NEWSLETTER

Spring 1996

The Guild of St. Luke, SS Cosmas & Damain

From the Editor

The theme of the current issue of our Newsletter is Euthanasia. We heard that the Government is going to bring the issue into open discussion in the near future. This is certainly a very important issue both in the medical and ethical aspects. Our council has held a meeting on this and will closely follow up the progress. Several articles have been collected reviewing the different aspects of Euthanasia and the stand point of our Church is re-stated.

There is a call for the establishment of a Catholic Medical Fellowship Group. Please take note of the progress and support it, either by your physical attendance or prayers. The next function of our Guild will be the Chinese New Year Gathering. We hope to see you and your family at the celebration.

Master's Message

It is my pleasure to write in the Newsletter again after my 6-month overseas elective training. I would like to thank the Council's hard work, especially our Hon. Secretary Rebecca who acted as the Guild's Master during my absence.

It is always delighted to see new faces in the Council and old friends during Guild's events. Nevertheless, I must admit that this delight is becoming rare, particularly during the past two years. The office bearers, namely the Master, Secretary and Treasurer, as well as many Council members have served the Guild for quite a number of years. There is a general feeling that the Guild's vigor can be revived only if new 'blood' and leader appear so as to inject innovative ideas and strength to the Council.

Content:

I would therefore like to invite all of you to pray to our leader in Heaven, the Lord God, to guide the Guild to pass this difficult period. I would also like to ask you to open your heart and sacrifice your valuable time to accept our invitation to join the coming new Council.

Wishing you and your family a Happy and Peaceful Chinese New Year!

Paul Ho

Council News

A. The Medical Sunday Mass 1995

It was held on 15/10/95 at Christ the King Chapel, Causeway Bay. The theme this year was "Respect for Life".

Miss Alice Wong from the Birth Right Society shared with us her experience as a front-line worker defending for the unborn lives. She also gave a brief account on the work of the Birth Right Society. On the other hand, Fr. John B Tsang spoke on Euthanasia. He stressed on the sacred value of human life at the other extreme of life and the need to respect life no matter how feeble, weak and apparently non-functional it appeared. (Fr. Tsang's complete sermon is printed in this issue of Newsletter)

The mass was jointly organized by our Guild and the Catholic Nurses' Guild. The organizing team had a smooth and enjoyable co-operation with the Nurses' Guild and we treasure this very much.

B. The Mass of the Deceased 95

It was held on 12/11/95 at the Ricci Hall. It was followed by Lunch at the Medical Faculty at Sassoon Road. The attendance was low but it was a valuable activity to continue in the future. The list of deceased members of the Guild is printed separately in the issue.

Rebecca Yeung

Message from the Convenor, Catholic Medical Fellowship Group: Pilot Scheme 1996

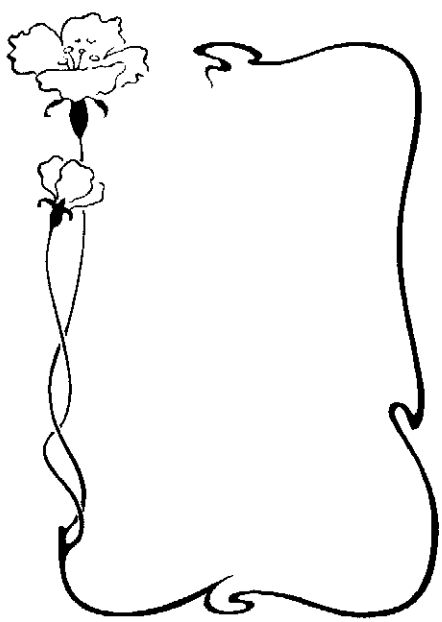
First of all, I wish to thank sincerely all members who have responded to our questionnaire. After careful deliberation, it was decided that a pilot scheme would be initiated early next year, probably in February or March 1996. It seems that most respondents prefer a Friday evening once every two to three months with sharing, light meals with or without mass. The venue will be decided upon soon. If any member have any suggestion to this Fellowship group, please contact Dr. Robert Yuen, Department of Paediatrics, Kwong Wah Hospital (Tel: 27815058, Fax: 27815261). Please watch out for the invitation to attend the meeting in the near future!

