醫生協助下自殺

Doctor-assisted suicide

(A talk to doctors and nurses)

Ironically, nothing is certain in life, except death. How and when one dies is however much less certain. Very few terminal patients would like to suffer too much before passing. When they think that their life has become meaningless and that their continued suffering would only add to the burden of their loved ones and those who look after them, quite understandably, they would prefer to go early and with dignity. But sometimes their physical or mental conditions are such that they are unable to do anything to end their own life or to give others a direction to this effect.

When a suffering patient who has no hope of recovery makes a request to end his life, can the doctors and nurses who are taking care of him accede to such request? Is that legally permissible? Is that medically ethical? Is that morally acceptable?

In this talk, I would like to discuss these issues in the hope of helping us to understanding the problems involved.

Legal position in Hong Kong

Murder

We start with the law. When a doctor or a nurse does something which puts a patient to death, he or she runs the risk of committing murder. A murder is defined at Common Law as the unlawful killing of a person with intention to kill him or cause serious bodily harm to him. In the context of a medical situation, it refers to (1) doing an act or taking some steps (2) which causes or cause the death of another person by shortening his life even for a short time (3) with the intention of causing his death or shortening his life. It is not a defence to murder even if the "victim" gives his consent to or even requests for such act or steps. In other words, "mercy killing", even with the consent or request of the patient, is still murder. Any doctor or nurse performing

such act or taking such steps would be found guilty of the offence. This is a policy which has been confirmed in many authorities. (See *Lau Cheong v HKSAR* (2002) 5 HKCFAR 415, #119; *Smith & Hogan on Criminal Law* 14th ed. 675 - 676; *R (Nicklinson) v Ministry of Justice* SC(E) [2015] AC 657, at 766 #17.) There is a reason for this policy: if it were otherwise, there would be a lot of controversial and hard disputes as to what amounts to a valid consent and whether there is such a consent in individual cases.

Suicide

If a person does an act which kills himself with intention to end his own life, this is suicide. At Common Law, suicide was an offence. The traditional reason was based on the religious concept that life was given by God and no man had the right to take way what God has given. As the religious flavour in the law is weakened, this reason has gradually lost its justification. The more recent and more acceptable rationale is that the criminal law is not aimed to punish people in such situation. Thus suicide was abolished as a criminal offence in 1967 by s. 33A of the *Offences Against the Person Ordinance, Cap 212.*

Assisted suicide

Although suicide is no longer a crime (abolished by law in 1967), it does not follow that a person who assists another to commit suicide would be free from criminal responsibility. As mentioned above, he might still be committing murder if he did it with the requisite intention. However, this would be unfair if all he did is to follow the request of a dying patient (or relative) with a kind motive. Thus when abolishing suicide as a crime, s.33B(1) of the *OAPO* also consequentially reduces the culpability of such a person. It provides:

"A person who aids, abets, counsels or procures the suicide of another or an attempt by another to commit suicide shall be guilty of an offence triable upon indictment and shall be liable on conviction to imprisonment for 14 years."

However, sometimes, it may not be easy to distinguish between the more serious crime of murder and this less serious offence. The law (s.33B(2)) allows the jury at the trial of a person for murder or manslaughter the alternative verdict of assisting the suicide of another in order to avoid injustice.

Where it is difficult to distinguish between assisting suicide and taking a lawful medical decision, prosecution under the s.33B(1) offence requires SJ's consent so as to give a greater safeguard to medical and nursing personnel. (s.33B(3)) Thus the law provides these two safeguards for medical personnel.

"Assisting" is just a general term and the offence in fact prohibits aiding, abetting, counselling and procuring. Aiding and abetting means helping, assisting, encouraging, instigating, inciting; counselling means advising, persuading; and procuring means endeavouring to bring about the result. What amounts to assisted suicide must depend on the facts of each case.

Principles relevant to medical care

In the discharge of their duty towards patients and their family members, it is desirable and often inevitable for doctors and nurses to give certain advice and counselling in order to help patients and their family members make a decision in relation to the taking or not taking of some medical treatment or to relieve their pain and suffering. As a result of the wide scope of the legal meaning of "assisted suicide" as mentioned above, whether what they do would be regarded as assisted suicide may be quite problematic.

