Ah Bun and Euthanasia in Hong Kong

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*1 Tang Siu-pun, also known as Ah Bun, wrote to the Hong Kong Legislative Council on 15 March 2004 to request euthanasia. His campaign for euthanasia alerted Hong Kong society to his plight and raised awareness of the issues relating to the “right to die”. This article explains Ah Bun's request in legal terms, illustrating the differences -- controversial as they may be -- between the right of a competent patient to have one's ventilator (or other form of life support) removed, as opposed to euthanasia or assisted suicide. Both assisted suicide and euthanasia are currently illegal and raise many difficult moral and social questions. However, the law recognises, by way of the application of a general legal principle, a more limited right of a competent patient to have a life support machine switched off, even if this would inevitably accelerate, or lead to, death.

Introduction

*1 Ah Bun, now aged 38, is paralysed from the neck down as a result of a gymnastics somersault accident when he was 21. After the accident, he was confined to his bed and attached to a ventilator. Desperate in his paralysed and isolated condition, he wrote a letter to the Legislative Council on 15 March 2004, 1 outlining his plight and requesting euthanasia. He also asked the Legislative Council to debate the possibility of legalising euthanasia in Hong Kong. The content of this letter was later reported in the press, 2 and his case attracted an enormous amount of local media attention. The public responded to his tragic story with an outpouring of support. Since then, he has been weaned off his ventilator (and can breathe on his own), 3 has access to a wheelchair, a computer and the Internet. He has been able to leave his hospital bed, has met Steven Hawking 4 and has published his *148 autobiography. 5 In October 2008, it was reported that Ah Bun had asked to leave the Queen Mary Hospital with a view to moving back into his parents' home. 6

*1 I teach a course for fourth and fifth year medical students on law and medical ethics in the Faculty of Medicine of the University of Hong Kong. I often ask the medical students, “What does Ah Bun want?” Most students respond that he does not want to live. I ask further, “What is he actually asking someone to do for him?” The class is invariably silent; an unexpected response especially in light of the huge publicity that Ah Bun's case has attracted. There may be good reasons why the students are either unsure or unwilling to engage in the issues raised. After all, this is one of the most sensitive and challenging topics confronting medicine and society today.

*2 Until recently, most of my understanding of Ah Bun's case had come from secondary sources. I had not read his autobiography, and had never thought of meeting him in person. In the summer of 2007, however, I received an email from Ah Bun asking me to share with him my expertise on the legal and ethical perspectives on euthanasia. I visited him at the Queen Mary Hospital, K Block, Hong Kong.

*2 Despite his limited resources, Ah Bun has managed a campaign for the “right to die”. He has also maintained a very active and positive profile, including the impressive task of publishing his autobiography. Although I have taught the subject of euthanasia to many undergraduate and postgraduate law students in the Faculty of Law (in the Medico-legal Issues and Health Care Law class), I had never met a person who wanted euthanasia. Unsure of the likely content of my conversation with Ah Bun, I researched his case, and having informed the head of department, Professor Michael Jackson, and the Dean, Professor Johannes Chan, I felt prepared for my visit.

*2 It is not the intention of this article to document the meeting; a brief outline is sufficient to put the
matter in context. During the meeting, I told Ah Bun that I admired him for his strength in raising people's awareness of the plight of those in a similar position; and that I admired him for his courage in speaking up on what he perceived to be the inadequacies of the law which prevented him from ending his life, if and when he wanted. "Ah Bun, what do you want?" I asked him. He replied, matter of factly, "I want euthanasia".

*2 *149 It seems simple, but is it? In this article, I will illustrate Ah Bun's request in legal terms; however, there is no legal definition of euthanasia. 7 In fact, euthanasia is a word which has different meanings for different people. Its popular meaning in Chinese <<foreign language>> is just a "good death". 8 However, from a medical perspective, as will be discussed in Part 1, it means the "direct and intentional killing" of a person. From a religious standpoint, its significance varies depending on the religion in question. 9 Depending on which meaning one chooses to adopt, euthanasia may be considered either morally acceptable or unacceptable. In this article, the focus is on how the law frames this complex moral, social, religious and personal issue in a medical context. 10

*2 This article is divided into four parts. Part 1 explains the legal distinction between voluntary active euthanasia and voluntary passive euthanasia. Here, the law draws a distinction between an act versus an omission, permitting voluntary passive euthanasia, but prohibiting voluntary active euthanasia (or using the currently preferred terminology, the withdrawal of life-sustaining treatment versus euthanasia respectively). Part 2 examines the law governing the withdrawal of life support in the case of a competent patient. Part 3 examines the law governing assisted suicide. Part 4 examines the debate on euthanasia and physician-assisted suicide globally and in Hong Kong.

