Chapter 8
Family Consent in Medical Decision-Making in Taiwan: The Implications of the New Revisions of the Hospice Palliative Care Act

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8.1 Introduction

The second revision of the Hospice Palliative Care Act added a new criterion that allows for a patient's family to petition for the withdrawal of life sustaining treatment if a terminal, incompetent patient's wishes are unknown and the patient satisfies DNR criteria. In the third and most recent revision, the requirement of consulting an ethics committee has been removed. These changes reflect the long established practice of family consent in medical decision-making in Taiwan as well as in Confucian cultural contexts. This paper presents some of the key features of this practice and the attendant rationale for family decision-making in hospice care. It argues how and why family decision making is beneficial for both the patient and the family as well as for medical professionals. Some short-comings and difficulties are discussed and solutions proposed. This paper also examines how family consent and the mediation of medical professionals can enforce and protect the best interest of the patient.

This paper ultimately proposes a Confucian model for medical consultation and argues for the cooperation of the patient, the patient's family and relevant medical professionals in making decisions that best reflect the will of the patient and reduce the suffering of the patient and family members. Further, it will be argued that family participation should be extended to and used as a model in other bioethical contexts. To conclude, the underlying core Confucian values and ideas for family involvement and medical consultation will be highlighted and developed by contemporary Neo-Confucianism.[1]

[1] The contemporary Neo-Confucianism referred to in this paper is the so-called third generation of Confucianism, that is, the successor of the pre-Chin Confucianism of Confucius, Mencius and Xunzi, and the Song-Ming Neo-Confucianism. The main figures include the late Professors Tang

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8.2 The Development of the Hospice Palliative Care Act in Taiwan

As medical technology and treatment have greatly improved in Taiwan, more and more lives have been saved and some have been sustained or prolonged in vegetative or semi-vegetative states. During the late 1990's, only about one-tenth of terminal cancer patients obtained hospice care while the rest occupied a large portion of intensive care facilities, resulting not only in a great demand for medical care, but also causing needless harm to patients and family members. Since laws in Taiwan require saving the patient at all costs, natural death is uncommon and end-of-life treatment becomes a last torture rather than a comfortable farewell to family and friends. Consequently, it has become more and more urgent for Taiwan to establish clear legal procedures for guiding end-of-life treatment. After years of vigorous debate, "do not resuscitate" (DNR) orders, as part of the Hospice Palliative Care Act, were finally legislated into law on June 7, 2000. The law's title suggests that its content provides for palliative care rather than directly addressing the ending of life for terminal patients. Reflecting the taboo surrounding this issue, some medical professionals will not mention "letting die" or "death" when referring to the law. However, the law addresses allowing terminal patients to die with their consent, DNRs, and withholding of other related invasive treatments. This is the first law to break the engrained medical tradition of saving patients at all costs, providing a first step towards solving some of the grave problems facing terminal patients, their families and medical professionals.

However, as it originally stood, medical professionals found the law to be almost useless because it only addressed the legal process for withholding life-sustaining treatments. When a patient was rushed in, in most cases, it was unclear whether the patient had a DNR order and it was rare to have two doctors available to certify the patient fit the legal criteria. At the same time, other medical laws required the immediate provision of life-sustaining treatment. Additionally, no law provided for the withdrawal of life-sustaining treatment once it had begun. Thus, the law was practically useless.

After two years revisions were clearly necessary. The second version of the Act allowed for the withdrawal of life-sustaining treatment if the patient's condition satisfied the requirements for withholding such treatment. This revision did make the law workable. Further application of the law meant further difficulties because patients usually entered a coma or became incompetent. According to the Act, if a patient did not have a DNR order in place prior to entering an incompetent state, life-sustaining treatment could not be withdrawn. This led to further revisions and protracted debate due to its introduction of family surrogacy when the patient's wishes are not clear. The debate reflected the deep-seated differences between the traditional Confucian acceptance of family involvement in medical decision-making and the disposition of some medical professional to respect patient autonomy.

