



In This Issue **30 years of bioethics 生命倫理學三十年**  
本期主題 **Environmental ethics 保育環境的倫理**

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## FEATURE ARTICLES 專題文章

### From Medical Ethics to Bioethics

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In accounting for the emergence of bioethics, we can regard bioethics as a response to the inadequacy of traditional medical ethics.

Traditional medical ethics is in essence a professional ethics. It is an ethics about what members of the profession should behave. It is an ethical code set by the profession and sanctioned by the profession. Within this professional ethics, "ethical" means "acceptable according to the ethical standard of the profession", and "responsible" means "responsible to the profession".

Take for example the recent case of a doctor using mobile phone while he was doing a surgical operation. From the perspective of traditional medical ethics, the key ethical question is whether the doctor has met the professional standard. It was concluded that he has made a minor mistake but there was no professional misconduct. If you ask a layperson, he or she would most probably regard it as clearly unethical to use a mobile phone to talk about personal matter in the process of surgical operation. However, from the point of view of traditional medical ethics, the doctor is held ethically responsible to his profession. And it is up to members of the profession to decide whether the doctor has acted unethically.

Traditional medical ethics regards ethics as a matter of professional standard. The professionals set the standards, and the professionals follow the standard.

The ethical standard set by the medical profession is rather simple. Usually it consists of a few statements about the code of practice, such as ten statements or seven principles.

According to this traditional view, the challenge of ethics does not consist in the theoretical but in the practical task. The ethical code is regarded as uncontroversial. The crucial question is whether you can follow it or not. Some elements of the code of practice are actually quite demanding, for example, one should always maintain one's professional judgment without being affected by political consideration, or one should always act in the best interest of the patient.

This traditional medical ethics can be summed up in the following formula: The interest of the patient is the end and paternalism is the means. The patient's best interest should be promoted, but in the judgment of the doctor.

### Challenge to traditional medical ethics

However such a complacent medical ethics encountered serious challenges in recent decades. I would say the challenges come from two directions.

The first challenge comes with the advances in technology. The old dictum "in the interest of the patient" can no longer provide an adequate guide. For example, is the interest of the patient best served by maintaining his life as long as possible? If a patient is in permanent coma and life support has been provided to him, is the removal of life support a harm to the patient? The answers to these questions are not clear within the framework of traditional medical ethics.

There is a generally acceptable ethical principle: "I ought implies I can". If it is beyond one's ability to do something, then there is no question whether the person ought to do it or not. But if now we can do something we cannot previously do, then we have to start thinking whether it is something that we ought or ought not to do. For example, with the advent of reproductive technology, we have to consider the moral question whether it should be used or not. The newly emerged problems are not readily answered by traditional medical ethics.

A second challenge of traditional medical ethics comes from the rise of individual rights in modern ethical discourse. The traditional Hippocratic medical ethics is framed in the language of the interest of the patient and the professional judgment of the doctor. The rights approach is totally alien to the traditional Hippocratic medical ethics. However, the rights approach is commonly used in everyday moral discourse, and the omission of the consideration of rights implies that traditional medical ethics does not constitute an adequate ethical account. To acknowledge the rights of the patient adequately, the model of the doctor as the sole decision maker has to give way.

A new bioethics has to replace the traditional medical ethics in deliberating what is right and what is wrong with matters regarding life and death.

I would like to go on to introduce the major approaches to bioethics. But before I go on, I would like to say a few words about how bioethics should not be done. I refer to these approaches to bioethics as "sham bioethics".

### Sham bioethics

Some people working in the area of bioethics are adopting one of these approaches to bioethics. I am not going to name them here. What I want to do is to give a characterization of these two types of bioethicists, such that you can recognize them when you see them.



The first approach of sham bioethics is what may be called "rational dogmatism". You have the conclusion first, and then you look for the arguments you need. R. M. Hare has given a very good characterization. "They have some deep unquestioned conviction, usually religious or political in origin, about, say, contraception or social justice, and having learnt some philosophy, are prepared to make any eristical move they can think up, not to test the conviction, but to support it. One is reminded of the famous remark about the way politicians use statistics as a drunkard uses a lamp-post, not for illumination but for support." (Hare 1986: 230)

The second type of sham bioethics can be called "opportunism". The writers react to ethical issues on a case by case basis without seriously seeking for any general principles and without serious concern about consistency. In one case, they uphold the sanctity of life, but in another case they can regard autonomy as the paramount value.

### Approaches to bioethics

Two landmarks are worth mentioning in reviewing the history of bioethics. The first one is the story told by Stephen Toulmin in his paper "How Medicine Saved the Life of Ethics". (Toulmin 1982) Why bioethics was born? Because there was a need for it. New moral dilemmas were encountered and the medical professionals did not know how to deal with them. As a result, there were calls from diverse professional policy making organizations for the supply of moral philosophers. Another landmark is John Rawls' *A Theory of Justice* (Rawls 1971). This book resurrected the interest in moral philosophy as it demonstrated that practical relevance and intellectual rigor could be maintained at the same time. It showed that philosophers can also have something interesting and important to say about practical ethical issues.

There have been different approaches to bioethics. I generalize them into three: applied ethics, pluralism, and casuistry.

The first approach to bioethics conceives bioethics as a kind of applied ethics. A certain ethical theory is accepted and used to solve bioethical issues. The assumed ethical theory might be a consequence-based or a rights-based theory. Such an approach operates moral justification and deliberation in a "top-down" manner - from theory to practice. Peter Singer's *Practical Ethics* (Singer 1979) and John Harris' *The Value of Life: An Introduction to Medical Ethics* (Harris 1985) are typical examples of this approach. An ethical stance is taken and logical conclusions are drawn to provide solutions to bioethical issues. The problem with this approach is that there are too many counterintuitive conclusions, such as meat eating is wrong and infanticide is right.

An alternative approach does not start with a ready-made ethical theory, but with some commonly accepted principles. In the *Belmont Report* (1978), three principles are identified: respect for persons, beneficence, and justice. In Beauchamp and Childress, *Principles of*

*Biomedical Ethics* (1979), four principles are put forward: respect for autonomy, nonmaleficence, beneficence, and justice. These four "Georgetown Principles" have more or less become the paradigm theory in bioethics.

