probably the most mature and comprehensive approach to Bioethics through Confucian concepts, cf. his *Rujia shenming lunlixue*, Taipei: Legion Press, 1999. Daniel Fu-tsang Tsai has proposed a Confucian analysis from the perspective of medical practice, cf. his "How Should Doctors Approach Patients - A Confucian Reflection on Personhood", in the *Journal of Medical Ethics*, 2001; 27: 44-50. Nie Jingbao has contributed to the new hermeneutic Confucian reflection of Bioethics problems in his two studies, "'Human drugs' in Chinese medicine and the Confucian view: an interpretative study", in Fan Ruiping (ed.) *Confucian Bioethics*, London (Kluwer Academic Publishers) 1999: 167-206 and "Abortion in Confucianism: A Conservative View," *Proceedings of Second International Conference of Bioethics*, Chuangli, Taiwan, 2000. pp. 130-155. Although these groundworks must be appreciated as parts of an ongoing research project, I believe that their preliminary findings strongly support my own hermeneutic deliberations.

¹⁶ In his interesting essay, "Confucian virtues and personal health", Ni Peimin argues that "the whole Confucian project is intrinsically one of health care", emphasizing that "health care is not a matter of biology alone; it is (...) a never ending journey toward the highest perfection of a human being". In Fan Ruiping (ed.) *Confucian Bioethics*, London (Kluwer Academic Publishers) 1999: 27-44: 28 and 42.



not an esoteric scholastic mind game but a venture that encourages genuine approaches to ethical re-interpretation, in the interest of people in need.

2.2 How can Confucian sources help us to assess death and dying in terms of ethics and social morality?

Regarding death and dying, the Confucian conceptual horizon differs obviously from Christian understandings, because it does not explicitly appeal to a physical afterlife. This feature it shares with the ancient Hedonists (e.g. Yang Zhu, cf. the book *Liezi*) and makes it distinct from the religious forms of Daoism and Buddhism.

Whereas death and dying are vividly present in the Confucian mind, it is well known that Kong Zi did not discuss metaphysical matters and the afterlife. What can be misunderstood as a tabooing verdict, "Do not talk about death", would more appropriately be appreciated as a reminder of our emphasis on learning how to lead a good life (which includes dying). For fundamental epistemologic reasons, we can not refer to positive descriptions and judgements about the situation of death in ethics. To acknowledge that these questions are subject for reasonable speculation, leaves room for moral and religious interpretations, which may inform the individual assessments ethics has to deal with. It is a matter of prudence and honesty that a Confucian perspective focusses on our ways to regard and deal with death and dying as aspects of life. We are requested to aspire for a way of life that is dignified at all points in time, including the end, by the moral standing of the subject. Medical ethics is designed to define the practical provisions which would allow everyone to *live a good death*. This demand, however, does neither include a general duty to discontinue a life that fails to meet such standards, nor does it tolerate *not* caring for a person in need, disregarding age and merits.

Death and dying are moments in a process of transformation of the *Dao*¹⁷. As an agent, every human being has the capacity to actively take part in this transformation. The ultimate goal it is to live a good life, namely to realize and manifest our moral capacities in whatever we do, willing only what is good in its own right. Death and dying should be understood as belonging within the scope of such a good life.

Every human being by nature cherishes physical life as something most valuable, owing to parents, forefathers and society. Yet, the mere sensual existence is meaningless without a constant orientation and adjustment according to our inborn moral sense and urge to do what is right¹⁸. This includes our interpersonal relationships above all other matters. As long as we are

¹⁷ Cf. Lee Shui-chuen, "A Confucian Assessment of 'Personhood'", in Ole Döring and Chen Renbiao (ed.), *Advances in Chinese Medical Ethics. Chinese and International Perspectives*, Hamburg (Mitteilungen des Instituts für Asienkunde) 2001 (in print). I would like to point out that this concept of the *Dao* represents Confucianism as well as early Daoist philosophy, as represented by Zhuang Zi. The topic of *Dao* as the "circle of life and death" according to this school nevertheless has a different emphasis on the oneness which tends to disregard the particular interests of the living part (in the absence of a "real and total death"), promoting a tranquil and joyful attitude towards dying as a mere stage in continuous transformation.

