醫生協助下自殺
Doctor-assisted suicide

Outline of talk

Legal position in Hong Kong

Murder

- Doing an act (taking steps)
- Which kills (causes death of another person – shortening his life)
- With intention to kill (intends to put an end to his life by the act)
- Consent of the victim not a defence

Mercy killing still murder:

Lau Cheong v HKSAR (2002) 5 HKCFAR 415, #119
(mandatory life sentence for murder)

R (Nicklinson) v Ministry of Justice SC(E) [2015] AC 657, at 766 #17 [also *AM v DPP*]
(AM had brain stem stroke, totally dependent on others, communicate with movements of head and eye through computer, wished to die, either self starvation or going to Zurich. N had similar condition and same situation, could use machine loaded with lethal drug)
Seeking declaration necessity is a defence to voluntary euthanasia and s.2(1) of Suicide Act against art 8 of right Human Rights Convention)

Suicide

- Doing an act
- Which kills oneself

Suicide was an offence under common law
Now abolished as a criminal offence in 1967
Offences Against the Person Ordinance, Cap 212 s.33A

rationale – the criminal law not aimed to punish people in such situation

If relatives/friends assist with intention to shorten life, this is murder but may be reduced to manslaughter if diminished responsibility, e.g. mental depression

If doctors / health care workers assist with intention to shorten life, also murder; no defence even with consent of patient

Assisted suicide

- Aids, abets, counsels or procures another to commit or attempt to commit suicide

- Aiding/abetting – helping, assisting, encouraging, instigating, inciting

- Counseling – advising, persuading

- Procuring – endeavouring to bring about

s.33B(1) OAPO – assisted suicide an offence punishable by 14 years

- Difficult to distinguish between murder and assisting suicide
  So, in murder trial, jury may convict on assisted suicide

  S.33B(2) OAPO

- Difficult to distinguish between assisted suicide and lawful medical decision;
  So prosecution under s.33B offence requires SJ's consent

  S.33B(3) OAPO

Principles relevant to medical care

(1) ***principle of sanctity of life*** – human life sacred and should be preserved if at all possible (*Re T* [1992] 4 All ER 649, 661

(2) ***principle of self determination*** – wishes of patient should be respected; must accept refusal to consent, however unreasonable;

if incapable of consent, principle of best interest (*Airedale NHS v Bland* [1993] 1 All ER 821, 866)

(3) ***principle of best interest*** – ethical, social, moral emotional and welfare consideration, sanctity of life yields to human dignity, touchstone to best interests is intolerability from patient's view, (*R (Burke) v GMC* (2004) 79 BMLR 126 3213(d))

(4) ***principle of consent*** – consent must be informed and free from outside pressure (*Re T* [1992] 4 All ER 649)

(5) ***principle of necessity*** – if patient unconscious and cannot communicate, treatment only justified by necessity (*Re T* [1992] 4 All ER 649)

(6) ***doctrine of double effect*** – if restoration of health cannot be achieved, doctor still entitled to do all that is proper and necessary to relieve pain and suffering even if incidentally shortens life (R v Adams (1992))

Also Re J (Wardship), Lord Delvin
ANH Medical Council v Bland, Lord Goff

But risk that jury may infer conduct as murder if death is virtual certainty

Controversial issues

Problems giving rise to ethical, medical, legal and social issues

Main issues:

(1) right to life: e.g. whether includes right to die with dignity

(2) consent of patient: e.g. how to ascertain consent, what if consent cannot be ascertained

(3) act in question: e.g. what can be done and cannot be done to avoid criminal liability or professional sanction

(4) decision making process – who to decide and when to make decision

Right to life

- Right to life: whether includes right to die with dignity

- Right to live with dignity – who to decide particular life worth living. Whether society has anything to do with which lives are worth living

- If right to die with dignity, criminalizing assisted suicide whether violate patient's right to life

- Abolition of suicide as offence may suggest there is a right to die

- No clear unanimous judicial opinion

(1) Canada

Rodriguez v British Columbia [1993] 3 SCR 519: not include right to die; 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 overruled *Rodrguez* and declared unanimously: criminal law may not prohibit "physician assisted death for competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition".

(2) Switzerland

Hass v Switzerland [2011] 53 EHRR 33, #51 "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".