Robert Yuen

Deceased members of the Guild

Please remember them in your prayers. Please also inform us if you have names that we have left out.

1. Rev. Cronin, S.J.
2. Sr. Aquinas
3. Dr. George Yeung
4. Dr. Cissy Yeung
5. Dr. Carlos Da Roza
6.
7. Dr. Wille Ho Asjoe
8. Dr. Anthony Christopher Fang
9. Dr. Poon Chung Chik
10. Dr. H.T. Bee
11. Dr. Y.Y. Tang
12. Dr. Li Kwok Biu
13. Dr. James Szeto Ming
14. Dr. Benedict Ng
15. Dr. Woo Pak Foo
16. Dr. Matthew Siu



THEME OF THE ISSUE - EUTHANASIA

The view of the Church on the subject of Euthanasia

Rev. John B. Tsang
(The following was the sermon delivered by Fr. Tsang for the Medical Sunday Mass 1995)

In keeping with the theme "Respect for Life" of this year's Medical Sunday. I have chosen to talk about the subject of "How does the Church look at Euthanasia?".

When a patient is terminally or hopelessly ill, he himself suffers extreme agony both emotionally and physically while his family is faced with equal pain and enormous pressure. Under these circumstances, has he got the right to choose the option of death? Or has he got the right to ask someone else to end his life? Can medical personnel take action to induce death according to the wish of the patients?

The answer given by the Church is "NO". The Church objects to the performance of the so called mercy killing of the aged, terminally ill or others considered not worthy of life by anybody under any circumstances because this is an offense of human dignity and against the concept of life. The duty of a doctor is to let the patients die a peaceful, bearable and dignified death by easing their pain and giving them and their families moral support with good hospice care. Euthanasia is contrary to the role of "Life Saving" of medical practitioners. Medical advances in recent years have made it possible not only to control pain, but also prevent the

occurrence of pain so that patients do not have to die in extreme sufferings and loss of dignities. If patients receive adequate and careful treatment and their sufferings under control, then they can pass away peacefully.

From the Christianity point of view, life is granted to us by God. He is the real master of our lives and we are only their trustee. We have to safeguard and value our lives and let them bear fruits. We have absolutely no right to destroy lives, even our own.

Suffering, especially suffering at the last moment of life, is placed at a special hierarchy in God's plan of human redemption. A patient participates and shares the pain of crucifixion of Our Lord Jesus, he sacrifices his life according to the wish of God in the same context as Our Lord did his.

Though death closes the chapter of earthly life, it opens the door of eternal life simultaneously. Bearing this in mind, we should be ready for this glorious moment in the light of the Faith of God.

When all hope of healing is vanished and the illness becomes incapacitated, what a patient needs is personal care, encouragement, support and a happy and comfortable environment so that he can face death with responsibility, courage, dignity and peace. We SHOULD NOT administer drugs to induce immediate death for we have no right to do it.

Controversy on Euthanasia brings response from Hospice Carers

(During July 1995 the Government had asked for opinions on euthanasia, with the ultimate aim of drafting a position paper on this topic.)

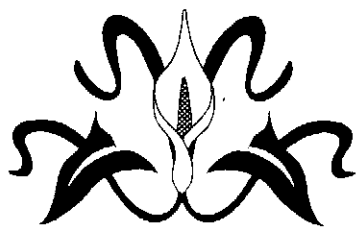
Euthanasia, or mercy killing, is the active termination of life at the request of a patient. In nearly all parts of the world, it is regarded as a serious crime. However, in the Netherlands, it is a medical act permissible under Dutch law if it is carried out by a physician.

The General Medical council in the UK, where euthanasia is illegal, has stated that it is the doctor's duty to do their utmost to make a patient's death bearable and dignified by easing pain and suffering. An article in the South China Morning Post included interviews with medical practitioners in hospice care. Dr. Michael Sham, consultant in palliative medicine at Nam Long Hospital, and Dr. Lau Yu-lung of the University of Hong Kong are both adamant that euthanasia is contrary to a physician's role as a healer and is something they would never consider. In keeping with the belief of the founder of the hospice movement, Dame Cicely Saunders, they believe that the control of pain among cancer patients should be of a level to remove their fear of pain so that they could "live until they die." Dr. Sham says, that thanks to modern drugs, it is not necessary to die in undue pain and with dignity.