Chun-i, Mou Tsung-san and Hsu Fu-kuan, who have written influential classics on Chinese and Confucian philosophies.

8.3 The Rationale for Family Involvement

The main revision included in the Act's third version introduced family members as surrogate decision makers when the patient was in a comatose state or incapable of making known his or her will. The Act outlines how the patient's family can arrive at a decision to enact a DNR when the patient is comatose, incompetent or under the legal age. It should be noted that family involvement is permitted only when the patient loses competency. This means personal choice still remains the foundation for decision-making. The Act also specifies that a family decision cannot contradict the explicit will of the patient before entering into a state of incompetence. The Act is written with Western priorities, that is, with the spouse, adult children, grand children, parents, brothers and sisters, grandparents and so on in that order. In cases of conflict, family members given priority on this list can overrule the decisions of others. The Act also guards against abuse or neglect of the patient's interests by further requiring that in such cases an ethics committee must be consulted. Consequently, it is clear that the third version of the Act is in line with the mainstream thought of Western bioethics. It is clear that family surrogacy is introduced because the patient's wishes are unknown and needed for the purpose of end-of-life decision making. Family decision making is crucial and necessary in such cases, but it is not a mechanism capable of overruling the personal decision of the patient.

However, in practice, family consensus is the aim of the Act and medical professionals usually uphold it. Even in cases where a DNR is in place and the patient's condition fulfills the required criteria, if there are family objections, medical professionals will not take the actions prescribed by the Act. This shows that family consent is paramount. In many cases, the presence of all relevant family members is requested. For example, in determining critical medical treatment for a parent, the consent of all brothers and sisters is usually requested. Even if the spouse and elders are present, medical professionals insist that other known family members be present before the final decision is made. In non-urgent cases medical professionals usually request the family members hold meetings to arrive at a consensus decision before taking further action. There have been cases where reasonable decisions were made and later contested by absent family members who blamed the medical professionals for acting against the will of the deceased patient. Sometimes extended family members, such as uncles or cousins, participate and are involved in the final decision. It simply is not true that family members with legal priority necessarily make the final decision. It is in practice that the significance of the Confucian concept of the family is recognized as a decision-making entity.

Family involvement appears to bring to the bedside a complicated decision making procedure that sometimes leads to disaster or a delay in treatment. Some also doubt the legitimacy of family participation and see it as a violation of the patient's right to make his/her own medical decisions. However, because the family is a closely knit and sharing unit, its members do not only share household expenses, but also intimate experiences and affection. Because family members share common experiences that constitute their self-identity, family members usually have a strong identity with their family and with each other. Joy and grief are shared and

not just observed like bystanders. Strong sympathetic or empathetic feelings usually exist between family members. In Taiwan, it is said that when one family member is sick, the whole family is sick. The pain of a patient is also the pain of their family members, much like how a mother very often feels more pain with her child's illness than her child. Mutual concern and intimacy derive strong mutual responsibilities that naturally develop into a kind of care and duty to each other. End-of-life decisions are especially critical and painful for the patient and the family.

In Taiwan, family relations are generally still very intimate and family involvement in all kinds of personal activities is common practice. Medical decisions are no exception. Even though family members may not be living under one roof, they still share household expenses, the joy and grief of the family, and take strong responsibility for each other. For instance, a family member usually accompanies the patient when seeing a doctor and they receive the diagnosis together. Family members very often are the main respondent to queries and instructions from health professionals. The medical law in Taiwan is even written in such a way that diagnoses and results can be disclosed either to the patient or to the family, and in some cases the diagnosis is not made known to the patient at all. Family members can provide the most needed help and trust when one is sick and vulnerable. Family members are also usually a reliable source of the patient's values and preferences, which provides the best guidance for treating the patient and grounds the medical decisions for the health professionals. In cases of terminal illness, the family's legitimate participation is critical because it is often the case that the wishes of an incompetent or comatose patient are unclear for health professionals trying to determine which alternatives to deploy. The family as a whole is usually competent to make such a decision. This may help health professionals avoid some of the hard moral dilemmas. On the other hand, family participation is also useful for preventing the abuse of the weak and lonely patient by health professionals.