Doctors and nurses do not always have legal consequences in mind when they discharge their duties towards their patients. To these professional people, the first priority is to save life and to relieve pain and suffering. There are other equally if not more important principles which are of greater concern to them in their work. The more common principles are as follows:

(1) ***the principle of sanctity of life*** – that human life is sacred and should be preserved if at all possible (*Re T* [1992] 4 All ER 649, 661). This is one of the most sacred obligations on the part of doctors and nurses;

(2) ***the principle of self determination*** – that the wishes of the patient should be respected; doctors and nurses must accept his refusal to give consent to treatment, however unreasonable it is; the sanctity of life yields to human dignity and personal choice, (*Airedale NHS v Bland* [1993] 1 All ER 821, 866);

(3) ***the principle of best interest*** – that if the patient is incapable of giving consent, the principle of best interest applies; the touchstone with regard to the best interest of the patient is "intolerability" from the patient's point of view (*R (Burke) v GMC* (2004) 79 BMLR 3126, 3213(d));

(4) ***the principle of necessity*** – that if the patient is unconscious and cannot communicate with others, treatment is only justified by necessity (*Re T* [1992] 4 All ER 649) and the principle of sanctity of life also plays a part.

These principles often overlap and clash with one another thus making the decisions of the medical team more difficult. But they very often provide the necessary guidance when doctors and nurses are faced with difficult situations.

Controversial issues

The application of the above principles in practice very often presents a lot of problems. These problems give rise to ethical, medical, legal and social issues. It is worthwhile to discuss these issues in order to understand their nature and how to solve the practical problems facing doctors and nurses. The relevant issues are as follows:

(1) **the right to life**: e.g. whether this includes right to die with dignity;

(2) ***a patient's consent***: e.g. how to ascertain a patient's consent, what if his consent cannot be ascertained;

(3) **the act or steps to be taken**: e.g. what can be done and cannot be done to avoid criminal liability or professional sanction; and

(4) ***the decision making process***: e.g. who is to decide and when to make a decision.

Right to life

In Hong Kong, the right to life is protected by the Hong Kong Bill of Rights Ordinance which is based on the International Covenant of Civil and Political Rights. This right is now guaranteed and entrenched by the Basic Law. (art 39) We are not in this talk concerned with how to protect the right to life, but with whether this right includes the right to die, or more precisely, the right to die with dignity. If there is in law a right to die with dignity, then, not only is suicide not a crime, but those who assist the patient to put an end to his life should not incur criminal liability.

A terminal patient who has to depend entirely on others for his every day activities may think that he has lost all his dignity and life is not worth living any more; he would want to put an early end to his life thus saving all the burden of those who take care of him. One would have thought that if he has the right to life, he should also have the right to pass away with dignity. The abolition of suicide may suggest that this is the case. But the law still makes assisted suicide a crime and this may violate a patient's right to life since the existence of this offence may deter people from assisting the patient to die.

This issue is much more complicated than it appears. Who is to decide whether life is worth living: the patient himself, those who take care of him, the doctors and nurses? Has society anything to do with deciding which lives are worth living and which are not? Should society adopt an utilitarian attitude and accept the early termination of a patient who has no hope of recovery to provide resources to those who have much greater hope of surviving? It is not surprising that there is no clear unanimous opinion.

(1) Canada

Rodriguez v British Columbia [1993] 3 SCR 519: the Canadian court decided that the right to life did not include the right to die with dignity; but Cory J dissented: "dying is an integral part of living and the

right to die with dignity should be as well protected as is any other aspect of the right to life".

Carter v Canada (AG) [2015] SCC 5: the court overruled *Rodrguez* and declared unanimously that the criminal law might not prohibit "physician assisted death for a competent adult person who clearly consents to the termination of his life and has a grievous and irremediable medical condition". Thus, in Canada, it seems that the law upholds the right to die with dignity.

(2) Switzerland

Hass v Switzerland [2011] 53 EHRR 33, #51: the court held that "An individual's right to decide by what means and at what point his or her life will end … is one of the aspects of the right to respect private life." The existence of such a right is also supported in Switzerland.

(3) Indian

Gian Kaur v State of Punjab [1996] AIR 946: the court held that "criminalising suicide violates the right to life"; but this case was overruled by *Rathinam v Union of India* [1994] AIR 1844. The situation is thus different in India.

(4) Netherlands

The Human Rights Committee impliedly held that assisted suicide in extreme circumstances did not violate the right to life. But this was subject to the most vigorous scrutiny.