Ms. Lucy Chung, Nursing Director at Bradbury Hospice and one of the earliest proponents of hospice care in Hong Kong, said "We care for the terminally ill with one fundamental belief - that no human life should be seen as less valuable because of physical or mental impairment. it is the respect for

the inherent and intrinsic worth of the patient which enables us to persist in trying to help, even under adverse circumstances... Hospice care should be available to all patients with terminal illness... As stated by Dr. D.J. Roy and his colleagues of the European Association for Palliative Care, the challenge of civilization at the end of this decade is to transform our care of the suffering and the dying, not to legalize an act that would all too easily become a substitute for the palliative competence, compassion and community that human beings need during the most difficult moments of their lives."

(The above is an abstract from the Autumn 1995 issue of the Hospice Newsletter. The Editor thanks the Society of Hospice Care HK for their permission for reproduction.)



Euthanasia : Medicine at the Interface of Life and Death

(Reproduced from SYNAPSE Dec. 95 issue- HK College of Physician. Abridged)

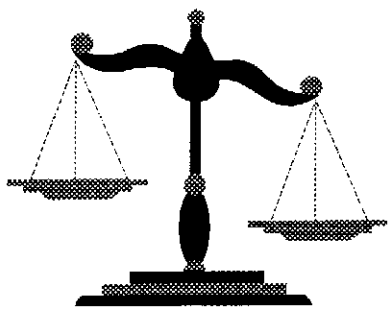
This articles discusses euthanasia, and relates it to the ethics of medical care at the interface between life and death. The term " Euthanasia" is derived from the Greek rooted "eu" meaning well and "thanatos" meaning death. An article in the British Medical Journal in 1988 defined euthanasia as " an active intervention by a doctor to terminate life, and a decision not to prolong life"

While the issue of euthanasia is not new, a number of factors relating to contemporary life and modern day medicine have increased its importance. When euthanasia is discussed it is common to draw a distinction between active euthanasia, passive euthanasia and assisted suicide.

Active Euthanasia

Active euthanasia is defined as "a deliberate intervention to terminate life by someone other than the person concerned and at the request of that person". Active euthanasia may be further subdivided into involuntary euthanasia, non-voluntary euthanasia and voluntary euthanasia. Involuntary active euthanasia refers to the termination of a life without the consent of the person concerned. Clearly this is ethically unacceptable and illegal. Non-voluntary euthanasia refers to the active termination of a life when the individual concerned is incompetent to give consent. This also would be regarded as being ethically and legally unacceptable. The definition of active euthanasia as given above applies solely to voluntary

euthanasia, it is at the request of the individual whose life is to be terminated. Active voluntary euthanasia is currently illegal in Hong Kong as it is in the UK and USA. It is prohibited by the Hippocratic oath and the current stand point of the Hong Kong College of Physicians is that euthanasia, at least in the active form, cannot be condoned and should not be legalized.



In the UK a proposal for legalization of active euthanasia was rejected by the House of Lords in February 1994, the reason being that one cannot ensure adequate safeguards for either voluntary euthanasia or assisted suicide. These problems may be summarized as follows:

1. Requests for euthanasia may be made to avoid burden on relatives rather than to relieve pain or suffering.

2. There is a danger of euthanasia being used for economic rather than humanitarian reasons.

3. It may be impossible to exclude the inherent danger of non-voluntary euthanasia.

4. It may be difficult to exclude a contribution from a treatable psychiatric disease, for example depression.

5. A request may be made at a time when pain or distress is particularly severe and could be regretted later.

6. There is a risk that euthanasia may become a substitute for high quality terminal care.

Assisted Suicide

Assisted suicide differs from active euthanasia in that the death is caused by the patients own hand rather than by outside intervention. In the UK, under the Suicide Act of 1961, it is illegal for anyone to aid another person's suicide. However the Institute of Medical Ethics in the UK does consider that doctors may be morally justified in assisting the death of terminally ill patients to release them from intolerable pain and distress. The legal framework in relation to assisted suicide has been tested recently in a number of countries in high profile cases which have achieved much publicity.