A third alternative, which seems to be gaining recognition, is casuistry. "In formulating theory we start with particular moral judgments about which we are certain, and we abstract and formulate the relevant features of those cases to help us in turn to decide the unclear cases." (Clouser and Gert 1990: 232) The basic spirit of this approach is that you start with what you are certain, then you move on to what you are less certain. An ethical position is built eventually rather than taken as a foundation. There are three steps in making moral judgments in difficult cases: (1) Collection of moral data: Particular moral judgments that are intuitively appealing are taken as the foundation. (2) Generalization: The moral theory is a generalization based on the particular moral judgments that are intuitively appealing. (3) Limited application: The moral theory can be applied only in cases where people have no strong intuitive judgments.

Bioethics began as a disciple of ethics, and it has grown up to be an intellectual peer that ethics can learn from.

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## ❶ Bioethics - how did it come about?

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What is bioethics? How did it come about? A lucid historical account is found in Albert R. Jonsen: *The Birth of Bioethics* (Oxford, 1998). In this book, Jonsen designates the forty years between 1947 and 1987 as the era during which bioethics emerges as a distinct discipline. 1947 was the year of the Nuremberg Trial, in which twenty-three physicians were convicted of war crimes committed under the guise of medical experiments under Nazi Germany. Medicine's traditional ethic and the ethics of research in medicine have ever since been vigorously examined and scrutinised.

### What it is

Bioethics was defined for the first time in 1972 in the *Encyclopedia of Bioethics* as "the study of the ethical dimensions of medicine and the biological sciences". A more elaborate definition has evolved in its 1995 edition: "The systematic study of the moral dimensions - including moral vision, decisions, conduct and policies - of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting."

The origin of this term was modest. A bi-located birth of the term "bioethics" was offered by Jonsen: Van Rensselaer Potter, research oncologist at University of Wisconsin, published an article in 1970 entitled "Bioethics, the science of survival", and subsequently, a 1971 book "Bioethics: Bridge to the Future". However, his original meaning of this word refers to a vision of incorporating of human values into the booming "New Biology" - the new biology was beginning to unfold the ultimate mystery of DNA and molecular biology, of ecology and our biological milieu. The appeal was to integrate human values into the quests of objective knowledge.

Bioethics in its present meaning probably originated from the second locus. One night in 1970, Dr Andre Helleger, a Jesuit-trained Catholic and an academic in ethics, was chatting with friends on the vision of an institute devoted to the study of the religious and ethical aspects of advances in the biological and medical sciences, the term "bioethics" was conceived as a term to bring biology, medicine and ethics together. This institute was subsequently founded with funding from the Kennedy Foundation - The Kennedy Institute. (Another major center, the Hastings Center, was founded from Rockefeller, Ford and other foundations.)

### Bioethics ≠ Medical Ethics.

Is bioethics simply re-iteration of the millenniums-old medical ethic (merely adding research ethics into its scope)? Not in its present formulation. Traditional medical ethic is a set of moral codes handed down over centuries within the medical profession, usually tracing its roots to the Hippocratic Oath. The subsequently evolved professional-defined body of ethical codes has earned trust and upheld professional integrity for a long time. Yet, in the modern era, the ethical issues in medicine and biological research are also public affairs. Some even go so far as to argue that bioethics is a "lay ethics" - in contrast to the "professional ethics" of the physicians. Lay persons increasingly gained legitimacy in debates on bioethical issues.

### Birth of Bioethics

The critical scrutiny of biomedicine began not with poor medical practice, but problematic research ethics. It started in 1966 when Henry Beecher, Dorr Professor of Research in Anaesthesia at Harvard Medical School, published a paper "Ethics and clinical research" in the *New England Journal of Medicine*. In the paper Dr Beecher presented twenty-

two examples of unethical experimentation, drawn from published articles by leading research scientists, and showed that they exposed patients to excessive risks, ignored proper consent, or used poor, mentally incapacitated persons, in some cases even withheld therapies of known efficacy. This unveiled the institution of medical research for queries and scrutiny by the non-medical world.

More scandals and misbehaviours within the biomedical research and health care were to feed the fire. In the Tuskegee project from mid-1930's to early 1970s, The US Public Health Service had been visiting and monitoring a group of black patients suffering from secondary syphilis without treating them, in order to study the natural course of the illness. This was in spite of the fact that Penicillin had already been widely available for treatment of the condition. Also in the 1970's, researchers at the U of Cincinnati General Hospital applied partial body radiation to patients with terminal cancer in order to provide data to Department of Defense on what might protect troops from radiation exposure. These scandals, and a few others, led to public and political outcry for non-physicians to participate in major decision-makings in biomedicine.

### The real issues

However, the birth of bioethics is not just about scandals and political dynamics. Real issues have emerged from new biotechnology and medical treatments. Complex issues cannot find solutions in the traditional code of beneficence and non-maleficence.

In 1960, a simple ingenious invention - the Scribner's shunt - made long term renal dialysis possible. Who is to receive dialysis, and who to be excluded? The new technology was needed by many, but resources were not available for all. Seattle physicians asked the local medical society to appoint a committee of seven lay persons to determine who to receive dialysis. This explicit form of rational medical resources did not subsequently become a general mode of ethical deliberation. However, it did signal a new era where lay persons values had to be incorporated in medical ethics.

In 1968, Dr Henry Beecher led a committee at Harvard to define criteria on brain death. On this apparently technical subject, the committee included a lawyer and a philosopher in its membership. Even then, the technical set of definitions, when published, were to encounter strong objections by religious groups and its proponents had to engage in a long debate on this subject.

### The society

The 1960's was a decade of social unrest. Following the civil rights movement, the prevailing political culture "fostered an extraordinary identification with the underdog and the minority." The medical profession was perceived to be part of "The Establishment" which might not be truly beneficent to the poor and the minorities. In 1970, Patient's Bill of Rights was promulgated in the US. The liberal president Walter Mondale led a crusade against conservative physicians, and medical cases - from the Karen Quinlan case in 1976 - were increasingly brought to the Court for rulings.