(5) United Kingdom

R (Nicklinson) v Ministry of Justice (SC(E)) 2015 AC 657: 3 judges that declined to declare the law making assisted suicide an offence was incompatible with art 8 of the European Convention on Human rights; 2 judges said they would have made such declaration.

4 judges said that whether the law against assisted suicide is compatible with art 8 involved the consideration of issues for Parliament

But when these cases went to ECHR (*Nicklinson & Lamb v UK* (2015) 61 EHRR SE7) the EHRC rejected the claim.

(6) European Court of Human Rights

Pretty v UK (2002) 35 EHRR 1 #39: the ECHR held that the right to life did not include the right to die (art 2 was not engaged); that art 8 was engaged, but a complete prohibition of assisted suicide was not disproportionate to the state's concern to protect vulnerable members of society. Hence, the ECHR takes a different view.

It is clear from the jurisprudence of different countries that the right to die with dignity is not free from controversies. It would not be easy in Hong Kong for the medical profession to successfully challenge that the offence of assisted suicide under s.33B(1) of the *OAPO* is unconstitutional on the ground that this crime violates the patient's right to die with dignity.

Consent of patient

The next issue is the patients' consent to treatment. Generally, a patient's consent is required for treatment. Treatment with no consent amounts to battery (which is a civil tort) or assault (which is a crime). Consent, to be valid, must be (1) informed and (2) free and voluntary. It may be vitiated by outside influence.

Consent must be informed, for otherwise, there is no way for the patient to make a free and voluntary consent or even a sensible consent. To what extent must a patient be told or informed by the doctor or nurse? Generally, the following requirements must be met:

(1) the patient knows in broad terms the nature and effect of the proposed treatment;

(2) it is the duty of the doctor (or nurse) to give the appropriately full information of the nature and likely risk of the treatment;

(3) if the doctor (or nurse) does not provide sufficient information, this may amount to negligence on the part of the doctor (or nurse) but this may not vitiate the consent; the difference is that negligence is a

ground for a civil claim but since the consent is not vitiated, it does not amount to the offence of assault;

(4) if the patient is misinformed or information is withheld where such information is expressly or impliedly sought, this may vitiate the patient's consent (*Re T*).

There are rules to determine whether a patient's consent is valid or not.

(1) a person is presumed to have full capacity to give consent unless the contrary is shown;

(2) whether a patient has the capacity to give valid consent is to be judged in relation to the decision or transaction in question;

(3) the test is: whether he understands in broad terms what he is doing and the likely effect of his decision.

This is a question of fact in each case.

The requirement of a valid consent of a patient before a doctor or nurse can perform any treatment is important because a patient has a right to refuse treatment and this follows from the principle of self determination. As Lord Goff in *Airedale NHS Trust v Bland* [1933] AC 789, 864 said:

> " … the right to self determination overrides the principle of the sanctity of human life or the duty of the doctor to save life".

But if a patient is incapable of giving consent, e.g. he is under age, or in a coma or in dementia, then a different principle applies:

> "if a patient is of unsound mind, unconscious, or incapable of giving consent, the doctor has duty to treat patient if it is in his best inter ests".

In the case of a patient who wishes to end his own life early, the Hong Kong Law Reform Commission referring to *Bland* and *the case* of *NHS, Trust A v M* [2007] Fam 348 makes the following observation:

> "… if a person is either unable or incapable of indicating whether he wishes to continue to be kept alive, it is not permissible for doctors to take active steps to terminate his life, e.g. by a lethal injection but it is permissible to passively withdraw treatment, life support and presum ably nutrition where continued medical intervention would be futile."

Advance directive (consent given on earlier date)

The principle of self determination also applies to consent expressed on an earlier date before the patient is unconscious or incapable of communicating his consent. (See Lord Goff in *Bland.)* Consent given on an earlier date, i.e. when the patient was still able to give his consent to treatment or to give direction as to refusing treatment or life sustaining treatment, is usually referred to as "advance directive".

(1) What is an "advance directive" ?

According to a suggested definition by the University of Michigan Health System (which is referred to in an article, "Advance directives: a case for Hong Kong," in the Journal of the Hong Kong Geriatric Society, vol. 10, No. 2 July 2000, 99), an advance directive is:

(a) a written or oral instruction about the future medical care to be administered to a patient,

(b) which is given by him when he is mentally competent and provided with full information, and

(c) which is not effective until the patient is no longer able to make decisions.