¹⁸ *Mengzi* 6 A 10.



healthy and fully functioning agents, attentive to our inborn knowledge, the moral sense does not fail to move and motivate us, in a quite physical sense. For example, if we see a child falling into a well, our immediate impulse is to rescue it (without any second thought); if we are confronted with the visible suffering of a creature (even an ox), we sense original sympathy; if we come across situations of gross violence, we spontaneously begin to sweat and turn away our eyes¹⁹. Of course, this infant state of our moral sense has to be informed and cultivated by our reason (*Xin, Ren, Yi*), in order to function as a reliable guide within this confusing world.

The general attitude of a *Junzi* (noble man) is to live a humane life according to *Ren*, and to be guided in his actions by his moral judgement of righteousness (*Yi*).

Dying of the body is intrinsically connected over time with our physical existence. A good life is a life where dying would not be feared at any point. However, as long as we are able to live a meaningful life, there is no justification to accelerate dying, and an unnatural death must be avoided. Even in rare and extreme situations, where it appears appropriate to die as well as not to die, it is better (that is: brave) to continue life, as an imperative of the virtue of unselfishness²⁰.

This does not suggest a negative or careless attitude towards the body on the side of Confucianism. In fact, great physicians and medical scholars subscribed to Confucian ethics, from Sun Simiao to Sun Yat-sen²¹. Our physical nature is vitally instrumental for humaneness, but not an end in itself. Therefore we must nurture and refine it.

At the beginning of the book *Jin Xin*, Meng Zi says: "He who has completely realized the capacity of his heart-and-mind understands his nature. By knowing his nature he understands Heaven (our higher nature). We serve Heaven by preserving the heart-and-mind and by nourishing our (inner) nature. If the cultivation of one's self according to (the higher nature) is not disturbed, by premature death or unnaturally long life, we (can) establish ourselves upon our given fate."²²

This passage expresses the idea of an individually given life span, which is neither cut off nor arbitrarily prolonged. By all means we should try to avoid a premature death. A humane (*Ren*) person is tranquil and healthy because he focusses on the essentials of life, nourishing nature by morality. "Those who are humane shall live long"²³. It is therefor irresponsible to

¹⁹ *Mengzi* 3 A 5.

²⁰ *Mengzi* 4 B 23.

²¹ Cf. eg. Zhang Daqing and Cheng Zhifan, "Medicine is a Humane Art: The Basic Principles of Professional Ethics in Chinese Medicine", *Hastings Center Report*, Special issue, July-August 2000: 8-12. The fact that many scholars refer to some kind of "Confucian" inspiration in recent medical ethics related literature does not suggest that it is actually legitimate to address the quoted physicians as models for a Confucian Bioethics. Although I strongly argue in favour of a reconstruction of Confucian ethics in terms of contemporary medical ethics issues, I acknowledge that such a work should be based on solid philologic and hermeneutic research. The very meaning of "Confucianism" is part of a related research programme.

²² *Mengzi* 7 A 2.

²³ *Lunyu* 6.21.



stand under a trembling wall²⁴ and to travel areas of war without strong reasons. Dying „naturally“ at old age must be distinguished from a „premature“ death. Everyone has the obligation (towards himself and his relatives) to fulfill his given life span and to make best use of it. On the other hand, society, physicians and political decision makers have the duty to provide the necessary conditions for everyone's life to become fulfillable and to assist each others in this quest as best as we can. This refers to everyone, including infants and prenatal human beings.