But it would be inaccurate to say that bioethics was a movement against the medical profession. Ethics Committee is now very much a part of the biomedical institution, and interdisciplinary discourses on ethical issues have stimulated, rather than stifled new perspectives in biomedicine. Bioethics as a discipline, like medicine itself, is open to scrutiny and reflection.

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## Some aspects of environmental ethics and education in a teaching/research organization

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'Genetic engineering' is rapidly becoming an entrenched part of our lives. The public and those providing money for research projects are showing much interest in how this genetic engineering is being accomplished, and what in the long run will it mean for them.

Genetic engineering can result in big financial advantages to those who can successfully tap into the commercial market. There is thus strong incentive to succeed.

On the other hand a proportion of the public are skeptical partly because of the profit motives and partly because a proportion of GE proponents have been slow in the field of public relations.

There are no binding genetic engineering regulations or codes of practice in Hong Kong. That is a strong reason the professionals in education need to take a lead and drive the environmental ethics program.

### Safety in genetic engineering - biological and environmental

Genetic engineering needs to be done in a safe manner and needs to be shown to be done in a safe manner. Indeed not being able to demonstrate that your research has been accomplished in a safe manner may be detrimental to one being able to publish one's work in prestige journals. This is analogous to animal ethics situations where the use of chloroform in animal experiments decreases the likelihood of acceptance of papers in the USA and in Europe.

There is clearly a strong association between genetic engineering, biological safety and environmental safety. To illustrate this I will use the example of the use of Vaccinia recombinants. Vaccinia is basically the cowpox virus that was also the component of smallpox vaccine.

Vaccinia recombinants are extremely good transferors of inserted genetic material and some may say it can be too efficient. Vaccinia work needs to be done in a biosafety level three (physical containment level three) facility. The virus is quite hardy and if it escapes following a mishap it can remain alive in the air-conditioning ductwork for about four years. Contact with a small area of broken skin on say one's face could lead to a vaccination scar at the contact point. A splash in the eyes of a laboratory worker could lead to scarring in the eye. Thus there are real potential problems when working this recombinant virus even if the genetic material to be transferred is innocuous. Today the number of persons who have had primary vaccinations is diminishing, and in my experience even the vaccination may not prevent a lesion in the above circumstances.

We do not doubt that genetic engineering has been involved in many medical successes. The production of human insulin in bacteria, production of Human Growth hormone in yeast, the production of safe hepatitis vaccines and hopefully in the not too distant future the production of a successful "AIDS" vaccine. There is also an impressive list of successes in genetic engineering in the plant arena.

### Responsible control

So how does one ensure a reasonable degree of responsible control of the research endeavours in this field?

In many countries of the world the research process is highly



regulated. However even that does not ensure compliance. While a safety approval should be sought, for some reason it may not always be sought for genetic engineering or other areas. To do lead-up research before making a research funding application is an example. Thus there needs to be emphasis on training and facilities.

Notwithstanding this, one way in which reasonable assurance can be sought, is that all laboratory research should require safety approvals, being subdivided into chemical, radiation and biological / genetic engineering. There are further methods available to cross check including animal research ethics and human ethics. Failure to obtain such approvals through proper and fair channels should result in funding being withheld. While not a perfect system it is a strong deterrent for those undertaking unauthorized work in teaching/research institutions. The approval systems need to have avenues for reasonable confidentiality as research is highly competitive, fairness to be able to be achieved by the existence of an appeal process, and the availability of independent referees / assessors where required.

A number of elements need to be involved in the assessments.

1. The suitability of the researchers' facilities including maintenance and validation programs.
2. The training and abilities of researchers and their staff.
3. An assessment of any risks.
4. An audit of the laboratory procedures.
5. What is the purpose of the intended work?
6. The use of independent outside expertise to help ensure that safety is being achieved and can be shown to be being achieved

To shortcut some of this, it may be prudent to certify facilities and to certify users of those facilities to do set levels of work; on the understanding that regular inspections will take place.

Sometimes it may be that only the researchers who really understand the in-depth details of their genetic engineering projects and what the ethical problems really are! Besides ethics, there must also be trust in the process.



## 可持續發展教育初探

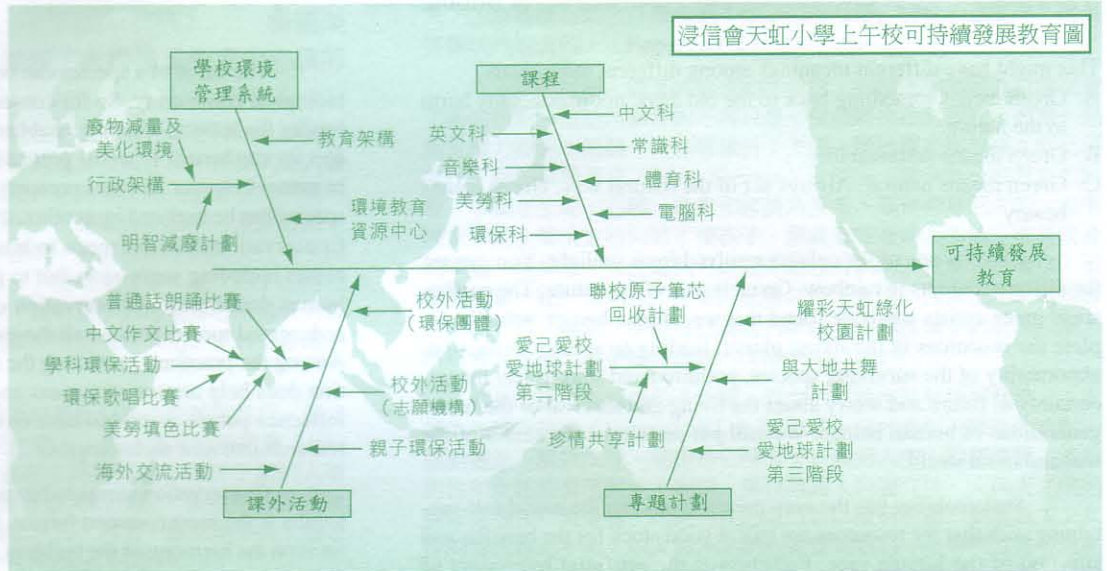
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聯合國科學及文教組織自1994年起推動「可持續性教育」(Education for Sustainability)，主旨是把環境教育、發展教育與人口教育彼此連合，讓環境教育與人類的文明進步和延續掛鉤，擴展環境問題在全人教育中的比重。深層的環境教育應把生態哲學、環境倫理結合於負責任的環境行為中(汪靜明 2000)，而現代教育的趨勢，是拓展環境教育的範疇，把生態思想融入各個學科，教導學生和社會去兼顧生活、生產與生態圈的可持續發展(李永展 1997；汪靜明 1999、2000；王鑫 1999)。

