

Chapter 2

The Case of Ah Bun: Euthanasia and Other Alternatives

Ho Mun Chan and Chun Yan Tse

Abstract This chapter begins with the story of “Bun Zai,” a quadriplegic person who openly demanded the legalization of euthanasia in Hong Kong in 2003, triggering off widespread media coverage and public attention. The controversy about the legalization stems from the conflict among the rival views on value of life, pain and sufferings, and the meaning of death. After a discussion of these views, the moral arguments for and against euthanasia are examined, which shows that the moral disagreement in regard to euthanasia arises from the set of conflicting values and moral considerations, including the intrinsic value of life, autonomy, well-being of the patient, and the social consequence of legalizing euthanasia. As this moral disagreement cannot be settled, the latter part of the chapter discusses public policy alternatives to the legalization of euthanasia based on a compromise among the conflicting values and moral considerations.

The Case of Ah Bun

Tang Siu-bun (鄧紹斌), also known as “Ah Bun” or “Bun Zai” (斌仔), was a quadriplegic person who demanded for the right to die with dignity. In 1991, at the age of 22, Ah Bun was a student of the Northcote College of Education. His spine was severely injured after a failed backward somersault in a rehearsal for his graduation performance. Although his life was eventually saved, he became paralyzed from the neck down. After the accident, he was confined to his bed. He was

H.M. Chan (✉)

Department of Public Policy, City University of Hong Kong, Kowloon Tong, Hong Kong
e-mail: sachm@cityu.edu.hk

C.Y. Tse

Hong Kong Society of Palliative Medicine, Tseung Kwan O, Hong Kong
e-mail: tse_cy@hotmail.com

not even able to breathe but had to rely on mechanical ventilation (Chong 2010; Evans 2010).

Staying in Queen Mary Hospital for more than ten years, on March 23, 2002, Ah Bun heard of a news about the UK court ruling that a quadriplegic woman has the right to end her life by withdrawing life-sustaining equipment (Tang 2007, pp. 111–2). In 2003 and 2004, he used a chopstick in his mouth to type letters to Tung Chee-hwa, the then chief executive of Hong Kong, and members of Legislative Council, demanding the legalization of euthanasia (Evans 2010).

Widespread media coverage and debate were triggered by Ah Bun's alarming appeal, even though assisted suicide is illegal in Hong Kong and the Legislative Council decided not to legalize euthanasia in May 2001. Many people, including legislators and celebrities, were very sympathetic to Ah Bun's situation. They visited Ah Bun and donations poured into pay his medical expenses (Tang 2007, pp. 141–3). A team of professionals for his rehabilitation was set up by the Hospital, and more advanced life-supporting equipment was installed (Ibid, p. 155). The facility of his living environment was also improved. He did not need to rely on positive pressure mechanical ventilation all the time, and so he could talk to other people during the day. With the assistance of Jockey Club Rehabilitation Engineering Centre, The Hong Kong Polytechnic University, Ah Bun, could control the computer more easily and communicate with friends by using a laser mouse (wearing on his face like glasses) instead of a chopstick (Lam 2004; Tang 2007, pp. 160–3).

In 2005, Ah Bun started writing his autobiography, and the book titled *I Want To Have Euthanasia* was published in 2007.

After spending 19 years in Queen Mary Hospital, on August 19, 2010, Ah Bun was discharged to live in his new home at Sham Shui Po. He changed his mind and did not want euthanasia at that moment. But he still held the belief that being able to choose to live or to die is a basic human right that should be guaranteed (Evans 2010). Unfortunately, he died of an acute infection in December 2012 (AM730 2012).

How Bad Is Death and How Good Is Life?

The case of Ah Bun may lead us to ask the following philosophical and ethical questions. Is it ever possible that someone is better to die than to live? What is the meaning of death? Is it something that is always bad? What is the meaning of life? Is the meaning of life entirely determined by its quality? Does life have value in and of itself?

Ah Bun's quality of life was significantly improved after his poor conditions had been widely known in the community. Yet there are patients who are so unfortunate that they cannot even move the head to control the computer and are in other conditions worse than that of Ah Bun before the improvement. If it is impossible to improve the conditions of these patients, will it be better for them to die than live? Is death always a bad thing?

Many people are fearful of death, but the fear often stems from the concern about the sufferings that they have to go through before they die. Such a fear is not of death itself but of the dying process. Dying can be painful. Even though such pain can be managed quite effectively these days, it is still sad to see that your body and mind are deteriorating when you are dying. It is natural to be fearful of the *dying process*, but how about death itself?

Some people may believe that death is something harmful, but you no longer exist after you die. How can death harm someone who no longer exists? Also death is not something that you can experience. As Epicurus says in his *Letter to Menoeceus*, “Death is nothing to us, since when we are, death has not come, and when death has come, we are not” (Long and Sedley 1987). When you are still alive, you are not dead, and when you are dead, you no longer exist. In either case, you cannot experience death. So as Wittgenstein (1961) says, “Death is not an event in life: we do not live to experience death” (*Tractatus*, 6.4311).