Passive Euthanasia

Passive euthanasia may be defined as respecting the will of the patient or close relatives to allow the natural forces of death to follow their course, in the terminal phase of sickness, by not intervening medically to prolong life. It is generally considered unethical in Hong Kong and no changes in the law are envisaged.

From the ethical point of view the distinction between active and passive euthanasia may not be clear cut. For example one may easily envisage situations in which active euthanasia may be regarded as being more humane than withdrawal of treatment, which would be regarded as a form of passive euthanasia. Also the conventional

definition may lead to life and death decisions being made on irrelevant grounds. Furthermore, in terms of moral philosophy, the distinction between "killing" and "allowing to die" may have little moral importance.

The Presumption Against Taking Human Life

When considering euthanasia it is perhaps helpful to consider the moral principals which should be considered when any life is to be terminated by outside forces.

1. What or who is the source of authorization for the taking of life?

2. What is the purpose, cause or objective for which the life is to be taken?

3. Have all alternatives to obtain this purpose short of taking life, been exhausted?

4. What outcomes can reasonably be anticipated to ensue from the taking of life?

5. Will there be a favorable balance between the anticipated benefits of taking life and the certain harms of such an action?

6. What safeguards will ensure that the taking of life is limited to those for whom it is intended?

Possible ways of Curtailing Life

In the context of medical practice this may be by administration of a deadly substance. Life may also be curtailed by either not beginning a treatment or by suspending a treatment. Finally it may be curtailed by the setting up a treatment with life curtailing side effects. As soon as one begins to consider such issues as not beginning a treatment, suspending a treatment, or administering a treatment with life curtailing side effects, although these may be defined as passive euthanasia and therefore currently regarded as illegal, they clearly interface with many aspects of contemporary medical practice. There can be few doctors currently practicing clinical medicine who can honestly say that they have never withheld or withdrawn a possible treatment modality , at any level, from hopelessly ill patients or who have never practiced the policy of "not striving officiously to keep alive".

Who are hopelessly ill?

On the assumption that discussion of these issues relate solely to patients who may be regarded as hopelessly ill, it is worth considering to whom this may

apply. Firstly, it may apply to those for whom treatment is manifestly futile. Secondly, it may apply to the terminally ill, and thirdly, it may apply to those with poor quality of life, although this may be highly subjective and difficult to define.

Recent advances in medical care and technology have made it possible, in many situations, to sustain life beyond previous limits. Doctors in the modern age are inevitably faced with decisions as to when it is no longer reasonable to use this technology.

Treatment may be limited at a number of levels:withholding of rescue or emergency, life sustaining measures; withholding major surgery, or intensive care; withholding of antibiotics; withholding of intensive nursing care with no intention of proceeding further with medical care. It should be emphasized that there is no clear cut conceptual difference between the different levels at which treatment may be limited. Ethically, there may be no distinction between withholding and withdrawing treatment and this applies to all means of medical treatment which can prolong life including nutrition and hydration.

At this point it may be helpful to consider briefly the implications of limitation of medical treatment in patients who have decision making capacity or have given a advance directive, compared to patients who have lost their decision making capacity and not executed an advance directive.

Patients Who Have Decision Making Capacity or Have Given Advance Directive

For patients in this category, refusal of treatment should be respected without penalty as long as explanations and level of understanding are deemed complete. This is a situation in which requests for voluntary euthanasia may be made. At the moment, active voluntary euthanasia is illegal and the doctor should also remember that this is morally questionable.

Patients Who Have Lost The Decision Making Capacity And Not Executed An Advance Directive

In this situation the doctor has a duty to ascertain a full medical prognosis, to explore all options, to ascertain as far as possible the patient's values and preference, and to share all alternatives with the family so that best-interest decisions may be made. If these measures fail to produce agreement then formal processes either within the institution, e.g. by referral to department heads, or outside the institution e.g. by referral to the courts, may be required. Futile treatments need not be offered or provided even if requested. Active euthanasia clearly has no place in this situation.