(3) India

Gian Kaur v State of Punjab [1996] AIR 946: criminalising suicide violates right to life; but overruled by *Rathinam v Union of India* [1994] AIR 1844

(4) Netherlands

Human rights committee impliedly held assisted suicide in extreme circumstances not violate the right to life. Subject to the most vigorous scrutiny

(5) United Kingdom

R (Nicklinson) v Ministry of Justice (SC(E)) 2015 AC 657

3 judges declined to declare making assisted suicide an offence is incompatible with art 8 of ECHR; 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 consideration of issues for Parliament

ECHR (*Nicklinson & Lamb v UK* (2015) 61 EHRR SE7) EC rejected the claims

(6) European Court of Human Rights

Pretty v UK (2002) 35 EHRR 1 #39
(P motor neurone, progressive & degenerative, H willing to help her commit suicide, asked prosecution to undertake not to prosecute H)
HL in UK held no violation of right

(i) right to life not include right to die (art 2 was not engaged);
(ii) art 8 was engaged, but complete prohibition of assisted suicide not disproportionate to the state's concern to protect vulnerable members of society

<u>Consent of patient</u>

Generally, patient's consent is required for treatment

treatment with no consent amounts to battery (tort) or assault (crime)

Consent must be free and voluntary – may be vitiated by outside influence

Consent must be informed

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

(2) duty of doctor to give appropriately full information of nature and likely risk;

(3) if doctor does not provide information, negligent but not vitiate consent;

(4) if misinformation or withholding information where it is expressly or impliedly sought, may vitiate consent (*Re T*)

Rules relating to ascertaining consent

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

(2) whether patient has capacity to be judged in relation to decision or transaction in question;

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

(4) a question of evidence

Patient's right to refuse treatment

Airedate NHS Trust v Bland [1933] AC 789 - Lord Goff: "the right to self determination overrides the principle of the sanctity of human life or the duty of the doctor to save life" #864

Re B [2002] EWHC 429
Tetraplegic, complete paralysis from neck down, connected to ventilator, repeated request to remove ventilator, doctor reluctant to do so, claimed not being treated lawfully, Court agreed she had right to refuse but not order doctor to remove ventilator, B transferred to another hospital

Whether patient capable of giving consent, e.g. under age, in coma, dementia

Bland [1933] AC 789 Lord Goff: “if patient of unsound mind, unconscious, incapable of giving consent, doctor has duty to treat patient if it is I n his best interests”

Law Reform Commission (HK) referring to *Bland and NHS*, *Trust A v M* [2007] Fam 348:

“ … if person either unable or incapable of indicating whether he wishes to continue to be kept alive, not permissible for doctors to take active steps to terminate life e.g. lethal injection but permissible to passively withdraw treatment, life support and presumably nutrition where continued medical intervention would be futile..”

Advance directive (consent given on earlier date)

Principle of self determination also applies to consent expressed on earlier date before patient unconscious or incapable of communicating consent - Lord Goff in *Bland*

No law in Hong Kong

In UK, Mental Capacity Act 2005

(1) What is advance directive

(a) written or oral instructions about future medical care, given by mentally competent patient, with full information;

(b) not effective until patient no longer able to make decisions
(University of Michigan Health System)

(Advance directives: a case for Hong Kong, Journal of the Hong Kong Geriatric Society vol 10, No. 2 July 2000, 99)

(2) Functions:

(a) allow patient to decide ahead of time what medical treatment he wants or not wants; usually involves decisions about life sustaining treatment;

(b) help family make decisions;

(c) make sure wishes are followed if they are different from family's wishes;

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

(3) Effect:

(a) the same effect as contemporaneous oral instruction;

(b) such directive recognized as valid unless challenged on incapacity or undue influence;

(c) when a dispute arises over his prior instructions or wishes as to his medical treatment, application may be made to the court for a decision;

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

(e) if patient, with sound mind and properly informed, clearly requires discontinuation of life supporting treatment, not suicide and medical staff not assisting suicide.

(4) Difficulties with advance directive

(a) decision must be clear: not merely expression of views or preference; medical staff need clear instructions;

(b) extent of instructions must 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

Act in question
(steps taken by doctor / medical staff)

An act is a crime if accompanied by the requisite mens rea (active)
Omission is only a crime if there is mens rea and a duty to act (passive)

(1) What are the steps taken – whether active (acts) or passive (omission)?

(2) Whether steps cause death – patient died of illness or the steps taken?

(3) What is object or aim of steps – to end life or to cure illness or to reduce pain and suffering?