(2) What is the function of an advance directive?

It allows a patient to decide ahead of time what medical treatment he wants or does not want. This usually involves decisions about life sustaining treatments. It is useful

(a) to help his family members make decisions when he is not able to do so;

(b) to make sure the patient's wishes are followed if they are different from the family's wishes;

(c) to protect medical staff for what they do or not do, so that they would not incur civil or criminal liability.

(3) ***What are the requirements of an advance directive?***

An advance directive should meet with the following requirements:

(a) the patient's decision must be clear: it is not merely an expression of views or preference since the medical staff need clear instructions;

(b) the extent of instructions must also be clear: what type of treatment to be accepted or refused;

(c) circumstances may change, e.g. new medical advancement, improvement of patient's conditions; or change of heart, e.g. persuaded by family to accept treatment.

(4) ***What is the effect of an advance directive?***

At the moment, there is no law in Hong Kong governing the effect of such a directive. But generally, it is a document which is usually respected. Arguably, it has the following desired effects:

(a) the same effect as the patient's contemporaneous oral instruction;

(b) such directive is usually respected and recognized as valid unless challenged on the ground that when it was made, the patient was mentally incapable of giving directives or he was under undue influence from other persons;

(c) when a dispute arises over his previous instructions or wishes as to his future medical treatment, and this arises only when the pa-

tient is no longer able to give any directive but a decision has to be made, then an application is usually made to the court for a decision;

(d) the court will take into account the particular facts and circumstances of the case in reaching its decision;

(e) if the patient, with sound mind and properly informed, clearly requires discontinuation of life supporting treatment, it is not suicide and the medical staff would not be committing assisted suicide.

The Law Reform Commission did not suggest the introduction of new law for the time being, considering that wider education in the community is required before this can be done.

Act or steps in question

A crime is constituted by an unlawful act (legally called acts reus) committed with the requisite criminal intent (legally called mens rea). This usually involves the doing of something or the taking of an active step to achieve an intended result. But the acts reus may be committed by an omission. An omission to do something or to take some steps is only a crime if there is a duty to act and the person with the duty to act has failed to do so and he has the necessary criminal intent. If there is no such duty to do anything or to take any active steps, then refraining from doing anything or taking any steps would not incur any criminal liability.

Whether the conduct of a doctor or nurse constitutes the acts reus of a crime (in the context of assisted suicide) has to be considered in the following way:

(1) ***What are the steps taken by the doctor or nurse?*** Whether it is active conduct (acts) or passive conduct (omission)? There are usually 3 situations. (i) If it is active conduct, e.g. giving the patient a fatal injection, the case is relatively clear. (ii) If it is passive conduct, i.e. not doing anything or not taking any steps, it is necessary to see whether there is any legal duty to act? Hence, where a patient refuses treatment or does not give consent to the proposed treatment, a doctor or nurse usually has no duty to act (unless it is a situation governed by the principle of

best interest which often does not apply in the case of a terminal patient). (iii) Where the patient requests the withdrawal of life sustaining treatment, the situation is more difficult to decide.

(2) ***Whether the steps taken have caused the death of the patient?*** Whether it is the disease or the failure to take any steps which caused the death. This question is not difficult to answer in the case of a terminal patient who has no hope of recovery or who has refused treatment or to give consent to treatment. The patient dies of the illness. Problems arise in the case of patient who is unable to give consent.

(3) ***What is the object or aim of the steps?*** Whether it is for putting an early end to the patient's life or to cure illness or to reduce pain and suffering? If it is done with the intent to end his life, then it may be argued that the necessary criminal intent is present.

This issue is not entirely without controversy. In *Rodriguez v British Columbia*, Cory J considered that there is no difference between permitting a patient to choose death by refusing treatment and permitting him to choose death by terminating life preserving treatment. But academics think that there is a difference in law between (i) ***active euthanasia*** which is the positive termination of life, and (ii) ***passive euthanasia*** which is the withdrawal or refusal of treatment.

In *Bland*, Lord Goff at p.864 - 866 also took the view that

(1) a doctor has no absolute obligation to prolong life;

(2) there is a critical difference between not providing or continuing to provide life prolonging treatment and doing an act (e.g. giving lethal drug) to bring about end of life;

(3) there is no difference between discontinuing treatment and not initiating treatment in the first place.