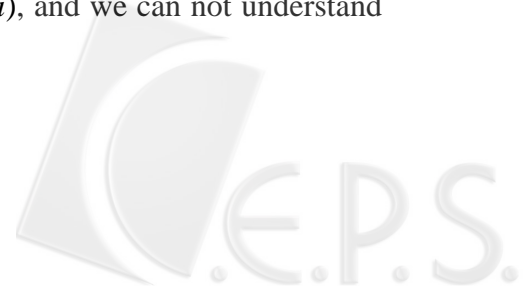
Yet, how does this concept of a natural lifespan make sense under the given conditions of invasive biomedicine? We have achieved a state of the art of medical technology that renders the ancient intuitive certainty of the concept of a natural death hard to maintain. As soon as we are able to introduce artificial life sustaining measures, a "natural" or "mature" death can not be inferred from the empirical description of a case of death. Instead, it becomes a subjective issue which largely depends on every individual's understanding of his or her fulfilled and meaningful life (and death). At the same time, the verdict against an arbitrarily prolonged life does not help us much. Historically, it is aimed against some religious Daoist attempts "to overcome death". From a Confucian view, the fear of death is always secondary to the motivation to be righteous. If the obsession to continue one's physical existence overrules the determination to realize one's moral capacities, this life becomes meaningless. However, in many cases, modern biotechnology, together with pain therapy (or relief) and socio-psychological counseling offers a real chance to maintain, and even to regain a meaningful life. Therefore, it goes quite well hand in hand with the Confucian concept of a good life, although we may not refer to this life as being "natural" in a naive sense any longer. As long as a human being preserves his capacity to act according to his deontologic ideal, he deserves to receive all due social, spiritual and moral respect and best treatment of a moral person. (This statement implies no judgement about withdrawing the respect if these conditions have seized to persist).

As a consequence, we can not simply refer to natural death any more, but should focus on the meaningful life of the patient and the conditions for dying in a sense of having lived a fulfilled life. One should be able to die at ease, exactly because life has been meaningful²⁵. In a medical context, this urges us to highlight the interpersonal relations, including the relationship between doctors and nurses and the patient, the family and society, together with our understanding of care, as an avenue of moral life. Inasmuch as other people are required to make someone's life meaningful the nature of humans as social beings urges us to approach ethical problems in medicine in terms of interpersonal relation and their governing principles.

The first and most general ethical principle in Confucianism is humaneness (*Ren*). As human beings, we can not practice *Ren* without righteousness (*Yi*), and we can not understand

²⁴ *Mengzi* 7 A 2.

²⁵ *Mengzi* 1 A 3.



Yi without *Ren*. One of the functions of *Ren* is filial piety (*Xiao*). As an original moral sense, it is something that can not be learned in the first place, but is born with every human being²⁶.

Because filial piety is often believed to constitute the very core of Confucian ethics²⁷, I would like to clarify that this is not the most appropriate way to make sense of this concept and its ethical framework for our present purposes. The Classics, at least do not recommend a such a way of reading. Addressed as a virtue, *Xiao* is expressly called a valuable "fruit" (*Shi*) of humanity, an application of *Ren*, and a fine seed from which to cultivate an attuned moral life²⁸. In the same line of thought, it is imperative to learn how to "treat the older as an older" (*zhang qi zhang*)²⁹, the "brother as a brother", and so on (including the other three, husband-wife, ruler-citizen, friend-friend, that make together the "Five Relationships", *Wu Xing*). The Confucian programme of the "restitution of correct names" (*Zheng Ming*), that is in general attempting to establish a morally truthful use of language, with regard to human relationships explores the concrete normative import of humaneness (*Ren*) as related to all different kinds of social relationship. The principles of humaneness and righteousness are adjusted by socio-moral empathy, or reciprocity (*Shu*), which should be present in all interpersonal relations if we wish to do right. In principle, there is no regional limitation of the range of humaneness. It is the very nature of human beings to be capable of realizing their moral character.

Xiao must go along with respect (*Jing*). If it does not, it means no more than caring for horses and dogs³⁰. The needs of the body are not all. The sufferings of the patients go beyond physical pain. In fact, respect to biology should not dominate but be regarded as subordinate to meaningfulness and dignity. This effects our attitudes toward patients who face a "certain death". People with multiple organ failure, for example, or cancer in the last terminal state, can not be regarded as living cadavers who just wait to pass away. Dying people are alive as long as they are not positively dead. They deserve and need the best of our humanity, that is to prepare them to die in a meaningful and dignified way. The appropriate way to respond to queues of people in emergency rooms who wait for the dying one's to "resume the bed" is not to rush but to call for more beds, more personell nad better facilities. How can we maintain the ethical imperative of medicine, when in the most crucial moment, where humanity must overcome biology, we calculate the futility of odds and resort to the biased conception and language of utility. The burden and joy of care can not be carried by the caretakers but by the caregivers only, that is any civilized society. Whenever we care, we should take our time and pay utmost attention. If caring is not a real pleasure, if caregivers only "pretend a smiling face" than it is hollow and unethical, namely without *Ren*.³¹ This is most evidently that this refers to dying patients in particular.