Sometimes death can be a good thing. A soldier may sacrifice his life for his comrades by using his body to cover a grenade that is about to explode. To sacrifice yourself for a good cause is an honorable death. It is something morally admirable (殺身成仁, 捨生取義。). Sometimes death may be the only way out to avoid humiliation (士可殺, 不可辱。). So death may not be so bad after all.

Having said that some people still believe that death is something bad although death does not harm you. Your close friends and relatives will feel very sad after you die.¹ Some may say that people are hurt because death is an eternal departure, but it is worse than that. Suppose a very close friend of yours says that he will devote the rest of his life to conduct research in the Antarctic Circle and you are absolutely sure that you will never see him or have any contact with him again. This does not sound as bad as hearing that he is dead. The difference between death and eternal departure is that people are deprived of the opportunities to live like other human beings after they die. This does not happen to your close friend because he still survives as a human being in Antarctic Circle. Death in itself is something bad because it is a *deprivation*. Many people are fearful of death for this reason.

Not being here or there can be something bad. Absence can be regretful. You may feel bad if you cannot attend your son’s graduation or wedding ceremony. This is something that you may not be able to do after you die, and there may be many other similar regrets resulted from your non-existence. For example, you

¹Established social relationships with regard to the loss of life will be very important in making moral decisions concerning certain ethical dilemmas in Confucian ethics. For example, Cheng and Ming (Chap. 3 of this book) point out that abortion in the case when the fetus threatens the health (and may cause death of the mother) is acceptable in Confucian ethics since the pregnant women have established social relationships with other members of the community (who may feel sad if she dies); thus, her well-being should be prior to that of the fetus who is merely a potential member of the community with no established social relationships with other members (implying that even if the fetus is not born, the resulted social disharmony will be comparatively less than the loss of life of the pregnant woman).

may die prematurely so that many things that look valuable to you may not have been achieved. Even though you have made some achievement in your life, after you die, you do not know and have no control of what will happen to your work and reputation and cannot defend yourself if you are misjudged. These regrets arise from the deprivation of a future life resulted from death. They can create a horror of non-existence which makes us feel fearful of death. So death in itself is something bad. It is a good thing only under some special situation in which the good achieved by killing yourself outweighs its badness.

Some religion has the conviction that there is the eternal life after death. This may give us some consolation. Yet there is no guarantee that God will let us go to Heaven on the Judgement Day, we may not survive after all, or have to go to hell. Also, it is scientifically and philosophically controversial that the soul can survive after death. Some philosophers even think that even if there is the eternal life after death, such life can be boring and not meaningful.² You do not need to strive for anything if you are immortal. In the long run, everything you wish, however small the chance, can happen since your life is infinitely long. An eternal life can be repetitious because the life span is so long that you will run out of new ideas and have to repeat what you have done again and again.

According to Heidegger, the anxiety stemming from the thought that you will die can bestow meaning to life (Heidegger 1962). Since your life span is limited, you should try to make the best out of it; otherwise, you may not be able to achieve what you find meaningful. It is very popular to converse the Confucian saying “If you do not understand life, you do not understand death” (未知生，焉知死?) as “If you do not understand death, you do not understand life” (未知死，焉知生?). This captures what Heidegger says well, but the original Confucian statement does not mean that we should avoid talking about death and focus on how to prolong our lives (長壽). Confucius says that if he can know the Tao in the morning, it is alright for him to die in the evening (朝聞道，夕死可矣). To Confucius, if you do not know whether life has meaning, what’s the point to have a longer life, and if you have already had a meaningful life, does it really matter even if you have a shorter life? The Confucian statement and its converse are not contradictory and indeed compatible.³ If they are both true, it only means that you cannot understand death without understanding life and vice versa. Confucius’s point is that it does not really matter when and how you die if you do not know the meaning of life.

²Wittgenstein writes “Not only is there no guarantee of the temporal immortality of the human soul, that is to say of its eternal survival after death; but, in any case, this assumption completely fails to accomplish the purpose for which it has always been intended. Or is some riddle solved by my surviving forever? Is not this eternal life itself as much of a riddle as our present life? The solution of the riddle of life in space and time lies outside space and time” (*Tractatus*, 6.4312).

³The two sentences can be captured by the form of “If P , then Q ” and its converse “If Q , then P .” From a logical point of view, they are not contradictory, and if they are both true, it means that you cannot understand death without understanding life and vice versa. It is similar to the case that “If a number is divisible by two, it is an even number” and “If a number is even, it is divisible by two” are both true. The understandings of being even and being divisible by two are inseparable from one another.