「可持續性教育」不單涵蓋了生態環境保育，更強調「人類的發展應尊重自然發展」這原則，要求人類與自然和諧共處，彼此相容，促進現代人和我們子孫在地球上的生存與發展能力。此外，可持續性教育強調互動促發，追求以人和自然界間共存共榮為主軸的全方位發展，是一種追求素質改善的文化，她有助提升人類對地球資源的運用效率，令社會走上公平、整全改革和不斷更新的道路，有利人類文明和生態系統的長期穩定。

在一片改革教育的浪潮中，我們應及早把可持續發展的理念鞏固在學校的體系內，成為新世紀學校環境教育的重要課題(汪靜明 1999；汪靜明等 1999；蘇慧貞 1999)。就可持續發展而進行的教育工作可從現有的環境教育活動延伸過來，透過教導學生「對環境友好」的觀念，可培養下一代的環境倫理意識、公民責任、事事關心的態度、善用資源的價值觀、科技開發能力、以至身體力行、以身作則的領袖氣魄。可持續發展要求人不要只顧自己的利益，更以自然界，我們的子孫和全人類的發展為考慮，不單可促進和平與穩定，更可及早實現社會、經濟和生態的協調開發(黃宇 2001)。因此，有認為可持續發展教育所扮演的角色，猶如一座橋樑，將課堂與職場、校園與社區緊密地聯繫起來(President 撮 Council on Sustainable Development 1994)。

浸信會天虹小學上午校是一所綠色學校。她以營造一個可持續的校園為目標，透過開放學校管理、改革校園設施、建構素質文化、綠化課堂和校園、善用再生資源、藉環保連系教師、學生、家長和社區等，建立了一個全人教育和全方位學習的網路。可持續性的概念借著環保方案的計劃、實施、評價和推動，提供了多姿多采的活動環節，概如圖1。這些活動讓教師和家長有可用的平臺去引導學生，讓他們更主動地探討校園生活及環境的現況，進而共同規劃和改善個人的行，甚而積極地向學校提出改革建議，帶動校園的學習氣氛和愉快上課的融洽風氣，是社會可持續發展的縮影。從實踐中累積經驗，可見校園的環境和學風都大幅改善，教師及學生間的互動關係也顯著進步。此外，學生從可持續發展教育所領會的「人與環境和諧」關係，幫助了學生理解人際關係的重要性，從而性格發展更加完備，令人欣慰。當然，透過教師的引導和校內環境的改善，學生也逐漸培養出對環境的敏銳度，能感知自然之美、增加了對旋律和美學的興趣。學生若建立及澄清對環境的價值，便能培養獨立思考與解決問題的技能，積極地創建可持續的校園和共存共榮的社會。



總結而言，「可持續發展」思想的形成，是我們汲取過往在科技、經濟、社會和價值觀念上不平衡發展的慘痛教訓後，熱切冀求促進社會，經濟和環境的協調發展(WCED 1987)的結果。因此，為了使發展與環保協調平衡，在社會建構工作上就要更注重公義及公平；在科技運用和研究上就要更詳細考慮資源的合理調配；而在教育上也應當更著重綜合思維鍛煉和多元化的學科整合。因此，21世紀的教育方向勢須改革，要更多著重綜合(Integrated)、整全(Holistic)、跨科目學習(Multi-disciplinary)和互動(Interactive)教學(何建宗 1999)，以培養能夠適應世界趨勢和可持續發展世代到臨的優秀下代。教育工作者和政治家一樣，也須具備承先啟後的觸角，以開明和活潑的方式，裝備學生去迎合「地球村」這個簇新的概念，才能面對二十一世紀的新挑戰(梁步青 1999)。

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## What is Green?

### A Bubble

This might have different meanings among different individuals.

A: Green means something back to the old days, not making any harm to the nature.

B: Green means sustainability.

C: Green means natural. Always act in the natural way. Green means beauty.

Green is one of the colours resolved from sunlight. You can see the different colours in rainbow. Green is part of the nature. The emphasis of green comes when we found that we, human beings, actually deplete the resources in the living planet, leading to species extinction, abnormality of the surviving species, pollution and start to feel the uncertainty of future and worry about the living and survival of the future generations of human beings. We still put our ego at the center of the real and mind world.

Sustainability has the very meaning to keep the world self-sustaining such that the resources are still at good stock for the benefits and survival of the human race. Pollution is the artificial byproduct of civilization. The natural system does not evolve to have the means to solve all the pollution problems, e.g. plastics. This drives some people to suggest, 'why don't we stop? Why don't we go back to the living style in the old days? If there were no motor car, there would not be car exhaust, the major source of air pollutants in Hong Kong.' We could walk and/or swim to a place. Yet could we? Time is most valued in Hong Kong. A train or bus save time going to work so that we can spend more time in meaningful work. The Internet enables us to communicate bridging the geographical barrier and can even be among a group of persons.

These technologies or products do not exist in the past. Could we really go back to the old living style? We generate a lot of the artificial products and it is not nature that could manage to degrade and recycle the components back to this living planet. It therefore has to depend on us to invent the proper technology to solve the environmental problems. We are the destroyers and we have to be the creators too.