²⁶ *Mengzi* 7 A 15.

²⁷ For example, cf. Fan Ruiping, „Self-Determination vs. Family-Determination: Two Incommensurable Principles of Autonomy“, *Bioethics* Vol.11 No.3&4, 1997: 309-322

²⁸ *Mengzi* 4 A 27.

²⁹ *Mengzi* 4 A 11.

³⁰ *Lunyu* 2.7, 2.8.

³¹ *Lunyu* 1.3, 17.15.



Meng Zi makes it quite clear that the "parents of others", or elderly people in general, are to be included in our moral considerations. "Treat with respect due to the aged your own family's elderly, so that you become able to treat the elderly in other families alike. Treat with affection due to infants the minors in your own family, so that you become able to treat the infants in other families alike."³²

More generally, solidarity with people in need and despair is imperative³³. It is the commitment of the state to make the people wealthy so that no one lacks the basics³⁴. Whereas the principle of humaneness relates to all human beings, the ways to act accordingly may differ, according to the actual relationship between the agents involved in a given situation. For example, if I find somebody being about to murder someone, I shall try to interfere. Yet, I will do so in a more moderate manner in case of a stranger than in case of someone closely related to me, because the stranger might rather listen to that kind of intrusion, and the relative might be more perceptive for my emotional and direct plea³⁵. It is a mere matter of prudence to apply the universal principle of *Ren* on the basis of sound information according to the respective situation.

In clear contrast with a common preoccupation that renders unconditioned reverence towards one's parents an intrinsic concept of Confucianism, Confucian ethics does exclude any notion of an unqualified material principle in ethics. All principles are qualified by their relation to the regulative principle of *Ren*. (This applies for the assessment of *Ren* as a virtue as well). All moral duties are reciprocal. A King may only be called a king (*Wang*) if he embodies highest virtue and serves the people, or else he is called a true usurpator (*Ba*). Parents must respond to filial piety with parental love (*Qin*), whereas children owe them gratefulness and respect³⁶. Only the systematic reciprocity of our moral obligations may represent the wealth and meaningfulness of *Ren* in changing social situations.

Thereby we are encouraged to be independent thinkers and judges by ourselves, as to how humaneness must be observed in any given situation. Accordingly, it is the highest goal in ethics education to encourage the students' hearts-and-minds to cultivate their humaneness so as to prepare them for independent and creative reasonable judgement and flexibility under changing situations with always new people to care about, but not to make them "repeat what the teacher says"³⁷. For example, for a mature adult to play the foolish child in front of his old parents in order to entertain them as a "good son", if they will so, is not only a perversion of

³² *Mengzi* 1 A 7.12.

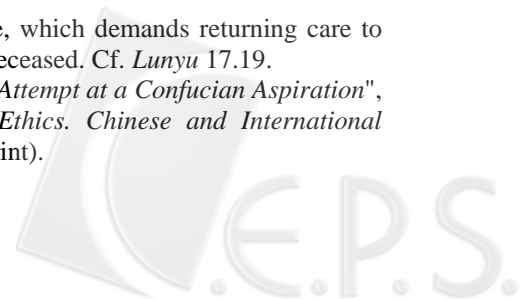
³³ *Lunyu* 16.4.

³⁴ *Lunyu* 13.9.

³⁵ *Mengzi* 6 B 3.

³⁶ Even *Xiao* can be rationalized as based on the experience of parental care, which demands returning care to them when they need it, or to "give back through three years of grief" for the deceased. Cf. *Lunyu* 17.19.

³⁷ Cf. Ole Döring, "Moral Development and Education in Medical Ethics. An Attempt at a Confucian Aspiration", in: Ole Döring and Chen Renbiao (ed.), *Advances in Chinese Medical Ethics. Chinese and International Perspectives*, Hamburg (Mitteilungen des Instituts für Asienkunde) 2001 (in print).