Now, if it is not so bad that we are mortal, why shouldn't we be allowed to kill ourselves if we are suffering from some terrible disease? After all, we are allowed to or sometimes even should kill ourselves for something very honorable, why should we not be allowed to end our miserable lives by euthanasia, killing ourselves or suicide with the assistance of a physician or somebody else? Some religion has the conviction that life is a gift from God, it belongs to Him, and so we do not have the right to end it. Also, people with such a conviction may think that an honorable death is different from killing yourself to avoid the pain and sufferings because they are a test of your faith in God, and so you should not terminate your life to avoid them because you do not have a right to do so.

For those who uphold a secular point of view, they may still accept the principle of the sanctity of life. According to this principle, even if the quality of our lives is very low, life itself still has its intrinsic value. After all we should not arbitrarily kill any life, even if it is an animal or a plant, without good reason. Yet the key question is how much weight we should assign to the intrinsic value of human life. Can it be trumped if my quality of life is extremely poor? Here, we have to face a brute fact that from a philosophical point of view, there is no definite answer to this question, and yet from the point of public policy making, it is unavoidable that the government has to strike the balance somewhere.⁴

There are many such examples in biomedical ethics, animal ethics, environmental ethics, and other areas of applied ethics. Philosophers can have endless debates about abortion and the moral status of embryos and fetuses.⁵ They can keep on and on to discuss who are the parents and children arising from the use of different human reproductive technologies (HRTs), including artificial insemination by donor, surrogacy, and human cloning, and whether they should be made legally permissible under some specific circumstances, if any. However, public policy makers just cannot wait too long for a resolution. They need to develop a set of clear and well-defined laws and regulations for determining under what conditions, if any, abortion or the use of various HRTs is permissible. They cannot drag on and on and let the issues unsettled. They have to fill up the regulatory loopholes or vacuum so that there can be settlements should disputes arise. Having said that, it does not follow that philosophers do not have an important role in the public policy-making process. They play a key role in working out the justifications for various positions so that different stakeholders of the community can have a more fruitful deliberation of the ethical issues and arrive at better compromises.⁶

As policy solutions are often results of compromises, they often sound inconsistent. For example, in the case of abortion, even though early abortion is regarded as legally permissible under some circumstances in response to the voice of the pro-choice advocates in some society, the pro-life voice is also heard such

⁴For more discussion on public policy and the need to strike a balance, see Yung (Chap. 1 of this book), pp. 3–4 in particular.

⁵For detailed discussion on abortion, please refer to Cheng and Ming's chapter on abortion (Chap. 3 of this book).

⁶For a further discussion of this point, see Wolff (2011).

that late abortion (abortion of fetuses older than around 24–26 weeks) is made illegal. In the case of animal and environmental ethics, though there is the law against hunting and cruelty to animals in many societies, it is still legal to kill livestock for food. The key problem that public policy makers are facing is how to strike a balance among different points of views of the stakeholders. In doing so, they have to take into consideration the rationale of these views, the interests of various stakeholders, and the desirability of various policy options from a practical point of view so that the result will be widely acceptable by different walks of life in society; otherwise, the policy adopted will not be feasible and sustainable. The point at which the balance is stricken is also affected by the cultural and social conditions of different communities and that is why there are often different policy solutions to the same ethical issues in question around the world.⁷

The following discussion of euthanasia and other alternatives indeed can be a good illustration of the above account on the relationship between public policy and ethics.

Different Kinds of Euthanasia

Euthanasia for patients with advanced irreversible illnesses having pain and suffering is a frequently debated issue in the community. However, there is often confusion in the concepts and terminologies involved. Different people have different definitions for the terms used in the discussion.

Euthanasia could be defined narrowly or broadly. According to the broad definition, “euthanasia” means the intentional killing of a patient, by an act or omission, as part of the medical care. An action can be either an act or omission. If a parent has deliberately let his/her child starve to death, in a way s/he has done nothing, but this is an omission and can be even worse than the act of killing the child.

Euthanasia in the broad sense includes both active and passive euthanasia. “Active euthanasia” means the killing is achieved by a direct act to kill. Passive euthanasia means the killing is achieved by omission of treatment. Euthanasia, active or passive, can be voluntary or not, depending on whether the killing has got the informed consent of the patient. If an act of euthanasia, be it active or passive, is not voluntary, it can be either non-voluntary or involuntary. It is non-voluntary if the patient killed either is not capable of making the request, or has not done so. Involuntary euthanasia means the killing is against the wishes of the patient.

According to the narrow definition, “euthanasia” is the same as “active euthanasia.” In its narrowest sense, the term means that the direct act of killing has got the informed consent of the patient. The categorization of different kinds of euthanasia is summarized in Table 2.1.

⁷Yung (Chap. 1 of this book) points out that societal values help to select the exact policy option (within a wide range of acceptable policy solutions) to be adopted by the society concerned to tackle certain policy issues, including policy to deal with ethical issues.