In the same case, Dame Butler Sloss considered that the deprivation of life is prohibited but the withdrawal of treatment is not deprivation.

The UK General Medical Council considered that simply providing a patient who wished to have an assisted death with the patient's notes would not be sufficient to challenge a doctor's fitness to practice and prosecution would be unlikely.

Hospital Authority Guidelines (April 2002)

Guidelines on Life sustaining treatment in the terminally ill (1st ed. April 2002)

The main positions taken by Hong Kong Hospital Authority as follows:

What is "terminally ill" ?

(1) suffering from advanced progressive and irreversible disease,

(2) fails to respond to curative therapy, and

(3) having short life expectancy

What is the "goal of care" ?

(1) provide appropriate palliative care, and

(2) provide support to family

What is Euthanasia ?

(1) it is the "direct intentional killing as part of the medical care"

(2) it is unethical & illegal.

Is "withholding/withdrawing life sustaining treatment" acceptable?

This is acceptable when

(1) a mentally competent and properly informed patient refuses such treatment, and/or

(2) the treatment is futile

What is "futile" must be decided (1) from the physiological view: whether clinical reasoning & experience suggest life sustaining treat-

ment highly unlikely to achieve purpose; and (2) from the clinical view: balancing burdens and benefits of the treatment, whether in the best interest of patient.

Encourage consensus regarding treatment or no treatment

The HA favours consensus building process among health care team, the patient and his family. The following factors are relevant for consideration:

(1) the refusal by competent and properly informed patient must be respected;

(2) any advance directive should be respected;

(3) the informed view of the guardian of the incompetent patient is to be sought;

(4) it is the doctor who makes the final decision where the patient is incompetent, and there is no advance directive and no guardian;

(5) matters for consideration include: effectiveness of treatment, likelihood of pain and suffering, likelihood of irreversible loss of consciousness, likelihood and extent of recovery, invasiveness of treatment;

(6) in emergency situations, the health care team can go ahead with the life sustaining treatment even if the family disagrees if the treatment is essential and for best interest of the patient;

(7) the health care team is under no obligation to provide physio logically futile treatment or comply with a request which has an in equitable demand on resources;

(8) If futility is not uncertain, the health care team may set time limits after which it is acceptable to withdraw treatment;

(9) a minor's views and wishes are to be seriously considered, but it is for the doctor, patient and family to share the decision with the doctor taking the lead but the parents' decision should be accepted

unless there is a conflict on what is in the best interest of the patient. Any disagreement between the health care team and the family is to be referred to the ethical committee.

Medical Council of Hong Kong Code (Jan 2009)

Medical Council of HK's Code of Professional Conduct [revised January 2009]

The following paragraphs in the Code are relevant to the present discussion.

#34.1 Where death is imminent, the doctor is responsible to take care that the patient dies with dignity and with as little suffering as possible.

#34.2 Euthanasia is defined as "direct intentional killing of a person as part of the medical care being offered". It is illegal and un-ethical.

#34.3 The withholding or withdrawing of artificial life support procedures for a terminally ill patient is not euthanasia. Withholding or withdrawing life sustaining treatment after taking into account the patient's benefits, wishes of the patient and family, and the principle of futility of treatment for a terminal patient, is legally acceptable and appropriate.

#34.4 The right of patient is to be respected; the views of relatives are to be solicited if the patient is incompetent; in case of conflict, the patient's right of self determination prevails over the wishes of relatives; the doctor is always guided by the best interest of patient.

#34.5 where there is disagreement, the matter is to be referred to the ethical committee.

I would like to make a few observations on the guidelines set by the Hospital Authority and the Medical Council.

First, they are not the law, but they should be followed. If they are not followed and any dispute arises, then failure to follow these guidelines may be evidence of the fault or shortcomings of the medical staff. Secondly, in special circumstances, even if the guidelines are followed, it may not necessarily mean that the medical staff can be free from civil or criminal blame. Special cases may require extra care and special treatment. Thirdly, even where there is no civil claim by the patient or his family and no criminal liability, the conduct may still, although unlikely, amount to disciplinary misconduct.