"filial piety" (*Xiao*), but also a violation of humaneness and respect due to the parents³⁸. A young man does not under all circumstances have to ask his parents for permission to marry, because, evident for everyone, it is the intrinsic imperative of *Xiao* that he builds a family in order to procreate and hence it is the related parents' duty to permit it anyway³⁹. The general moral rules (*Li*), a common set of instructions including models for moral action, are not dogmatic principles but subject to interpretation according to the real context of an action (*Quan*). Whereas it would be inappropriate for a man to touch the hand of his sister-in-law under conditions of regular social life, it would be a moral outrage if he refused to lend her a helping hand to rescue her from drowning in a pool⁴⁰. Situations of emergency or other urgent necessities or unprecedented cases strongly require our moral senses to act freely, without respect to any of the elaborate rules which must be followed under normal conditions. This has a particular impact on medical ethics, because medical situations are regularly situations of crisis, emergency and existential necessities, without room for socio-moral niceties. Independent moral judgement on the basis of well trained practice of *Ren* is therefore a basic qualification for medical professionals inspired by ethics.⁴¹

3 Can the Dutch law, or any given law, be a model for Korea and China? The imperative of care

In this light, I will now investigate the Dutch law, as a potential model for other countries, with a special interest in its applicability in different socio-economic and cultural settings. The law defines three major criterias which combined constitute the terms under which euthanasia may be performed. The patient has to (1) experience irremediable and unbearable suffering, (2) be aware of all other medical options and (3) have sought a second professional opinion. The request has to be made voluntarily, persistently and independently while the patient is of sound mind. I shall take the third criterion for granted here, that is professional counter-check. From an ethical perspective, I have serious doubts about the first and the second criterion, namely that a certain degree of pain must be diagnosed and that the patient has to "be aware of all other medical options".

As to pain. At the first glance, this appears to be quite a humane and practical criterion. However, closer empirical inspection reveals that it is highly ambiguous. How do we know about agony, and who decides whether our understanding and related action is accurate? What is the nature and cause of pain? Physicians in palliative medicine report many situations they describe as pain in reality being a "cry for help". We ought to bear in mind that acute pain usually functions as a natural indicator for problems, and it is our task to study this language

³⁸ This incidence is narrated in *Xiaojing* 10.

³⁹ *Mengzi* 4 A 26.

⁴⁰ *Mengzi* 4 A 17.

⁴¹ An interesting interpretation of Chinese traditional thinking about suicide and euthanasia is offered by Lo Ping-Cheung in his essay „Confucian Views on Suicide and their Implications for Euthanasia“, in Fan Ruiping (ed.) *Confucian Bioethics*, London (Kluwer Academic Publishers) 1999. Also cf. George Khushf's comment in the same volume.



deligently. Whereas acute pain may suggest that a curative medical approach is indicated, chronic pain can not be treated in the same sense, but calls for more comprehensive approaches to pain management, which may include sufficient quantities of narcotic analgesics, especially for dying patients.⁴² To base an action on a mistaken understanding of the cause of pain can easily result in torture, especially if the patient is entrapped in a weak body. Pain may indicate the feeling of meaninglessness, abandonment, unresolved problems, and so on, amounting to a complex socio-psychological syndrom, expressed through psycho-somatic symptoms. Unfortunately, pain research is fairly underdeveloped. One of the leading experts and pioneers in pain research and pain therapy in Germany, Michael Zenz (of Bochum university) emphasizes that only a small proportion among the patients who express that they want to die, or demand to have treatment withdrawn, actually wish to end their life because of unbearable pain but because of a reluctant application of morphin. In fact, cases have been reported which suggest that lack of medical attention or even malpractice, such as inaccurate administration of drugs, or improper resuscitation, might motivate some of these pleas. Patients may desire to escape a situation they perceive as a trap with no other way out, by seeking death.