Table 2.1 Categorization of different kinds of euthanasia

Euthanasia	Active (narrow sense)	Voluntary (narrowest sense)
		Non-voluntary
		Involuntary
	Passive	Voluntary
		Non-voluntary
		Involuntary

Regarding active euthanasia, it is morally unacceptable if it is non-voluntary, because the wish of the patient is not known, and it may be against his/her wish to kill him. In the case of involuntary active euthanasia, the patient does not want to die. So it is against the patient’s wish. The act violates the principle of autonomy and can be regarded as a case of murder.

The most hotly debated form of euthanasia is voluntary active euthanasia. In the medical and legal field, when the term is used without qualification, euthanasia usually signifies “voluntary active euthanasia.” According to the Professional Code of Practice of the Medical Council of Hong Kong (2009), euthanasia is defined as “direct intentional killing of a person as part of the medical care being offered.” Such euthanasia is illegal throughout the world with the exception of the Netherlands, Belgium, and Luxembourg, where active voluntary euthanasia has been legalized since 2002, 2002, and 2009, respectively. Additionally, physician-assisted suicide⁸ has been legally permitted in Oregon State, Washington State, and Vermont State, and California of USA since 1997, 2009, 2013, and 2016, respectively. On the other hand, for many years, Switzerland has allowed assisted suicide (not necessarily physician assisted) based on altruistic motives.

In the 1990s, the public prosecutor in the Netherlands would not prosecute physicians for euthanasia if they have adhered to a number of requirements. In 2002, the Euthanasia Act was passed. The Act allows euthanasia in patients with “no prospect of improvement, and were experiencing unbearable suffering.”⁹ In 2001 and 2005, 2.8 and 1.8 deaths out of 100 deaths, respectively, were the result of euthanasia

⁸In the case of physician-assisted suicide (PAS), the patient kills himself/herself with the lethal drugs provided or the apparatus set up by a physician. It is different from euthanasia in the sense the patient is not killed by the physician. Some people think that this is less morally controversial because it is the patient who kills himself/herself, while some maintain that it is against the professional ethics of medicine because physicians have the duty to save lives, cure patients, and alleviate their pain and sufferings, but not to help them commit suicide. The legalization of PAS will also lead to the legalization of voluntary active euthanasia. If an attempt of a PAS is not successful because the dosage of the lethal drugs is not strong enough or with some other errors, the patient may suffer a lot and also be incapable of taking further action to end his or her life quickly. Provided that voluntary active euthanasia is legalized as well, the physician can step into help the patient ending his/her life. For further discussion of the ethical issues of PAS, see Warnock and Macdonald (2008) and Dworkin et al. (1998).

⁹One should note that the patient eligible for euthanasia in the Netherlands is not necessarily terminally ill, nor suffering from physical pain. More details of the law could be found in <http://english.justitie.nl/currenttopics/pressreleases/archives2002/-euthanasia-and-assisted-suicide-control-act-takes-effect-on--april-.aspx>.

(and assisted suicide) in the Netherlands (Van der Heide et al. 2007). It is alarming that the proportion was so high (Keown 2002).

Regarding passive euthanasia, the example of killing by omission given earlier, i.e., a parent deliberately letting his/her child starve to death, is obviously morally unacceptable. On the other hand, with the advances in medical technology, there are situations when forgoing certain forms of life-sustaining treatment is morally acceptable. Though this is sometimes still labeled as passive euthanasia, forgoing life-sustaining treatment in appropriate circumstances is legal in most parts of the world. What constitutes an appropriate circumstance and how the decision is to be made will be discussed in a later section. This chapter would go on first to discuss voluntary active euthanasia.

Reasons for Voluntary Active Euthanasia

There are a number of reasons to support the legalization of voluntary active euthanasia. First, one may argue that we should respect the patient's personal choice to end his/her life to relieve his/her suffering because the autonomy of a person has to be duly respected. Second, there are hard cases in which the unbearable pain and suffering of a patient cannot be effectively alleviated by pain management and palliative care, despite forgoing burdensome/futile life-sustaining treatment and palliative care. Active euthanasia may well be the last resort. Third, one might argue that the intrinsic value of human life is duly respected if active euthanasia must be voluntary and used only as a last resort for hard cases. According to this view, providing such euthanasia under an exceptional circumstance does not constitute a denial of the sanctity of life because the intrinsic value of life is not absolute and so can be trumped by other moral considerations. Finally, some severely ill patients, such as those who suffer from quadriplegia, are not able to kill themselves even when the option of physician-assisted suicide is available because they are not able to put the lethal drug into their mouths or press the button to switch on the lethal injection. Voluntary active euthanasia seems to be the only way out for these patients to relieve their sufferings. It seems unfair if they are deprived of this option of ending their lives simply because they are in a more miserable situation.¹⁰

¹⁰Cheng and Ming (Chap. 3 of this book) discuss that a minimal level of mental and physical health is important for a meaningful life and abortion is acceptable if the fetus is known to have serious physical incapacities (because of the low possibility of leading a meaningful life after birth). Similarly in the case of euthanasia, the option to end one's life may be acceptable if the patient concerned is facing serious terminal illness, with intense sufferings, thereby little or no prospect of leading a meaningful life.