Conservation might be different. A historic building can be conserved with legal status against destruction. In conservation biology, the unit for conservation is a species. The species so chosen may have spiritual value (e.g. maple in Canada), or it may be an endangered species (e.g. giant panda), or it may have practical value.

The value of a species can be very basic - its ecological role in a biological community. So for conservation, the practice is usually protecting the habitat, creating a habitat, restoring a habitat and thus many species can benefit from the protecting of the geographical region. Life in nature however includes competition and survival of the fittest. One species can be replaced by another, the phenomenon is called succession. Conservation does not mean to hinder the occurrence of natural processes including succession, but to protect the nature from undesirable human disturbance. Conservation could also be practiced to save the endangered species because all the species have the equal right to survive. Among the practices, protecting the nature is the most effective. Education does help arouse awareness and interests about the environment, influence people around to have environmentally friendly practice and research into new technologies.

Conservation seems to be rural but it is not. Protecting a natural habitat is the most common format. In modern architecture, the emphasis is on the harmony of the building, a human art, with the environment. Green gives a peaceful feeling to us. We like green. When the roof is constructed as a garden, it also attracts insects and birds besides man. A habitat is created in this way.

Environmental protection is a mother set while conservation is a subset. Conservation has a species as the focus. Environmental protection could be engineering methods to treat wastes generated or to reduce waste generation, or legislation to punish those doing harm to the environment.

The human species is a late-comer in history of living things. If by analogy this history is compressed to one day, we made our appearance at the very first minute of dawn while a lot of living organisms came on stage hours before us night. Our noses are not as sensitive as the dogs; our ears are not as good as the bats. Our uniqueness lies in our highly developed brain and its intelligence. Yet we are still part of the nature. We now all enjoy the biodiversity, e.g. the various colors in flowers, the different landscapes. Green is a practice that we show our appreciation of the nature and protect the existing world and its diversity.





## 墮胎：生存權、自主權與婦權爭議

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一九七三年一月，美國最高法院在著名的洛對韋德(Roe v. Wade)案中，以五對二的比數裁定，反墮胎條例違反美國憲法所保障的個人權利，標誌著墮胎在美國合法化的起點。自此美國國內有關墮胎問題的爭議一直沒有間斷，保守派人士甚至多次襲擊墮胎診所。至於香港，根據現行的法例，墮胎原則上是非法的，但容許以下例外：(一)因姦成孕；(二)因亂倫而成孕；(三)母親未成年；或(四)由兩位註冊醫生簽署證明，胎兒嚴重殘缺，或者懷孕對母親身心所造成的傷害比繼續懷孕為大。但事實上，到深圳墮胎或以其他形式繞過香港法例進行墮胎卻是相當普遍的現象。

早期有關墮胎問題討論，主要圍繞著胎兒地位的問題進行。保守派認為胎兒是人，所以墮胎就等同於殺人。按法學家約翰諾農(John Noonan)的觀點，我們至少有兩個理由將胎兒當作不折不扣的人看待。首先，雖然胎兒和成年人好像有很大的分別，但胎兒卻畢竟會(至少是有很大機會)發展成一個成年人。再者，既然胎兒的父母是人，順理成章地胎兒也自然是人。(Noonan, 1970)

對於墮胎等同殺人的觀點，自由派當然大力反對。例如瑪麗華倫(Mary Ann Warren)就辯論說，「人」可以有兩種不同的意思，其一是生物學意義的人(human in the biological sense)，這裏我譯為生物人；其二是具有道德位格的人(human in the moral sense)，亦即具有道德地位，並應受尊重的個體，這我譯為位格人。華倫認為「殺人」不道德，這個命題是否能夠成立，必須視乎我們這「說」的人是指生物人還是位格人。華倫認為殺害一個位格人固然是不道德的事情，但殺死一個生物人，卻並不一定不道德。華倫進一步論證，胎兒在當下並不具備任何成為位格人的條件，它沒有(或沒有太多)意識活動、沒有理性、沒有自我的概念、不能與人溝通、沒有自主自發的行為，因此我們沒有義務尊重它，故此孕婦應享有完全的墮胎自由。(Warren, 1973)

在胎兒地位的問題上，保守派和自由派各有自己的難處。諾農的困難在於，當他說胎兒的父母是人的時候，他已經假定了胎兒和父母同樣是人。這一點可以用一個例子說明：精子可以有一個主人，卻不能有父親，原因正是因為精子不是人。這樣看來，諾農並沒有真正證明過胎兒是人，他只是一開始就假定如此而已，這裏他犯了乞題的謬誤。至於說胎兒有很大機會發展成人，那其實相當於說，因為胎兒是一個潛在的人(potential person)，所以也就有一切與所有人相同的權利。對此，彼得辛格(Peter Singer)的反駁可說是相當有力的。辛格指出：一個太子當然也是一個潛在的君主(準君主)，但在他未登基之前，他卻不能享有與君主等同的權利。由此引伸，胎兒也不能享受與成年人一樣的權利。(Singer, 1993)

可是自由派也有他們的困難。華倫主張胎兒只是生物人而不即是位格人，固然有一定的道理(雖然她用以區別生物人和位格人的標準可以商榷)。但她的毛病卻在於完全否定了胎兒作為潛在位格人的道德地位，這一點剛好和諾農各走極端。太子的地位固然不能和君主等同，但卻也不能不比一般平民高。白米不過是潛在的飯，但一場大火燒掉了米倉也不能不算是糧食方面的損失。可見完全將潛在人的道德地位看作是微不足道的東西並不合理。

有關討論的焦點很快就從胎兒身上轉移到母親身上。一些極端的自由派主張，即使胎兒是人，母親仍然有權墮胎。對他們來說，墮胎問題的關鍵不在胎兒的地位，而在母親對身體的自主權。這個觀點的其中一位代表人物是萊迪湯遜(Judith Thomson)，她認為墮胎自由是婦女對自己身體自主權的體現。婦女有權處理自己的身體，因此有權決定自己是否讓胎兒在自己的子宮內生長。她強調婦女的權利與胎兒的道德地位毫無關係，即使胎兒是不折不扣的人，婦女對其身體的自主權仍不應受到威脅。(Thomson, 1971)