As to the "options". I believe that, first, "all medical options", as conventionally understood in a sense of curative medicine, are not necessarily sufficient to help the patient, (even in medical terms). Even if we accept the curative paradigm, it remains difficult in many cases to define the accurate line of medical futility. Also, the range of medical options is not exhausted where painkillers and technical devices fail to have an effect. The art of medicine invites doctors together with the nursing team to become interdisciplinarily creative, changing perspectives in order to invent adaptable measures for individual situations⁴³. Physicians should be encouraged and allowed to resort to the sources of their professional and humane imagination, seeking new ways in healing and communicating hope to the patient. The old remedy of the "human touch" could be strengthened again in clinical practice, permitting the members of the medical team to share their genuine affection with the suffering patient and being present as companions in bedside care. Both, therapy and nursing deserve it that more time is spent with and on the patient. The fact that real clinical conditions frequently rule out such a humane medicine does not defeat my argument but points at flaws in the present system. These flaws should be mended, given that we really wish to achieve the best possible medical system. And they probably could be healed in the spirit of Palliative care, that is the special care of a person whose disease no longer responds to treatment aimed at a cure. Palliative Care has the goal to provide as much freedom as possible from suffering, by giving physical, emotional, mental and spiritual comfort. It tries to relieve from suffering and to promote the best quality of life for patient and family. As it does not hasten or delay death it does not play a biased role in euthanasia. It focusses on a human diversiry of symptoms, ranging from pain over depression, fear, loneliness, and the search for meaningfulness or God.

⁴² Cf. Zenz and Ilhardt (2000): 9f.

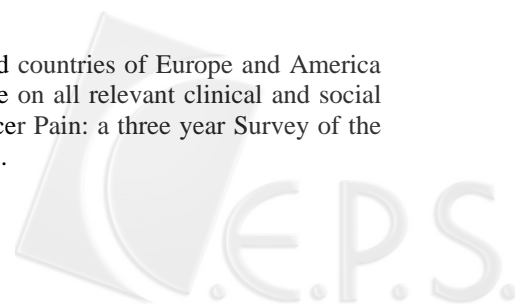
⁴³ Cf. Zenz and Ilhard (2000): 10.



Second, I would like to respond to the Dutch law that in situations of severe chronic pain the curative medical approach, even if based on the most humane purposes, is not the best way to treat a pain patient. For chronic pain patients, palliative medicine in its original sense suggests itself as probably the more ethical approach. Interestingly, here a Confucian assessment meets in substance with the state of the art in "Western" medicine⁴⁴. There are many practical ways in which to provide meaningfulness for some chronic pain patient and restore a sense of belonging, helping him to restore his strength to endure, assisted by reasonable medications. Some of them include direct interpersonal activities, which reinstall the sense of appreciation of the patient as a human being. We could be more creative and invent new methods. Why, for instance, are we keeping elderly people apart from children? For example, many old people may simply miss the easy mind of a child, meanwhile many children grow up without a sense of time and history. Who would not prefer to live in a society that brings its lonesome children and abandoned seniors naturally together for mutual benefit, if this is feasible? Palliative care and hospice work ought to be connected with social counselling and social work of many kinds, which might open new opportunities for the patient to connect to life. Such a policy will with no doubt enrich society.

I do not recommend that the Dutch law should be a model for legislation, neither in Korea nor in China. At least, it does not cater for the interests and the needs of the patients first. It is clearly in the enlightened interest of doctors who do not wish to work in a "fuzzy area of law". In their work, they depend upon a legally viable definition of allowed and not allowed practices of "euthanasia". This is by all means a legitimate interest on the physicians' side. However, notwithstanding this legitimate claim for legal safety, the focus of ethics includes the legitimate interests of all parties involved, with a special alertness to the less privileged. Such a law could be practical at best as small part of a greater project to reform society, with an emphasis on healing the country, the people and the diseases. As it has been discussed in the conference, it seems that about six lawsuits had been filed against doctors who had withdrawn life-sustaining measures according to §43 of the Taiwanese Health Care Law. It is certainly a great success of patient rights movement and civil society that the respective legal text has been revised and that the revision is now in force. However, why was this initiative necessary in the first place? As Tsai Fu-tsang (Taipei University's Medical College) pointed out, the revision makes no difference as regards the real medical situation and its professional and ethical evaluation. No doctor had been found guilty of any crime or offence under the conditions of the earlier law who would now go unpunished. Even under the old law, relatives could have asked for condemnation of a resuscitation practice that becomes unethical when it is more torture than assistance. Therefore, the revision of the law does not really help to change

⁴⁴ In referring to the state of the art I do not wish to suggest that the advanced countries of Europe and America have already drawn the practical conclusions from sound theory and evidence on all relevant clinical and social levels. For example, c.f. Michael Zenz et.al., "Severe Undertreatment of Cancer Pain: a three year Survey of the German situation", *Journal for Pain Symptom Management*, 10 (1995): 187-91.