Prosecution policy

Doctors and nurses who are involved in terminating a patient's life are naturally worried over whether they may be prosecuted for any criminal offence, e.g. murder, manslaughter or assisted suicide under s.33B of the OAPO.

In *R (Purdy) v DPP* [2010] 1 AC 345 where the patient who had primary progressive multiple sclerosis, asked for guidance as to the factors that the DPP (the prosecution) takes into account when deciding whether to prosecute. There were cases where family members went with patients to Switzerland for euthanasia, although there was police investigation for "assisting suicide", no prosecution was instituted under s.2 of the Suicide Act 1961. The English court held that the DPP should provide prosecution guidelines.

The scope of "assisted suicide" under s33B, especially what amounts to assisting suicide, is also a concern to them. Examples of some the doubtful acts are (i) a doctor permitting medical notes to be brought by family members to Switzerland for purpose of suicide; (ii) booking flight, driving patients to the airport, taking them there.

The UK prosecution policy is set out in "Policy for prosecutions in respect of cases of encouraging or assisting suicide" (issued in 2010 updated Oct 2014) can provide some guidance. But note that s.2A of Suicide Act 1961 is different from HK's s.33B of the OAPO. The relevant considerations are as follows:

Prosecution is more likely if the suspect:

(1) acts in the capacity as medical doctor, nurse, other healthcare professional, a professional carer or person in authority and the pa tient (V) was in his care,

(2) has pressured V to commit suicide,

(3) acted with a view to gain

(4) lacked compassion

(5) has history of violence or abuse towards V

(6) the patient is under the age of 18

Prosecution is unlikely if:

(1) V has reached a clear voluntary settled and informed decision to commit suicide;

(2) the suspect is wholly motivated by compassion;

(3) the suspect has sought to dissuade V;

(4) the suspect has reported the suicide to the police and assisted inquiries.

Emily Jackson, Medical Law 3rd ed 876-877, 2013, the authors noted that there has been no successful conviction for murder for doctors for complying with patients' request to end life. See *R v Moor; R v Carr; R v Cox.*

The Prosecution Division (of the Department of Justice) has not expressly adopted these prosecution policy issued by the UK Prosecution Authority. I should think that some of the matters are not entirely clear or uncontroversial. The situation in Hong Kong is also not the same as that in the UK.

Other common law jurisdictions

The legal positions in other common law jurisdictions vary. Some countries are more "advance" than others. There are the following examples.

(1) ***Canada***

Carter v Canada (AG) [2015] 1 SCR 331. The court held that prohibition on doctor assisted death is void insofar as it deprives a competent adult of such assistance where (1) the person has a grievous and irremediable medical condition (including an illness disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

(2) ***Netherlands***

A half way house is adopted: euthanasia is still a criminal offence, but doctors who carried it out would not be prosecuted if they complied with certain circumstances. This is now codified in Termination of Life on Request and Assisted Suicide (Review Procedures) Act which was effective from 2002 legalising physician assisted suicide and voluntary euthanasia - art 2 and 292 the Act.

(3) ***United States of America***

The positions differ in different states.

Oregon - Death with Dignity Act 1997: allows a terminally ill patient to end his life through voluntary self administered lethal medications expressly prescribed by physician for that purpose.

Washington State - in 2013 after a referendum, the state introduced a similar act - Patient Choice and Control at the End of Life Act.

California - End of Life Option Act 2015 effective June 2016

Montana - there is no legislation but the Supreme Court decided that physician aid in dying is not contrary to public policy

(4) ***Belgium***

Loi relative a l euthanasie (Act Concerning Euthanasia) s.3: where a patient in a medically futile position is of constant unbearable physical or mental suffering that cannot be alleviated resulting from illness or accident, if he is over the age of 18, competent and conscious, he can make a request euthanasia explicitly unambiguously repeatedly and durably.

(5) ***Luxembourg***

Similar to position in Belgium

(6) ***Switzerland***

Assisted suicide is a criminal offence under art 115 of the Swiss Penal Code but only if the defendant's motive is selfish. But art 115 does not specify that suicide must be assisted by a doctor; nor patient terminally ill or suffering unbearably; if a person's motive for assisting suicide is compassionate, then there is no offence.

Conclusion

The law and practice in Hong Kong relating to this area has developed in the past few decades but there is still a long way before the pubic have sufficient knowledge and understanding before the necessary legislation can be put in place.

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