問題是，為甚麼要把對身體的自主權看成無上權威呢？湯遜提出了一些異想天開的思想實驗來論證她的結論，但由於篇幅所限，無法一一反駁，在此我只能引波伊曼(Louis Pojman)的一個例子來說明我的看法。假設我在公車上找到一個座位，坐下時剛巧坐到鄰座乘客的

錢包上，鄰座乘客請我挪開一點兒讓他取回他的錢包，我是否也可以宣稱我對身體有自主權而拒絕他呢？同理，如果胎兒是人(或潛在人)，為甚麼它的生存權永遠不如孕婦的身體自主權般重要呢？這是很難說得過去的。(Pojman, 1992)

八十年代以後，隨著婦權運動的發展，有關墮胎問題的討論又有了新的焦點。墮胎所牽涉的不再只是一個個體自由的問題，而是一個兩性權力關係的問題。有些婦權份子主張，墮胎權是解放婦女的必須條件。例如蘇珊雪文(Susan Sherwin)就指出，懷孕對孕婦帶來的影響，不論在生理、心理、社會和經濟角度看，都是非常巨大的，如果婦女不能全權決定她何時才要孩子，那就意味著婦女不能主宰其自身的幸福。理論上，女性當然可以以拒絕性行為的方式來防止懷孕，但事實卻是，在一個兩性不平等的社會之中，女性的性自主空間是相當有限的。雪文強調，孕婦自己就是判斷她是否適合懷孕的最佳人選，所以旁人不應干預孕婦的決定。(Sherwin, 1991)

可是即使是在婦權份子之間，雪文的立論也沒有得到共識。「支持生命婦女組織」(Feminist for Life)提出了一個非常引人深思的論點：墮胎權並不解放女性，理由是它隱含了一套男人中心的價值觀。傳統男性和女性的價值觀並不相同，男性強調人的獨立性，人與人之間的關係是潛在的競爭者，因此男性的價值觀以權利和權力制衡為主；女性的價值觀則不然，以人與人之間的連繫為重心，主要的道德考慮在乎人與人之間的關懷和休戚與共。(Gilligan, 1982)爭取墮胎權，按該會的看法，就是將母親和胎兒硬生生斬為兩截並對立起來，也因此是使女性的價值觀屈服在男性價值之下，這正正對是女權的最大的威脅。(Feminist for Life)

由此可見，墮胎是一個極為複雜的問題。不過，我卻認為以下三點是相當可靠的：(一)胎兒的權利並不是無足輕重的；(二)胎兒的權利輕於孕婦的同類權利；(三)懷孕後期的胎兒應享有和已出生嬰兒相近的權利，而嬰兒的生存權和成人的生存權大致相同。一個合理的墮胎條例必須同時反映這三個原則。我同意孕婦在絕大部份情形下都是有關墮胎問題的最佳裁判者(如果她真能無私地為腹中的小生命著想的話)，再者，即使胎兒有其獨立的道德地位，仍然需要由孕婦來為它的權利發言，正如子女的利益往往需要由父母代表決定一樣。如此看來，一套較寬鬆的墮胎法例是可以理解的。可是，美國不少州份都有一些旨在減少濫用墮胎權的措施，例如賓夕凡尼亞州就規定婦女墮胎前必須有二十四小時的等候期，期間醫護人員必須向意圖墮胎者解釋所有墮胎所可能帶來的各種後果，以及所有在墮胎以外的可能的選擇，例如社會上各種對母親的支援等。(Naral, 2001)為了保護胎兒，諸如此類的措施都有其存在的理由。至於如何才能在各方的權利和各種價值之間做出最佳的平衡，恐怕還需要更多的討論和社會實驗來確定。

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## ♥ Selective non-treatment of critically-ill or extremely preterm newborn infants (Part II) - Medico-legal perspective and decision-making process

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*(Editors' note: The first part of this paper was published in Vol. 5 No. 1 of this Newsletter, for selective non-treatment of these infants. This is Part II of the paper, which deals with the medical-legal considerations and the role of Infant Bioethics Committee. Sections of Professor Yu's paper has been edited and abridged. References and footnotes have also been omitted.)*

### THE MEDICO-LEGAL PERSPECTIVE

In 1983, the Department of Health and Human Services in the USA published rules to ensure that newborn infants with disabilities, no matter how severe, are provided with all possible life sustaining treatment, unless death is imminent or the risk of treatment is considered excessive. This had elicited mainly negative responses from health care professionals directly involved in the care of such infants and their opinions had indicated that such an edict is unacceptable. Alternatives have been formulated to such rules which have ensured that clinical decisions are made in the best interests of the infant and that they are made only after careful thought. Very few cases of selective non-treatment have reached the courts. It is considered appropriate for these difficult decisions to be made within the context of the infant/neonatologist/parent relationship and experience has shown that there is no excessive abuse in such private decision-making processes. The legal position appears to recognise the importance of respecting parental decisions but emphasis that the law court has the right to intervene and overrule a decision should that is necessary to protect the best interests of the infant.

References have been made in a recent publication to instances in which British law courts had upheld selective non-treatment in the three categories of neonatal conditions referred to previously. Firstly, selective non-treatment was ruled to be legally acceptable when death was inevitable in the case of a hydrocephalic preterm infant on the verge of death. Secondly, legal precedence for selective non-treatment for an infant with severe brain damage, who was neither dying nor in severe pain, was found in a case presenting to court with a high risk of multiple sensorineural disabilities. Thirdly, selective non-treatment was considered lawful in an infant where the benefits of life with treatment failed to outweigh the burdens of a "demonstrably awful life" of pain and suffering. Neonatologists and paediatric neurologists have advised selective non-treatment in many severely damaged infants with spina bifida based on some of Lorber's criteria without threat of prosecution. In spite of the presence of legal precedence, lawyers have continued to urge further clarification of the law to provide doctors with protection from charges of unlawful killing.