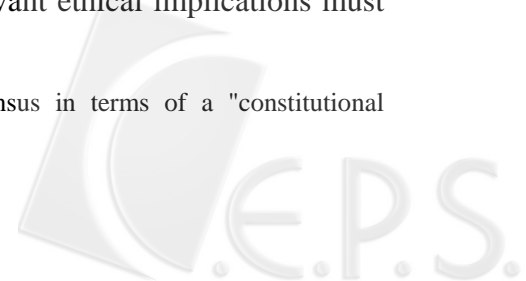
the real situation. But nevertheless, it might have its most significant outcome in reducing the incidence of litigations. It seems to cater more for an interest to keep a low public profile, according to the motto "no legal affair is a good affair". This bias is not recommended under the conditions of a democratic society where, in fact, the public's attention provides a key to legitimacy and competent independent judges guarantee fairness. What would be wrong if there were even more lawsuits, given that medical practice is continuously performed on the basis of best standards? Many countries have learned to live well with legal checks, as a means to control and remind physicians of their peculiar social and individual responsibilities. On the other hand, if citizens do not trust in their laws and courts but feel that "a lawsuit is a sentence, no matter the verdict", this indicates a serious problem on the side of political culture and legitimacy of constitutional organs. The focus on positive legal action under these conditions can be misleading if the fundament for a state of law, namely a basic social consensus⁴⁵, is not well established. It would appear just as taking the third step earlier than the first. We can not provide a meaningful death without caring for the meaningfulness in life. Good laws and sound policies can only serve their purpose as functions of humane culture.

Care in Confucian terms means both, to *care about and for* one's self and others. This circumscribes a strategy of humaneness. The meaning of the "quality of life" is essentially a personal issue, depending on the individual's stage of moral development. Therefore, it can in principle not be assessed by general criteria. However, we may refer to procedures that allow for a tentative estimation of the individuals' needs and his real will, such as through advance directives, other positive statements of the patient, or accounts of the presumed will, a profile of the character drawn by close relatives and friends. As a lesson from our extremely paternalistic past, in Germany, it has become legal practice to appeal to the *real will* of the patient, be it outspoken or assumed, whenever a case seems to include a contradictory conflict. In other words, the final decision after a long and thorough process of consultation and deliberation is not made under the paternalistic principle to "act in the (assumed) best interest" of the patient, but to "act in his (most probable) real interest". If we can, we always have to ask the patient what he wants. (In the special case of emergency situations, if no time for confirmation of the will is given and no further evidence can be provided, the chief task is to restore the patient's capacities for competent decision making.) A Confucian might explain that this is a sound policy, because, in the most extreme situations, physical life is less important than moral self-determination.

4 Concluding remarks

It is evident that biomedical progress urges us to revise traditional ways to assess dying. Our powers to interfere and thereby to do good or wrong to people have increased dramatically. Our related capacities to understand and make sense of the relevant ethical implications must

⁴⁵ Germany has, to some extent, been successful in defining this consensus in terms of a "constitutional patriotism", as different from nationalism or chauvinism.

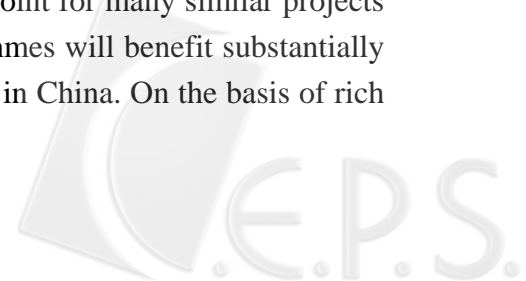


be developed in order to let us cope with this situation. Owing to the diversity of individual characteristics of dying situations we can hardly hope to find clear ethical guidance, but we need to strengthen decision making capabilities. A related initial step would consist in realizing and establishing a better understanding of the meaning of life in the light of dignified death and dying. Such an understanding might be achieved best by understanding the individuals who we refer to as subjects, clients, patients. We ought to rediscover them as human fellows whose process of dying reflects our own moral maturity.