Reasons Against Voluntary Active Euthanasia

However, there are also a number of reasons against the legalization of voluntary active euthanasia. First, with modern palliative care, pain and suffering of the great majority of patients can be controlled. In many situations, a request for euthanasia is a request for relief of symptoms. Second, licensing killing in non-war situations has significant impact on societal values. The licensing may lead to the belief that the life of the disabled or those who suffer physically or psychologically from severe illness is less valuable because on the one hand voluntary active euthanasia is applicable to them, but on the other hand, direct killing of other people with their consent is morally impermissible. This differential treatment is based on the view that these patients have no promising future and so their lives are less worthy such that killing them under some circumstances is morally acceptable. Yet this view is discriminatory because lives in whatever conditions should be treated as equally valuable. Third, there could be implicit pressure on the chronically ill and the vulnerable groups to choose euthanasia, especially in a Chinese society like Hong Kong, because they might think that their choices of staying alive may lead to wastage of scarce healthcare resources or a burden to their family. Fourth, there may be negative implications on resource allocation to the chronically ill and terminally ill. Since voluntary active euthanasia is a quick and easy solution, there may be much less effort for developing palliative care and hospice services which can alleviate the pain and sufferings of the chronically or terminally ill and can be a good alternative to euthanasia. Finally, the legalization of voluntary active euthanasia can create a “slippery slope.” Once the barrier to euthanasia is broken, abuses are prone to occur because it is difficult to ascertain that the request for euthanasia is entirely voluntary and no better alternative is available. The legalization implies that under some circumstances, killing those who suffer from severe illness is something good and acceptable. It may give an excuse to end their lives even when their wishes are not so certain. The legalization of voluntary active euthanasia may subsequently lead to more and more non-voluntary active euthanasia in practice. That has already happened in the Netherlands, where euthanasia is extended to infants (Verhagen and Sauer [2005](#)).

Alternatives to Voluntary Active Euthanasia

The above discussion shows that the controversy about the legalization of voluntary active euthanasia arises from a set of conflicting values and moral considerations, including the intrinsic value of life, autonomy, well-being of the patient, and the social consequence of the legalization. Supporters of voluntary active euthanasia base their arguments on the value of autonomy and the concern about the well-being of the patient, while opponents base their arguments on the intrinsic value

of life and the negative social consequences arising from the legalization of voluntary active euthanasia. It is difficult to come to a conclusive answer to the question of which position is right. Different stakeholders in society may uphold different views, and it will be divisive if either of the rival views is adopted to formulate public policy in regard to the end-of-life decision making. Just dragging on and on in an endless theoretical debate about the pros and cons of euthanasia provides no practical alternatives to alleviate or relieve the pain and sufferings of patients with advanced irreversible illness. From a practical point of view, policy makers have to work out alternatives to voluntary active euthanasia based on a compromise among the conflicting values and moral considerations upheld by various stakeholders. These alternatives will be more feasible and widely supported by people in different walks of life. In the following sections, we will discuss the alternatives adopted in Hong Kong.

Palliative Care

Euthanasia is to end a patient's pain and suffering by killing him/her. However, with appropriate treatment, most symptoms can be adequately controlled without resort to killing the patient. It is true that many terminally ill patients suffer from a lot of physical symptoms. They may also suffer from psychological and spiritual distress. Modern palliative care, which is a specialized field of health care to help the terminally ill patients, addresses the suffering of the patient with a holistic approach. The service is provided by a multidisciplinary team of doctors, nurses, social workers, counselors, and other professionals. With the appropriate use of analgesics and other modalities of medical treatment, coupled with psychological, social, and spiritual support, most terminally ill patients could attain a peaceful death. Sometimes, strong narcotics are used as analgesics to control pain. These are very effective and safe if appropriately used and in most cases do not lead to shortening of life. In the rare situations when the symptoms cannot be controlled adequately (the "hard cases" discussed under the earlier paragraph "Reasons for Voluntary Active Euthanasia"), palliative sedation may be given as a last resort (Cherny et al. 2009). The patient is given sedation to reduce the awareness of the symptoms. Though the life of the patient will likely be shortened by this, palliative sedation is not active euthanasia and obviates the need for active euthanasia.

Modern palliative care was pioneered in the UK in the 1960s as a response to the plight of the terminally ill. Now, palliative care is developed in many parts of the world, including Hong Kong. Unfortunately, because of resource limitation in some parts of the world, not all needy patients could have access to appropriate palliative care and are suffering needlessly. However, the community should consider providing more resources to help the terminally ill rather than resorting to euthanasia.