### THE DECISION-MAKING PROCESS

The importance of less medical paternalism and more informed parental involvement in the decision-making process of selective non-treatment has been emphasised for over 20 years. Unilateral decisions regarding the right to die should never be made by the neonatologist alone. Adequate and consistent parental communication carried out by

medical and nursing staff must begin with the admission of all infants into the NICU so that trust can be developed between the parents and staff irrespective of outcome. An open-visiting policy for families is essential to promote such parental contact. A realistic assessment of the infant's clinical condition should be given by the neonatologist to the parents as soon as possible. The medical facts should be presented with an honest, sympathetic and caring attitude. Often the information has to be repeated and reinforced by the entire staff. Otherwise, misunderstandings and unrealistic expectations can lead to confusion, suspicions, bitterness and frank hostility.

As with most medical decisions made by neonatologists require parental informed consent, much of the discussion on selective non-treatment depends on parental trust in the knowledge, judgment, and integrity of the doctor. However, subjectivity is not always easy to avoid even with experience neonatologists when the condition of a critically-ill infant is being appraised. It is therefore important to recognise deceptive signals before voicing an argument for selective non-treatment in infants and before initiating discussion with their parents on the matter. The four questions which one should ask are: (1) Am I being driven by despair? (2) Am I being unduly influenced by the external appearance of the infant? (3) Would I think differently if the parents had been visiting the infant every day? (4) Are my predictions about outcome based on current scientific knowledge?

Five decision-making principles have been published which define the obligations of the neonatologist and parents to ensure decisions are made only after careful thought (Appendix 2). When a consensus has been reached by the NICU staff that selective non-treatment is an appropriate option to raise with the parents, one or more intense and intimate meetings would be required to discuss and to reach a decision on the matter. These meetings usually involve both of the parents, the attending neonatologist, a nurse representative and the social worker. Ten questions have been suggested which will elicit the parents' perspective, communicate the neonatologist's empathy and commitment, and help the parents reach an appropriate decision (Appendix 3).

One exception to the above policy was reported from Japan. Although the Japanese neonatologist does listen to what the family is thinking, the parents are not asked to make a decision involving selective non-treatment. This approach is a total anathema to western medical practice. However, it was suggested that because of the paternalistic relationship between doctors and patients in Japan, the doctor's opinions are highly respected and influential, so that a "parental decision" is likely to be that made by the neonatologist anyway. In view of this, it is considered inappropriate to put an unnecessary burden on the parents by involving them in the decision-making process. Such concerns that participation by the parents in a shared decision for selective non-treatment would adversely affect their psychoemotional health have however not been substantiated. These studies showed that informed parents can accept the responsibility for the decision to withdraw life sustaining treatment for their infant, can feel they have made the right decision without carrying a burden of guilt for their participation, and can adjust to their loss with a healthy grieving process. The fact that Japanese neonatologists are less ready to withdraw neonatal intensive care is reflected by a report of over 100 children from 52 hospitals in Japan who were chronically ventilator dependent for an average of over 2 years. Over 60% of these children were suffering from irreversible disorders including perinatal asphyxia, Wednig-Hoffmann disease, various myopathies and congenital heart disease.



## PALLIATIVE CARE

The neonatologist's duty does not end with the decision for selective non-treatment. Principles and guidelines for palliative care have been published. Basic nursing care should continue with the emphasis to provide comfort to the infant. Electronic monitoring of physiological parameters, diagnostic investigations (such as x-rays and blood tests), medications (including oxygen and antibiotics) and therapeutic procedures (including resuscitation, all forms of assisted ventilation and intravenous infusion) which might prolong the dying process, should be discontinued. Prolonged terminal weaning, defined as a stepwise or gradual decreasing of ventilator support over a period of hours, is inappropriate. Dragging out the withdrawal serves only to prolong the dying process and any attendant suffering. The argument that the sudden withdrawal of ventilator support resembles an intentional killing does not hold merit, as in both cases, a treatment on which the infant depends for life is being discontinued and death is the expected outcome. Warmth is provided by clothing the infant who should be nursed in a normal cot. If the infant has apparent distress, symptomatic relief should be provided, such as suctioning to remove oropharyngeal secretions and sedation with normal therapeutic doses of morphine, on a p.r.n. basis, even if the pain relief measures may inadvertently shorten the dying process. One survey showed that opioid analgesia was provided to over 80% of infants as their life support was either being withheld or withdrawn.

A controversial issue involves the withdrawal of enteral nutrition and hydration during palliative care. Preterm or sick infants require gavage feeding and although it has been advocated that this feeding method is part of medical treatment and should therefore be discontinued during palliative care, others consider it as basic nursing care with must not be withheld under any circumstances. A number of court decisions have supported the withdrawal of nutrition thus equating the administration of artificial nutrition with other medical procedures. A procedure has been set in a British court on the legality of withholding gavage feeding. Nevertheless, a survey in Australia has shown that 80% of neonatologists would be reluctant not to provide gavage feeding, even when it might be lawful and seem to be in the infant's best interest. There is an obvious perception of a moral difference between withdrawing ventilatory support and withholding fluids or nutrition with selective non-treatment. The following statement has been made in an attempt to develop universally acceptable guidelines in terminally ill adults - "Naturally or artificially administered hydration and nutrition may be given or withheld, depending on the patient's comfort." However, opinions on this aspect of neonatal palliative care remain different in individual cases.

Parents need a quiet place to be with their infant during the dying process. They may wish that other family members and religious advisors be present. Hospice concepts have been applied to neonatal care by providing a family room which is private yet close to the NICU, and by training NICU staff in more supportive approaches towards the families. Such a programme allows the staff to cope better with the dying infants offered selective non-treatment and facilitates the grieving process in the parents. In certain circumstances, withdrawal of intensive care may be arranged to take place in the home, so that death can occur in more comforting environment for the family.