Ethics education in medicine is an obvious key to facilitate this understanding and the resulting humane competence. It is also self understood that this education can not be designed according to the traditional models for training and teaching, but must be suitable to stimulate creativity and individual decision making ability, giving back part of the absolute authority of teachers to the students. Case orientation, early access to clinical practice and role plays should be part of such an education method as well as plain language and clear ethical concepts.

However, education of this kind should be framed by education of society in general. The related sciences and policy makers need at first to build a solid empirical basis for these activities, seeking more and more accurate first hand information about the real interests of terminal patients. Much more work should be dedicated to understanding of the real situations of patients who request withdrawal of treatment or ask for active euthanasia, as a basis for building an informed policy and practice. To know that these people belong to a Chinese (or any other) community in some sense does not help us. We need to understand what they really believe and want individually, even if the results confirm that they adhere to "community" based morals. In fact, such an orientation needs to be confirmed and analyzed empirically before any normative judgement may take place.

A recent example from mainland China might be an encouraging signal for some change in the right spirit, even under unfavourable socio-economic conditions. The Dalian municipal has launched a research project in February 2001, investigating the background of requests for withdrawal of treatment for terminal patients receiving home care. This pilot project is conducted at the First Dalian Medical University Hospital, directed by the university's president Jiang Chao, and involves 100 patients. A team of 3 doctors, 4 nurses and a driver, supplemented by post-doctoral medical and psychology students visit the patients in their homes and inquire into their living conditions, their family situation and their real wishes. Care and consultation is offered as well as mediation of social workers' services. The study is funded by a grant from Hong Kong businessman Li Jiazheng, amounting to annually 1 million RMB over 5 years. It is hoped that this will not only provide more adequate understanding of the nature of the really needed help, but also serve as a starting point for many similar projects all over China. It can be foreseen that social and medical programmes will benefit substantially and that in particular the Hospice movement will get momentum in China. On the basis of rich



empirical data covering a representative part of Chinese society it will be much easier for Chinese ethicists to arrive at a sound advice for how to deal with the issue of euthanasia. The advice could in part be as simple and obvious as the world wide evidence suggests: we ought to become more reasonable in administering morphine derivatives so as to relieve some of the chronic patients' pain, and we ought to promote palliative medicine as a new model for a humane medicine.

In more general terms, we should take serious the concern about bio-reductionist attitudes and reduction of political engagement for the sphere of mere legal aspects of biomedicine as well as worry about the increasing degree of socio-economic pressure on all levels of medicine and health care. It seems that developed countries, such as the home of modern health care and social insurance systems itself, first designed by Duke von Bismarck in Germany, take a sad lead in offering humane reasoning on the altar of economic rationality. When reduced budgets and rising expenses define the real practical range of medical work, it is time for us to clarify the priorities in clinical decision making. Under conditions of economic pressure and social fragmentation, especially when given a lack of the most basic moral orientation in a society, any debate about euthanasia is untimely. Instead, the economic pressures ought to be relieved first, because individuals' health and a healthy society constitute a major resource for stability and prosperity. Accordingly, attempts to develop a civil consensus, expressed by a culture of law in a civil society ought to be fostered. A Confucian view recommends that we put less emphasis on economics, technology and mere law, but focus more on the humane foundation and mission of medicine. Economy, technology and law are *instrumental* for ethics, nothing more or less but servants for humanity. The related rationalities must not overcome the principal reason of humaneness and righteousness.

In practical situations of medicine, the ultimately guiding question from an ethical standpoint ought to be: Which kind of society do we really wish to live in and what kind of life do we really wish to live? If it is feasible "to heal sometimes - to relieve often - to comfort always", as palliative medicine in a nutshell promises, then we ought to act accordingly. A Confucian perspective might help us to assess an ethical medicine in light of the social mission of medicine. We would try our best to become more humane in acknowledging dying as part of life, and good care as the essence of medicine always.