Withholding Cardiopulmonary Resuscitation

This is again an issue which most hospital based medical practitioners find themselves making and which perhaps deserves more detailed consideration it is often given. The omission of cardiopulmonary resuscitation(CPR) is not morally or legally valid unless adequate reason is present. Omission is a choice, itself an action, which can only be justified by acceptability of the consequences, in this case the death of the patient. It should be stressed that the best interests of the patient are paramount. For noncompetent patients it should also be stressed that relatives have no legal rights in the treatment of adult patients. The policy of the British Medical Association and the UK Royal College of Nursing on the withholding of cardiopulmonary resuscitation outlines the following reasons which may be considered reasonable grounds for non-resuscitation:

1. When patients are competent and either give informed consent to refuse resuscitation or have issued an advance directive.

2. It is reasonable to withhold CPR in a patient who is not competent to give his consent, and in whom the clinician judges resuscitation to be against the patients best interests.

3. CPR may be withheld if the clinical condition of the patients is such that the probability of successful resuscitation approaches zero.

Conclusion

Active(voluntary) euthanasia and assisted suicide are currently illegal in Hong Kong. Consideration of the complexities and difficulties involved, both morally , legally and in clinical terms, do not persuade that any change, or review of the law is required at the present time in Hong Kong.

Passive euthanasia, whereby the patient is allowed to die as a result of limitation of treatment or imposition of a treatment with life-curtailing side effects, is also currently regarded as illegal. This is misleading and the term should perhaps be abandoned as it provokes confusion. If a doctor stands by and allows a patient to die when useful treatment to sustain life is available, then morally this can be argued as being no different from active euthanasia, since the primary intention is to cause death. This needs to be distinguished from situations where the primary intention is not to cause death, even though death could be a possible secondary result. Examples include withholding of futile treatments, treatment in which the risks outweigh the anticipated benefits, and the use of opiate analgesia to alleviate suffering during terminal illness. This distinction may be considered to be morally and legally more important than the distinction between "active" and "passive" euthanasia.

C.S. Cockram, Professor, Department of Medicine, Chinese University of Hong Kong.

(The Editor thanks Dr. C. S. Cockram and the HK College of Physicians for their permission to reproduce the above article)

教會對安樂死的聲明（撮要）

(撮自教宗若望保祿二世於 1980 年批准之聲明，中譯本由天主教中國主教團社會發展委員會編譯)

梵蒂岡第二屆大會議曾鄭重地再次肯定人類尊嚴的崇高，以及每個人特有的生存權利。爲此，大公會議譴責危害生命的罪行，「例如各種殺人罪、屠城滅種、墮胎、安樂死或惡意自殺」（牧職憲章 27）

一、人類生命的價值

許多人視生命爲神聖的，任何人不得隨意處置它，但有信仰的人，更視生命爲天主愛的賜予，要我們妥爲保管並使結出果實。

任何人若企圖奪取無辜者的生命，就是抗拒天主對那人的愛，違反人的基本權利，觸犯了非常嚴重的罪行。

每個人都有責任依照天主的計劃，度他的生活。

故意導致一個人自己的死亡，與殺人是同樣的錯誤？除非是爲了崇高的理想而犧牲，例如爲了天主的光榮，靈魂的得救或對弟兄們的服務，而甘冒生命危險，甚至獻出生命（若十五13）。

二、安樂死

所謂安樂死，是指爲了消除一切痛苦而有所爲或有所不爲，這些作爲或不爲的本身都會導致死亡，或因有意圖執行而導致死亡。因此安樂死的發生是在於意向和所運用方法。

必須再一次堅定地聲明，不准許任何人以任何方式殺害無辜，無論他是胎或胎兒、是嬰兒或成人、是老人或患不治之症而受苦的人、或是將死之人。此外，任何人不得要求毀滅生命的行爲，無論是爲自己或是交給他照顧的人；同樣，任何人不得明確答應或默許此事，任何權力也不能合法地規勸或允許這種行爲。因爲這是違反天律，冒犯人性尊嚴，是反生命的罪行，也是對人性的打擊。

病人因爲長期受到難以忍受的痛苦，有人會爲了純個人的理由或其他原因，以爲可以合法的爲自己或爲別人請求結束生命。雖然在這種情形下，個人的罪過可減輕，甚或完全無罪，可是良心所做的錯誤判斷，即使是出於善意，也不能改變謀殺行爲的本質，此行爲本身就該受到責斥。當然重病的人有時會要求結束自己的生命，但我們不能以爲那就表示他眞的希望安樂死；事實上，這常是一種渴望獲得愛和幫助的哀求。