Forgoing Life-Sustaining Treatment

Palliative care is to relieve the suffering of the patient rather than to hasten death. On the other hand, palliative care accepts that death is an unavoidable fact and does not aim to prolong the dying process meaninglessly.

Because of advances in medical technology, even for a terminally ill patient, there could be many treatment modalities that can prolong life. These are classified as life-sustaining treatments (LSTs) and include, for example, dialysis, mechanical ventilation, and cardiopulmonary resuscitation. For the terminally ill patients, these treatments have the potential to postpone the patient's death, but the underlying terminal illness would not get better. While the biologic life of the patient is prolonged, the patient could become unconscious because of the underlying illness or because of brain damage during resuscitation measures. The patient could also have pain and suffering from the complications of the treatment or from the underlying illness. The prolongation of life could thus be regarded as a prolongation of the dying process and may not be appropriate. Modern medical practice considers that it is sometimes appropriate to forgo the LST in these terminally ill patients (British Medical Association 2007, p. 3). Forgoing LST in appropriate circumstances is medically and legally distinct from euthanasia in its narrowly defined meaning. In contrast to the latter, the former is legally acceptable in most parts of the world including Hong Kong. Many medically advanced countries in the world have issued guidelines on this, and the Hospital Authority of Hong Kong has issued the guidelines in 2002.

Forgoing LST is considered appropriate when it is the wish of a mentally competent and properly informed patient, or when the treatment is considered *futile* (Beauchamp and Childress 2001, p. 141). But what counts as futile, and what counts as treatment? We will have further discussion of these concepts below.

Respecting the wish of the patient involves the ethical principle of "autonomy." One cannot force treatment to a patient who has refused it, as long as the patient is mentally competent and properly informed when the decision is made, even though the treatment is considered by others as beneficial to the patient. Legally, forcing such treatment to a patient may constitute an offense of battery.

Forgoing futile LST implies the acceptance of the fact that human is mortal. On the one hand, this approach recognizes the intrinsic value of life and so rejects the direct intentional killing of a person as part of the medical care being offered. On the other hand, it does not regard the intrinsic value of life as absolute and does not fight death to the very end because the well-being and the autonomy of the patient have to be taken into consideration.

The determination of *futility* involves the ethical principles of "non-maleficence" (do no harm) and "beneficence" (do good). To determine whether a treatment is futile, one has to balance the burdens and benefits of the treatment toward the patient (British Medical Association 2007, p. 14), asking whether the treatment is in the best interests of the patient. However, the determination of futility is not easy. Other than cases of physiologic futility, which means that the chance

of sustaining life by the treatment is minimal, the determination of futility involves quality of life considerations and can be value-laden. The decision-making process in most cases is therefore not a pure medical decision, and one should consider the wishes, values, and preferences of the patient (Department for Constitutional Affairs 2007, Chap. 5).

In Hong Kong, if the patient is not mentally competent and does not have a guardian, the doctor in charge may legally make medical decisions for the patient, based on the best interests of the patient (Hospital Authority 2002). However, as most decisions on futility of LST are value-laden, the patient's family should be consulted for their views about the patient's best interests and to see whether they have any information about the prior wishes and feelings, values, and beliefs of the patient. To make a decision, the healthcare team should try to build consensus with the family if possible.

Forgoing LST could mean withholding or withdrawing the treatment. One should note that there are no legal or necessary morally relevant differences between withdrawing and withholding LST (British Medical Association 2007, p. 19). Allowing withdrawal may safeguard those patients whose benefit from LST may appear uncertain at first. For these patients, if withdrawal is not allowed, LST may be withheld because of the worry of prolonged suffering if the LST turns out only to prolong the dying process without leading to meaningful recovery. If withdrawal is allowed, LST could be tried first, only to be withdrawn when there is no meaningful recovery from the treatment.

Though artificial nutrition and hydration are legally classified as medical treatment, the withdrawal of such is controversial, because some people would consider this as basic care. Except when death is imminent and inevitable, or it is the wish of a mentally competent patient, some guidelines on LST require special procedural safeguards before artificial nutrition and hydration can be forgone (British Medical Association 2007, p. 17). It is most important to understand that forgoing LST in appropriate circumstances does not at all mean abandoning the patient. Basic care, symptom control, care, and concern should always be offered.

Advance Directives

Sometimes, what is in the best interests of a mentally incompetent patient is difficult to decide, especially if the prior view of the patient is not known. In recent years, the concepts of advance care planning and advance directives are promoted in various parts of the world, so that the wish of the patient could be made explicit before losing capacity (Capron 2009). An advance directive is an expression by a mentally competent adult person of how s/he wishes to be treated when s/he becomes mentally incapacitated. There are two kinds of advance directives: an instructional directive and a proxy directive.