It should be acknowledged that family participation sometimes makes cases more complicated and sometimes can result in a deadlock. One common problem is when family members cannot arrive at a consensus among themselves. Family members may have significant disagreements about what is the best for the patient. The need for family discussion is important. Here medical professionals and ethics consultants can assist in conducting and moderating family meetings. Medical advice is important for preventing misunderstandings and unfounded worries about the medical possibilities. Ethics consultations can also clarify and reduce mistaken conceptions of the ethical and legal responsibilities involved. The hope is that through good will family members will arrive at a reasonable and harmonious decision. Through open discussion medical professionals can learn not only about the differences expressed among family members, but also about the family's structure and the values and preferences of the patient and the family as a whole. With such understanding, in cases of deadlock, medical professionals would be better able to protect the best interest of the patient. In cases of malicious manipulations, medical professionals are usually powerful regulators and protectors of the vulnerable patient. Since family members may be far apart and untraceable, the Act specifies

how a family decision can be made without all members present and also provides a priority ranking of the family members in case deadlock occurs.

There may be instances where the family makes a choice that does not benefit the patient or is against the patient's expressed will. In such cases, medical professionals need to use their best judgment in managing the final decision. In cases of apparent abuse, medical professionals need to have courage and the support of the hospital and their colleagues to fight for the patient's rights and best interest. In cases of deadlock, one might consider the family as temporarily dissolved and the individual as temporarily constituting the family—one person is one family. In such a case medical professionals should employ their best judgment to treat the patient in line with his/her best interests.

A small puzzle may be what constitutes a family in modern society. In this essay, it shall be defined as one with the basic natural family as its base, usually containing those living under the same roof. Since members of Chinese society share household expenses even if they live and work in other cities or countries, these individuals are also regarded as family members. Sometimes, people with no legal status, such as partners or friends living and sharing together like family, are also eligible for membership. In such cases it is better if the patient has properly confirmed such a partner's membership in his/her family. It is often the case that a key person in the family is someone who does not belong to the family at all. It is supposed that this key person can represent the values and preferences of the patient and, therefore, his/her opinions should be consulted and carefully considered.

8.4 The Incorporation and Elimination of the Ethics Committee

In the case of DNRs, family consensus and decision is vital. Proponents of the Act largely include families who have had a terminal relative suffering the great pain of dying and those health professionals who take care of medically hopeless and suffering patients. Health professionals and hospice services in Taiwan will not accept a decision made by one or some family members without the consensus of all known family members because they are afraid of endless protests against them if a family member was not told of the decision and would have opposed the DNR if informed.

In order to prevent the possible abuse of family members, the third version of the Act requires an ethics committee be set up to make the final decision. It is not that medical professionals favor individual autonomy and the rights of the patient, but rather it is a check to guard against family members abusing the incompetent patient. It is necessary to be careful about such issues when preserving family involvement in medical decision-making, especially concerning end-of-life cases, because there are in fact tensions between patients and family members in East Asian societies.

In the old traditional Chinese family, there is no doubt that family members were more intimate and ethically related in almost all kinds of individual and family

activities. Medical decisions were usually made in the best interest of the patient through a harmonious consensus in which everyone was satisfied. However, there were abuses, exploitation, and suppression of the wishes of vulnerable family members by those with superior power in the decision making process, especially the ruling father or some other person. Although family ties are still strong in modern Asian societies, it is obvious that they have weakened and diverse personal interests have become a part of modern life. Conflicts abound between family members. In medical decision making, decisions reached by patients or family members are usually other-regarding and self-sacrificing, however, it should be acknowledged that there are obvious cases in which a conflict of interests between the patient and family members, or amongst individual family members, may lead to the unnecessary suffering of the patient and a difficult moral dilemma for the relevant medical professionals. In the Act's third version, an ethics committee is required to review the decision. This is a reflection of the concern of medical professionals and bioethicists in Taiwan that the family could abuse the Hospice Palliative Care Act. This requirement is understood as shielding medical professionals from the burden of denying a family decision as well as providing critical protection for the benefit of the patient.