三、基督徒受苦的意義及使用止痛劑

依人道和基督徒的看法，都建議多數的病患該用能減輕或抑制痛苦的藥物，即使這樣會引起半昏迷或神志不清等副作用。爲那些無法表達自己的病人，我們可以合理地假設他們願意使用止痛劑，而依照醫生的指示給他們服用。

教宗比約十二世曾答覆一群醫生提出的問題：「宗教和道德上是否允許醫生和病人使用麻醉劑等藥物，以抑制疼痛和喪失知覺（即使是在臨死

之時，且能預見使用麻醉劑會縮短生命）？」教宗當時的聲明，至今仍深具意義。教宗說：「假如沒有其他方法，而且在這種情形下，並不阻礙病人履行其宗教上和倫理上的本份時，可以使用麻醉劑來止痛。」當然，這並不是求尋死亡，即使有此危險，然其意向只是爲有效地減輕痛苦，而使用醫學上可用的止痛藥。

但是，會引起病人喪失知覺的止痛藥物，需要特別注意。因爲一個人不但必須滿全倫理責任及家庭義務，也需要在神志完全清醒的情況下，準備自己迎接基督。因此，教宗比約十二世警告說：「沒有重大的原因而剝奪臨終者的知覺，是不對的行爲。」

四、適當運用各種醫療方法

由無數病例中，錯綜複雜的情況會使人對道德原則的應用發生懷疑。總之，最好由病人或有資格替病人發言者的良知，或醫生們根據道德規律和病人的各種情況來做決定。

爲了幫助我們應用這些一般性的原則，可加上以下幾點說明：

- 假如沒有其他有效的醫療法，在病人的同意下，可以採用最新式的醫術，即使這些方法尚在試驗階段，並且有相當的危險。接受這種治療的病人，可顯示出爲人類服務的慷慨精神。

- 如果醫療結果未達預期的效果，在病人同意下，可中斷此種方法。但在做決定時，必須尊重病人及其家屬的合理願望，並且詢問對此有專長的醫生們的意見。醫生們特別要判斷，在儀器和人力的投資上，是否和預期的結果不相稱；他們也要判斷這些醫療技術，是否增加病人的壓力或痛苦而與得到的益處不相稱。

- 只用醫學上能提供的普通方法來治療也是可以的。因此不得強迫別人採用已經使用但有危險或負擔過重的醫療法。拒絕這種方法並不等於自殺，相反的，應被視爲接受人類的病痛，或願意避免使用與預期結果不相稱的醫療，或是不願加給家人或社會額外的負擔。

- 即使用了各種方法仍無法避免死亡，那麼可依據良心，拒絕採用希望極小而又麻煩的方法來延長生命，只需照樣給病人正常的照顧。在這樣的情形下，醫生若救不了病人，也毋需自責。

結語

生命是天主的恩賜，而死亡是無可避免的；因此我們必須在不急速促成死亡的情形下，能以完全負責的態度和尊嚴來接受它。

Spiritual Refreshment

好書介紹

「苦，有何難？」

徐錦堯，蔡元雲合著
「突破出版社」1995年

愛滋病對全球的威脅、東歐國家的民族清洗、澳洲邪教的集體自殺、（屠殺？）印度的鼠疫；有一天，你突然接到消息，你的一位至親，在一次車禍中喪生……

漫長的人類歷史，原來只是一場集體又不斷重複的遊戲；它的名字統稱爲苦難。但誰也沒有弄清楚它的遊戲規則。它是每一代人的老朋友。……

徐錦堯神父和蔡元雲醫生，透過文字對話，剖白他們在人生旅途中，對苦難的一點體會。並非要提供答案，乃是在這時空下尋找新啓迪、新角度和更合宜的態度。看我們以後參與這遊戲，會否多一份自信、瀟灑？

Comments and letters to the Editor are most welcome. Correspondence can be sent to the Chief Editor :

Dr. Francis Mok Chun Keung
Department of Medicine
Tuen Mun Hospital
Tuen Mun

NOTIFICATION OF CHANGE OF ADDRESS

When notifying change of address, please fill in the new address in the space provided below and return

BLOCK LETTER PLEASE

_____

_____