An advance instructional directive (a living will) usually comprises instructions about what kind of LST that a patient wishes to refuse when s/he becomes mentally incapacitated under some specified circumstances. In Hong Kong, a valid and applicable instructional directive is legally binding and should be followed (Hospital Authority 2010). For an advance instructional directive to be valid, firstly, it must be clear. Secondly, at the time of making the directive, the patient has to be mentally competent and properly informed and has to understand the consequence of the instruction. To be applicable, the present clinical situation must be a condition specified in the directive, and there are no unforeseen events that lead to the clinical deterioration, like an accident or foul play.

An advance proxy directive (enduring power of attorney for health care) expresses the patient's wish to appoint another person, usually a family member, to make healthcare decisions on his/her behalf when s/he becomes mentally incapacitated under some specified circumstances. A proxy directive is not legally binding in Hong Kong even if it is valid, but that is not the case in some other jurisdictions, including USA, and some territories in Australia. UK also recently changed the law to allow this.

In Hong Kong, the term "advance directive" is usually used in a narrow sense to mean an instructional directive for the refusal of LST. This usage will be followed in the discussion below.

The legal force of a valid advance directive stems from a respect of the autonomy and the bodily integrity of the patient. Treatment against the wishes of a patient could be regarded as an offense of assault or battery. Similar to a contemporaneous refusal, if the validity of the advance directive is not in doubt, the advance directive should be followed even though the treatment is considered by others as beneficial to the patient.

Advance directives are useful tools for healthcare professionals to understand and ascertain the wishes of the patient and so can serve to promote patient's best interests. However, it should be noted that an advance directive is only a tool to document the decision of the patient to refuse certain LST. If a patient faces an incurable disease, it is important to have an adequate process of communication among the patient, the family members, and the healthcare team regarding what kind of care is considered appropriate when the patient becomes mentally incompetent. This communication process, called "advance care planning," allows improved understanding, reflection, and decision making regarding end-of-life care (The NHS End of Life Care Program 2008). The signing of an advance directive is only one of the outcomes of the advance care planning process.

Advance care planning is an integral part of palliative care and should be promoted to suitable patients with advanced progressive diseases, in anticipation of progressive deterioration, before death is imminent. At this moment, advance directives are seldom practiced in Hong Kong. The Hospital Authority of Hong Kong has issued guidelines on advance directives in 2010. With more community education, the concept of advance directives may be more understood and accepted by the general public.

An Important Note on Terminology

In public debates and in bioethics literature, the term euthanasia often carries a broader meaning. Forgoing life-sustaining treatment (LST) is often considered as one form of euthanasia, labeled as “passive euthanasia.” Different ethicists define “passive euthanasia” differently. Some define the term as all forms of forgoing LST, while some define it as forgoing LST with the intention to shorten life which can be regarded as killing the patient by omission. It should be noted that, legally and medically, forgoing LST is distinct from active euthanasia. The former, if carried out under appropriate circumstances (when it is the wish of a mentally competent patient or when the treatment is futile), is legally acceptable in most parts of the world including Hong Kong. To avoid any unnecessary confusing connotations, the term “passive euthanasia” is not recommended by the medical and legal field, and the term is not used in relevant guidelines and legislations in many Western countries and Asian regions (including Hong Kong, Taiwan, and Singapore) on the issue. Forgoing LST is itself a complex ethical issue, and what constitutes futility is not easy to define. Some situations are non-controversial, like forgoing cardiopulmonary resuscitation in a dying patient with advanced cancer, which is being practiced everyday in Hong Kong, whereas some situations are controversial, like the withdrawal of ventilator support in a conscious quadriplegic patient. It would not help public discussion if the term “passive euthanasia” is used indiscriminately without a clear definition, especially when non-controversial cases of forgoing LST are referred to as “euthanasia.” They are not cases of killing the patient but allowing them to die naturally. The patient just dies of some life-threatening disease which is something unavoidable. The use of “euthanasia” may blur, for no good reason, the distinction between active euthanasia and forgoing futile LST which is a necessary sequel to advancement of medical technology. Without such forgoing, many dying patients would have to go through various meaningless futile treatments that only add suffering before they are certified dead. Since there is a distinction between forgoing futile LST and active euthanasia, the acceptance of former does not necessarily mean the acceptance of the latter.

The terminology issue in the Chinese community is further compounded by the loose usage of the Chinese term 安樂死, which is sometimes used to describe the state of the dying process or even palliative or hospice care, besides euthanasia in the standard sense or forgoing LST (Tse and Pang 2006, p. 171).

Such a loose usage of the term euthanasia or 安樂死 leads to difficulties in public discussion. Public opinion in support of euthanasia may actually include support for forgoing futile LST and support for palliative care. This confusion is totally unnecessary and should be avoided.