However, a similar problem arises for committee members. In one case reported by ethics committee members involved in the decision, the committee refused a reasonable decision arrived at by the head physician and the major family members for a DNR because some committee members were worried about accusations by other opposing family members. Requiring an ethics committee review can be seen as a result of the growing distrust of physicians and families in such cases of life and death decision making. In fact, the traditional mutual trust between physicians and patients has eroded over time because medical professionals have begun to protect their own interests and shy away from accusations brought by patients and their families. Understood as such, the ethics committee basically serves as a veto power in the decision making process.

The composition of the ethics committee includes members of fairly diverse disciplines and different walks of life. The ethics committee is meant to be representative and more objective in evaluating cases because they are less affected by personal predilections. However, committee members are usually somewhat detached and thus cannot meet the intensive commitment required for end-of-life decision making. Since such decisions require highly emotional and committed participation, it is not easy for someone removed from the patient's suffering and death to make a proper decision. The patient's family members actually share in the suffering. They are not and could not be bystanders. They are in deep emotional as well as moral dilemmas. It runs deep for intimate family members. Hence, their decision is critical and should be respected. Medical professionals are also supposed to be as concerned as the family members. In Chinese medical tradition, medical professionals are expected to treat the patient as they would be relatives and family members. Those called Confucian doctors have great compassion for the suffering patient. Hence, even though medical professionals may not be as affected as family members, they are committed to the patient as well. However, it is different for ethics committee members. As a fourth party in the decision making process, and very often not really

involved with the patient or medical matters, it is understandable that committee members are more conservative in reaching a final decision. Consequently, some of the painful decisions made by family members and the involved medical professionals are lightly vetoed by the committee. To block the decision of the patient and family in this way, the ethics committee becomes a mechanism that furthers the pain and suffering of both the family members and the health professionals. Thus, it is reasonable that this provision was recently deleted from the fourth version on December 21, 2012. Henceforth, decisions made by family members supported by the medical professionals are final. Family members usually respect the suggestions of the professionals, however, in cases of conflict, family decision has the last say both legally and in daily practice.

The role of medical professionals has changed from dominant decision maker to collaborator and facilitator in the decision-making process. In typical cases, health professionals should not only provide medical advice, but also facilitate the family decision making process. They should attempt to learn about their patient's preferences, the individual family members, and their role in family matters. In foreseeing possible moral dilemmas, the health professional should help the patient and his/her family members hold meetings to express their respective view points and their different opinions, to inform them of the possible outcomes and their respective legal rights and duties. In this way, when a final decision needs to be made, the decision can be reached smoothly and most satisfactorily for everyone involved. In the most difficult cases, health professionals have to stand by the rights and interests of the patient.

A good and reasonable decision in favor of a DNR requires the cooperation of the patient, his/her family members, and the relevant health professionals. It is unreasonable for any party to have the upper hand. If a decision becomes an insolvable case, the patient's preference should prevail, for, when this happens, we regard the patient's family as dissolved and reconstituted with him/her as the only member. Medical professionals also have to protect the best interest of the patient, even against the patient's family. This is demanded by the professional code of health professionals and need be upheld and supported both by its professional members and the public.

8.5 A Confucian Model of Medical Decision-Making and Its Ramifications

It is part of the ethos and philosophy of Confucianism that family is one of the most basic human relations. It is called an "ethical relation" to signify the somewhat intimate relationship that constitutes naturally the identity and reality of our lives[2]. Since no human child can survive its early years without family-like caring

[2] The justification for intimate relationships and relational autonomy was first proposed by feminists. My concept of Confucian ethical relational autonomy is a reflection of the Confucian emphasis on the ethical family relation. See: Lee2007; cf. MacKenzie and Stoljar 2002.