Cory J in *Rodriguez v British Columbia*: no difference between permitting patient to choose death by refusing treatment and permitting patient to choose death by terminating life preserving treatment

But academics think that there is a difference in law between

(1) active euthanasia - positive termination of life

(2) passive euthanasia - withdrawal and refusal of treatment

In *Bland*, Lord Goff at p.864 - 866

- doctor has no absolute obligation to prolong life

- critical difference between not providing or continuing to provide life prolonging treatment and act (e.g. giving lethal drug) to bring about end of life

- no difference between discontinuing treatment and not initiating treatment in the first place

Dame Butler Sloss – deprivation of life prohibited; but withdrawal not deprivation

UK General Medical Council: 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

Decision making process

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

Provide guidance to doctor & medical staff as to what they can do and and when they can do so

Main positions taken by HA:

"*Terminally ill*" is defined as:

(1) suffering from advanced progressive and irreversible disease,

(2) fails to respond to curative therapy, and

(3) having short life expectancy

Goal of care:

(1) provide appropriate palliative care, and

(2) provide support to family

Euthanasia is unethical & illegal: “direct intentional killing as part of the medical care”

Withholding or withdrawing life sustaining treatment accepted when

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

(2) the treatment is futile

Futility – (1) from physiological view: clinical reasoning & experience suggest life sustaining treatment highly unlikely to achieve purpose;
(2) from clinical view: balancing burdens and benefits of treatment, whether in best interest of patient

Favours *consensus building process* among health care team, patient and family

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

(2) advance directive should be respected;

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

(4) doctor makes final decision where patient incompetent, no advance directive and no guardian;

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

(6) emergency situations, health care team can go ahead with life sustaining treatment even if family disagree if treatment essential and in best interest;

(7) health care team no obligation to provide physiologically futile treatment or comply with request with inequitable demands on resources;

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

(9) Minors' views and wishes to be seriously considered, doctors, patients and family to share decision with doctor taking the lead but parents' decision should be accepted unless conflict on what is best interest.

Disagreement between health care team and family, refer to ethical committee

Medical Council of Hong Kong Code (Jan 2009)

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

#**34.1** Where death imminent, doctor responsible to take care that 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 unethical.

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

#34.5 disagreement – refer to ethical committee.

Prosecution policy

In *R (Purdy) v DPP* [2010] 1 AC 345 – patient primary progressive multiple sclerosis, asked for guidance as to factors that DPP takes into account when deciding whether to prosecute. Cases where family members went with patients to Switzerland for euthanasia, police investigation for "assisting suicide" but no prosecution under s.2 of Suicide Act 1961. Court held: DPP to provide prosecution guidelines

Policy applies to doctors & medical staff

Other examples of some acts

(1) doctor permitting medical notes to be brought by family members to Switzerland for purpose of suicide

(2) booking flight, driving to airport, taking her there - whether assistance

UK prosecution policy in “Policy for prosecutions in respect of cases of encouraging or assisting suicide” (2010 updated Oct 2014)

[Note: s.2A of Suicide Act 1961 different wording from HK’s OAPO]

Prosecution is more ***likely*** if the suspect:

(1) acts in capacity as medical doctor, nurse, other healthcare professional, a professional carer or person in authority and V 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) patient under age of 18

Prosecution ***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 - no conviction for doctor for complying with patients' request to end life.

See ***R v Moor*** – 85 yr bowel cancer, doctor admitted helping her to die painlessly – not guilty

R v Carr – unbearable pain from inoperable lung cancer, repeatedly asked for help to die, large dose of barbitone - not guilty

R v Cox – guilty of attempted murder but suspended sentence, also discipline only formal reprimand

Legalisation of euthanasia / assisted suicide?
(Emily Jackson)

Arguments for:

(1) Autonomy of patient
(2) Compassionate grounds
(3) Distinction inconsistent (artificial)
(4) Regulation better & sufficient

Arguments against:

(1) Sanctity of life
(2) Legalisation unnecessary
(3) Difficulty in ensuring request voluntary
(4) Risk of abuse

Other common law jurisdictions

(1) Canada

Carter v Canada (AG) [2015] 1 SCR 331 holding that "prohibition on doctor assisting 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

Half way house – euthanasia still criminal offence, but doctors who carried it out would not be prosecuted if they complied with certain circumstances 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

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

Washington State - 2013 after referendum introduced similar act - Patient Choice and Control at the End of Life Act

California - End of Life Option Act 2015 effective June 2016

Montana - no legislation but Supreme court decided physician aid in dying not contrary to public policy

(4) Belgium

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

(5) Luxembourg

Similar to position in Belgium

(6) Switzerland

Assisted suicide is criminal 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 person’s motive for assisting suicide is compassionate, then no offence