Conclusion

In this chapter, we have seen that although under some circumstances death is not always worse than life, it does not follow that voluntary active euthanasia is morally permissible. There are rival views about the legalization of voluntary active euthanasia, and the controversy stems from a set of conflicting values and moral considerations, including the intrinsic value of life, autonomy, well-being of the patient, and the social consequence of legalization.¹¹ There is no simple and clear answer to the question of whether voluntary active euthanasia should be legalized. A practical solution, as in the case of Hong Kong, is to develop alternatives to legalization based on a compromise among the conflicting values and moral considerations so that there are effective ways to alleviate or relieve the pain and sufferings of patients with advanced irreversible illness.

Acknowledgment The preparation of this chapter was supported by the Strategic Research Grant 7112019 and the Governance in Asia Research Centre at the City University of Hong Kong. Thanks were due to Mr CK Chui for his research support.

References

- AM730. (2012). Ah Bun suddenly passed way; close friend said: 'he eventually loosed the constraints' (bin zai ji bing li shi zhi you: zhong ke bu shou shu fu). 10 December.
- Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.
- British Medical Association. (2007). *Withholding and withdrawing life-prolonging medical treatment: Guidance for decision making* (3rd ed.). Malden, MA: Wiley.
- Capron, A. M. (2009). Advance directives. In H. Kuhse & P. Singer (Eds.), *A companion to bioethics* (2nd ed., pp. 299–311). Malden, MA: Wiley.
- Cherny, N.I., Lukas, R., & The Board of the European Association for Palliative Care. (2009). European association for palliative care (EAPC) recommended framework for the use of sedation in palliative care. *Palliative Medicine* 23(7), 581–593.
- Chong, D. (2010). Local: Home after 19 years, Ah Bun starts anew. *The Standard*, 20 August 2010.
- Department for Constitutional Affairs. (2007). *Mental capacity act 2005: Code of practice*. London: Department for Constitutional Affairs.
- Dworkin, G., Frey, R. G., & Bok, S. (1998). *Euthanasia and physician-assisted suicide: For and against*. Cambridge: Cambridge University Press.
- Evans, A. (2010). Hong Kong: Hong Kong euthanasia plea man goes man. *BBC News*, 20 August 2010.
- Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Oxford: Basil Blackwell.
- Hospital Authority. (2002). *HA guidelines on life-sustaining treatment in the terminally ill*. Hospital Authority Homepage. http://www.ha.org.hk/visitor/ha_visitor_index.asp?Content_ID=363&Dimension=100&Lang=ENG. Accessed April 7, 2014.

¹¹For another discussion taking a similar set of values into consideration, see Cheng and Ming (Chap. 3 of this volume).

- Hospital Authority. (2010). *Guidance for HA clinicians on advance directives in adults*. Hospital Authority Homepage. http://www.ha.org.hk/haho/ho/psrm/Guidance_HA_Clinicians_on_Advance_Directives_inAdults.pdf. Accessed April 7, 2014.
- Keown, J. (2002). *Euthanasia, ethics and public policy: An argument against legalisation*. Cambridge: Cambridge University Press.
- Lam, C.-H. (2004). Hong Kong: New equipment helps Ah Bun learning communication (xin yi qi zhu bin zai xiao gou tong). *Wen Wei Po*, 12 October 2004.
- Long, A. A., & Sedley, D. N. (Trans.). (1987). *The Hellenistic Philosophers* (vol. 1). Cambridge: Cambridge University Press.
- Medical Council of Hong Kong. (2009). *Code of Professional conduct for registered medical practitioners*. Medical Council of Hong Kong Homepage. <http://www.mchk.org.hk/code.htm>. Accessed April 7, 2014.
- Tang, S. (2007). *Wo yao an le si (I Want To Have Euthanasia)*. Xianggang: San lian shu dian.
- The NHS End of Life Care Program. (2008). *Advance care planning: A guide for health and social care staff*. Leicester: The NHS End of Life Care Program.
- Tse, C. Y., & Pang, S. M. C. (2006). Euthanasia and forgoing life-sustaining treatment in the Chinese context. In C. Chan & A. Chow (Eds.), *Death, dying and bereavement: A Hong Kong Chinese experience* (pp. 169–181). Hong Kong: Hong Kong University Press.
- Van der Heide, A., et al. (2007). End-of-life practices in the Netherlands under the Euthanasia act. *New England Journal of Medicine* 356, 1957–1965.
- Verhagen, E., & Sauer, P. J. J. (2005). The Groningen protocol: Euthanasia in severely ill newborns. *New England Journal of Medicine*, 352(10), 959–962.
- Warnock, M., & Macdonald, E. (2008). *Easeful death: Is there a case of assisted dying?*. Oxford: Oxford University Press.
- Wittgenstein, L. (1961). *Tractatus logico-philosophicus*. London: Routledge & Kegan Paul.
- Wolff, R. (2011). *Ethics and public policy*. London: Routledge.

Ethical Dilemmas in Public Policy
The Dynamics of Social Values in the East-West Context
of Hong Kong

Yung, B.; Kam Por, Y. (Eds.)
2016, VIII, 212 p., Hardcover
ISBN: 978-981-10-0435-3