by others and because the natural family is the paradigmatic case for all, family is regarded as part and parcel of our self-identity.[3] In traditional Chinese society, social and political duties are often bound up with the family, which is regarded as an inseparable whole for both fame and blame. Nowadays, in Chinese society, family ties are still quite strong. Though family members very often do not live under the same roof anymore, much sharing, including support for parents and elders, is still part of family life. Consequently, allowing family members to join us in personal decision-making is reasonable and very often provides the strongest protection for the individual. However, we need to acknowledge a number of reservations. First, in Confucianism and the Chinese family, there are other ethical relations, for example, nation and subjects, friends and social relations, that are significant as well. They all make different claims on one's responsibility. The family relation is of course a primordial one, but that does not mean it is absolute. The involvement of other relational parties, one's nation for example, is regarded as equally important, especially when medical resources are needed that are far beyond the financial resources of a person or a family. Mencius commended that a sage king had to provide family care for those in need (*Mencius, 1B:5*). This means that public authority and support are in the background of family relations. Second, parental disobedience is morally permissible, and sometimes necessary, when a family's decision is unreasonable (*Mencius, 5A:2*). The legitimacy of parental interference is based upon the reasoning that parents should be benevolent towards their children. Confucius never recommends blind obedience to one's parent or ruler[4]. Mencius admired Shun (the Sage king) in his deeds of disobedience to his father's unreasonable commands. Furthermore, other important and related persons could form part of the family and have equal status to other family members. For example, in the tradition of Confucian doctors, physicians are understood as becoming part of the patient's family. Medical professionals are not simply outsiders. Care providers form a close relationship with the patient and a virtuous physician is to treat his/her patients as his/her own relatives. In the physician patient relationship, the professional is assumed to treat patients as a parent devoted to their children. Thus great trust is usually vested in the physician to make the best medical decision for the patient. In the Confucian tradition, the physician plays a large part in medical decisions for the patient and the patient's family because of his professional skills and virtue. Hence, medical professionals have a duty to protect the reasonable interests of the patient, as a parent would for his/her child. In other words, the Confucian model of medical decision-making is a semi-familial one. In this model, family involvement in decisions is basic. However, the patient has the final say over his/her own treatment and decision-making, but the patient has to face the blame of his/her family if his/her choice hurts the family's interests. Medical professionals have to take into consideration the opinions

[3] Christine Korsgaard would call such an identity "practical identity" or "moral identity," with the implication that it defines our obligations and values. See: Korsgaard 1996, pp. 90–130.

[4] The *Book of Rites* mentions Confucius' story of Tsengzi who sustains slight, but not life threatening, punishment from his father.

and decisions of the family as a whole and also has to have the courage to stand for the rational as well as the personal interests of the patient.

In accordance with the usual Chinese ethos of death, the dying person, and sometimes the sick, becomes the supreme decision-maker. The patient's decision commands the respect of family members even though it may not be preferable for other family members and sometimes it may not be in the best interest of the patient him/herself. This is why it was previously proposed that the patient make the final decision, as though the family had been dissolved, when there are conflicts. Hence, the involvement of the family is not only necessary, but a better way to deal with the dilemmas that arise in end-of-life situations.

Based upon the Confucian conception of the family relationship, a proposal can be made for a basic model of medical decision-making.[5] The basic element of this model consists of four steps. First, physicians should try to build a good patient-physician relationship, so that both sides can achieve some degree of mutual trust and understanding; and in the process the patient's values, preferences and choices can be noted and clarified. Second, medical professionals should observe and determine the degree of competence and the rights of the patient, and should foretell the collapse of the patient and any possible urgent situations. Third, medical professionals should conduct family meetings to clarify the medical diagnosis, possible treatment, prognosis, duties and rights of the patient and his/her family, and provide medical recommendations. Finally, medical professionals should help generate reasonable consensus regarding medical treatments. With such a process for family consent, the decision is assumed to be a harmonious consensus within the family and also reasonably satisfactory for the medical professional.