The withdrawal of life-sustaining treatment may result in death of an infant. This remains unacceptable to some society. One report showed that 55% of the deaths in a Japanese NICU occurred after a decision was made either not to be initiate treatment or not to continue to provide all

possible treatments. However in the latter group, the infants were managed by continuation of their pre-existing treatments, although no new therapeutic measures were introduced. This approach was considered appropriate for that particular society even though it was understood that such a practice of limiting rather than withdrawing life sustaining treatment might not be in the best interest of the infants by protracting their death.

## ROLES OF AN INFANT BIOETHICS COMMITTEE

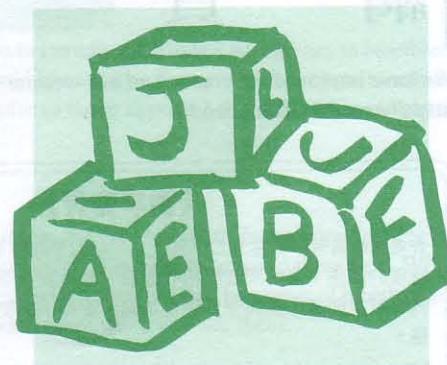
Guidelines for infant bioethics committees have been published. Their functions include:

- (1) education of staff and parents on relevant ethical principles and provision of literature and resources;
- (2) policy development and establishment of ethical principles;
- (3) prospective review through consultation in cases being considered for selective non-treatment and resolution of disagreements among staff and families, and
- (4) retrospective review of relevant medical records to determine the appropriateness of hospital policies and whether these policies are being followed.

Favourable experiences have been reported on the workings of such ethics review committees although a concern has been expressed that when they attempt to fulfill so many roles, they will do nothing well. The opinion is that such committees should serve only on an advisory basis without authority to implement any decision. An important function of an infant bioethics committee or consultative group is to provide ethical solace and support for neonatologists who have to face difficult and disturbing decisions.

## CONCLUSIONS

Continued advances made in the knowledge and technology in neonatal intensive care will necessitate ongoing revisions of the medico-legal and ethical guidelines. The principles behind decision-making on selective non-treatment will however remain interpersonal and intimate, respectful to the infants' lives and their parents' autonomy, and sensitive to the emotional concerns of parents and staff. Neonatologists have to be prepared to live with doubts regarding the correctness of some of the decisions they have made. William Osler has been quoted as saying, "Errors of judgment must occur in an art which consists largely of balancing probabilities. Clinical management principles in the NICU have been described as follows: (1) provide optimal care and assess the results of treatment, (2) alleviate suffering always, (3) cure sometimes and (4) allow death with dignity occasionally. This concept is based on the definition of the art of medicine in the Corpus Hippocraticum which states: "I will define what I conceive medicine to be. In general terms, it is to do away with the suffering of the sick, to lessen the violence of their diseases, and to refuse to continue to treat those who are overmastered by the diseases, realising that in such cases medicine is powerless."





## REPORTS 報 告

### Hospital Authority produces guidelines on life-sustaining treatment in the terminally ill

The Hospital Authority in Hong Kong is in the process of developing a set of ethical guidelines to assist health care team in making decisions on life-sustaining treatment in care of the terminally ill patients. This follows a more succinct guidance promulgated by the Medical Council of Hong Kong in the handbook of Professional Code and Conduct (November 2000).

The principle consideration of the HA ethical guidelines is that the initiation and continuation of any life-sustaining treatment must include an assessment of its burdens and risks, limits of efficacy and net benefit. There would be times when a life-sustaining treatment provides no net benefit to the patient and yet may be subjecting the patient to the harms and burdens of treatment. It is therefore imperative that access to life-sustaining treatment be coupled with an understanding of when and why the life-sustaining treatment should not be initiated or continued.

Sections in the guidelines deal with decision-making process for withholding or withdrawing life-sustaining treatment which is either medically futile, or in balance does not produce net benefit for the patient. The patient's best interests and his/her expressed choice are both core considerations. Thoughtful communication and continued palliative care are emphasised. Special sections deal with patients who are mentally incapacitated, and in case of child or infants.

From January to March 2002, the draft guidelines and its core issues were presented to various forums including public focus groups, patient groups, academics, clinicians, and professional organisations.

## MESSAGES 消 息

### Forth coming events

The Third International Conference of Bioethics will be held from June 24-28, 2002 National Central University, Chungli, Taiwan. Invited speakers include Professors H.T. Engelhardt, John Harris, Alex Capon, Kurt Bayertz and others. The theme of the Conference is "The Ethical, Legal and Social Issues of Stem Cell Experimentations in the Post Genome Era."

Further information can be obtained from Prof. Shui Chuen Lee, Director, Graduate Institute of Philosophy, National Central University, Chungli, Taiwan, R.O.C. (email: phil@cc.ncu.edu.tw)

## Our Website 網 頁

We have improved the contents of our website – come visit us!  
<http://www.bioethics.org.hk>

### 《徵求會員》

香港生命倫理學會在九六年底成立，目的是推廣本地及華人社區對生命倫理的關注。學會現公開招收會員，誠邀對生命倫理有興趣的朋友加入。有興趣者，請與學會秘書余錦波聯絡，或從本會網址下載入會表格。

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## NEXT ISSUE 下期預告

From next issue onwards, we shall establish a correspondence network on chinese bioethics news and commentaries. Readers are invited to send in short reports on recent bioethics news or discussions in your local community, or your commentaries of current topics in bioethics. News should be 500 words or less, commentaries 1000 words or less.

我們構想從下一期起，建立中華生命倫理議題的專訊與評論網，歡迎讀者提供各地華人地區的生命倫理、醫學倫理訊息或評論。訊息每條500字以內，評論1000以內，中英均可。

Please send by email to: Dr Derrick Au, [ksau@ha.org.hk](mailto:ksau@ha.org.hk)

Hard copy should be mailed to:

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## 刊登廣告

本通訊乃中、英雙語刊物，每年出版三期，讀者遍及香港、中國大陸、台灣和海外對生命倫理關注的教育、醫療、法律、社會學、哲學等專業人士。歡迎惠賜廣告，費用如下：四分一版 HK\$700，二分一版 HK\$1500，全版 HK\$4000。詳情請向執行編輯余錦波查詢。