This model could be applied to all sorts of medical issues, including the DNR requests addressed by the Hospice Palliative Care Act, treatment for terminal patients, and other related bioethical issues. For instance, the law providing for legal abortion in Taiwan has been accused of being too lenient, not discriminating between different types of requests for abortion and allowing for abortion based on the subjective feelings of the pregnant woman. On the one hand, it protects the pregnant woman from any possible harm due to the pregnancy, but on the other hand, it is too lenient, causing youngsters to engage in careless sexual behavior, which leads to an exceedingly great number of abortions in Taiwan. Some conservatives have proposed a mandatory waiting period and consultation before receiving an abortion. Without mutual trust between the pregnant woman and the consultant, the consultation would be a one-sided argument against abortion and may violate the spirit of the Confucian doctor. Even though by law a pregnant woman could independently decide to have an abortion, in practice, medical professionals in Taiwan usually require the husband to witness her request form. This practice may invite objections from the husband and often involves a violation of the woman's wishes. Consequently, this has led to women seeking underground abortions. There are also many reported cases of women being forced by their families or boyfriends to have an abortion against their will. A healthy abortion consultation should give full pro-

[5] I have elaborated a Confucian model of clinical consultation in Lee 2008.

tection to the woman while providing due respect to the innocent fetus, and should aim at reaching a mutual understanding with family members.

This kind of family consultation is also proper for research involving family members. For example, research involving biobanking should require family consultation because genetic materials and information contain many common familial elements. Even by personal freedom standards, individual consent is not enough in such cases. Genetic information is in fact the common property of the family.

The Confucian model proposed for family decision-making may also provide an alternative for the West. In Taiwan, some medical laws provide for the involvement of the family. In practice, family involvement is openly permitted even though in some instances there is a balance of shared authority with due respect given to the individual preferences of the patient.

8.6 Concluding Remarks: Clarifications and Refutations

The proposed model of family participation in medical decision making is built around those core ideas and values of Confucianism most prominently expressed in the *Analects* of Confucius and the thought of Mencius. The core value is *ren,* or *the mind of ren,* for Confucius and, for Mencius, the unbearable mind of other's suffering. For Confucians, this is the foundation of morality, which determines the moral actions of human beings. Some understand the Chinese word *ren* as composed of the roots, "two" and "man," and thus regard Confucianism as an ethic of relation. A recent archaeological discovery demonstrates that the original Chinese word, *ren,* is a direct combination of the two roots, "body" and "mind." This disposes a limiting interpretation of *ren* and Confucian philosophy to a relational one. There is no doubt that human relation guides our actions in practice, but it is obvious that this is not the only way. Confucian ethics is not limited to the familial relation. In the *Analects* and *Mencius* there is also mention of moral practice involving only the self. In fact, this is the most basic and profound way to cultivate one's morals. For instance, Confucius told his best student, Yan Hui, to: "Suppress your selfish desires and return to the ritual of *ren*" (*Analects*12:1). This is pure moral cultivation of the self. One is to rid oneself of any immoral desire and follow the spirit of *li*, that is, *ren* or *the mind of ren*. Mencius also emphasized the "thinking" of the heart/mind, that is, the determination of the unbearable heart/mind of what should be done. In the two later pre-Chin classics *Zhongyun* and the *Great Learning*, the practice of self-awareness for detecting and removing immoral desires is the most prominent and important step of moral cultivation. It is from this primordial starting point that different and diverse human lives are evaluated. Thus, human relations are the ways in which human morality can be expressed and moral ideals achieved. In a more concrete way, it is codified in *li* or rituals. However, Confucius points out that *li* has to be built upon the foundation of *ren,* and *li* should always be transformed according to the command of *ren* (*The Analects*, 2:23). This means moral rules should constantly be critically reviewed by the moral mind. Confucius would likewise take

filial piety as the first, natural step of the practice of *ren* because it is when and where one grows up all along, and the parent-child relationship is surely the most basic relationship. However, as has been indicated in this essay and as many records in *The Analects* show, respect for elders and parents is not the only way to practice *ren* or to be a virtuous Confucian gentleman, *junzi*. Furthermore, Confucius, as well as Mencius, condemns those who stick rigidly to the requirements of rituals, especially those who regard them as absolute moral commands. They are said to be the thief of virtue (*The Analects*, 17:13)! Not only should we be flexible in how we express moral concerns, but practice should also be updated through learning. There is an oft-quoted saying of Confucius that expresses the idea that we can always learn something through common people, which implies that there are good deeds and achievement through which we can learn to improve ourselves. Confucius said he himself never tired of learning. It is not only a devoted love for knowledge and wisdom; it is a moral command to always improve ourselves and our ability to be better. To improve our bioethical actions we must update our scientific knowledge of the world and our social and moral knowledge of human society. Self-limiting and self-exaggeration is not the attitude of Confucianism.

Though the basic concern of Confucianism is rooted in family matters, Confucians never stop here. Confucians are always concerned with others, especially their suffering. The others Confucians are concerned with expand from the family to the social, the national to all people, and from animals and plants to, ultimately, the whole universe. Confucianism is holistic. Even within the human world, it never ends without encompassing all human beings. Family is but one stage of our moral deliberation. Therefore, Confucianism cannot be properly understood as familism. Neither can it be understood as only having moral concern for the family alone, or as assigning supreme value to the family. Hence, the above analysis of family consent is based upon the underlying requirement of *ren* or the moral heart/mind for the sympathy of the suffering patient. It is through the closely knitted moral community of the family and the Confucian semi-familial relationship of the physician and the patient that we specify the necessity and significance of family participation.

There are a number of similarities between Confucianism and the ethical theories of the West. Care ethics is most closely related to Confucianism because both emphasize the importance of a shared caring relation. Nel Noddings, an American feminist, understands care as the primordial relationship and derives ethical care from natural care, forming the foundation of morality. However, Noddings limits caring as a kind of personal affection and neglects the rational aspect of moral deliberation. Noddings does not accept natural caring as itself moral and her concept of caring is limited to concrete relations. For Confucianism, caring and sharing the suffering and joy of others is a natural universal sentiment. It is more than just a sentiment. It is a moral and rational command to ourselves. The unbearable mind is by no means stuck to our personal affection, as parent to child, but in itself is a universal caring for all.

Given that Confucianism also emphasizes the importance of community, some understand Confucianism as a kind of communitarianism. This interpretation recognizes the community implications of Confucianism, but forgets that the community

is just another way to realize or express the moral command that flows from the moral mind. Community itself is not sacred and always needs to be checked by our moral mind or the virtue of *ren*. A community is a moral community only if it satisfies or is constituted by the principle or command of our moral mind. Moral principles constitute a moral community. For Confucianism, it is obvious that the origin of morality stems from our moral mind, which issues directives for action: when these directions are codified, they become moral principles. It does not matter whether they are called principles of *ren, yi, li, chi, shun*, or other names, as they all come from the moral mind and are constitutive of our moral community. These principles are the origin of community authority in moral matters. Similarly, virtue is the successful achievement of moral cultivation built into our predisposition to perform moral deeds. But, again, virtue is not the starting point of morality.

Although Confucianism cannot be strongly identified with Western ethics, this does not mean that Confucianism has nothing in common with Western theories. Confucianism does contain some Western moral elements, such as care, individual freedom, justice, etc., but it attributed different weightings to these elements. The primordial core of Confucianism is the heart/mind, such that we share each other's joys and pains. Through the sharing of experience, we form the first moral community within our family and extend our moral concern to an expanding circle from family to society, and ultimately to the whole universe. It is no accident that Confucians have a cosmic feeling: feeling upheld in awe of Heaven, the grand universe. In the mundane world, we start from the near at hand, that is, from our home. For the diversified modern world, our moral sharing may seem limited, especially to family sharing, however, this does not mean that we are and must be limited. In the field of medicine in particular, Confucianism provides a wealth of philosophical resources for better and more reasonable medical activity as an art of humanity or *ren-shu*.[6]

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Mencius. 1984. *Mencius.* In *The four books,* annotated & ed. by Zhu Xi. Taipei: Legein Publisher.

[6] In *Mencius*, 1A:7. "*Ren-shu*" is a political term first coined by Mencius. It was then extended by Chinese physicians in the Ming Dynasty to mean the art of medicine.