*3 The current legal position in Hong Kong is similar to many common law jurisdictions; both assisted suicide and euthanasia are illegal and as such no one has a right to carry out either. However, the law recognises, by way of the application of a general legal principle, the more limited right of a competent patient to have a life support machine switched off, even if this will certainly accelerate, or lead to, death.

*3 The article concludes that the fight for a "right to die" or euthanasia -- as a patient's movement -- in Hong Kong has only just begun. There is still a lot of confusion surrounding the subtle legal distinction between euthanasia and the withdrawal of life support (or passive euthanasia). As such, the debate still has a long way to go. It is an important (and appropriate) subject for the Hong Kong Law Reform Commission.

1. Euthanasia

*3 What is euthanasia? Euthanasia is a word with diffused meaning. The Chambers 20th Century Dictionary, published in 1983, defined it as:

*3 “an easy mode of death; the act or practice of putting painlessly to death, esp. in cases of incurable suffering.” 11

*3 In 2004, The Oxford Advanced Learner's English-Chinese Dictionary defined it as:

*3 "the practice (illegal in most countries) of killing without pain a person who is suffering from a disease that cannot be cured <<foreign language>>." 12

*3 From a legal standpoint, the dictionary definitions are not very useful. First, euthanasia is defined in a way that may imply a desired outcome for any individual. After all, no one wants a painful or torturous death. Second, it does not tell us what needs to be done to achieve the desired outcome and who performs it. Third, it does not indicate if it is permissible, either morally, or legally.

*3 Moving on from the dictionary definitions, there are two ways of classifying euthanasia. These classifications identify the mode of achieving death, as well as to whether the opinion of a competent patient (whose life is to be ended) is honoured or not. 13 Voluntary euthanasia is where a person is competent and is voluntarily requesting that his or her life be ended. Non-voluntary euthanasia, on the other hand, is where a patient is unable to request, or consent to, his or her life being ended. In the latter case, another person makes the decision as to life or death on behalf of the patient. A good example of non-voluntary euthanasia is shown in the controversial Florida Schiavo case 14 or in the case of an unconscious demented elderly person.

*3 The discussion in this article will be limited to voluntary euthanasia, ie where a competent patient is making a request to end his or her life. This is the case because, like Ah Bun, those who argue for a
"right to die" are competent (rather than incompetent).

Another way of classifying euthanasia is the mode or manner in which death is achieved. Active euthanasia refers to ending life by an act rather than an omission, e.g., by lethal injection or by shooting someone in the head. Passive euthanasia, in contrast, refers to ending life by an omission, i.e., letting the patient die by withholding or withdrawing a ventilator (or other form of life support). As will be seen later, whether any given case is active or passive euthanasia is often debatable (see Part 2).

The scope of this article is further confined to medically-assisted dying. The reason for doing so is twofold. Firstly, most deaths occur in hospitals. Secondly, society has an obligation to uphold the fundamental principle of the sanctity of life. Any deliberate taking of life (or premature ending of it) attracts criminal liability. In light of this, any discussion that there be an exception, in medicine, to this rule will no doubt be met with fierce opposition, and hence it must be narrowly framed both in terms of who carries it out (physicians as opposed to anyone, for instance a tormented family member or close relative), and on what type of patients (only the terminally ill, rather than generally on anyone who feels that life is not worth living, or a severely handicapped person like Ah Bun).

As mentioned, any deliberate taking of an individual's life (whether the person is dying or not) constitutes murder, and doctors are not exempted. In R v Adams, where the defendant doctor prescribed a large quantity of opiates (morphine) to an 81-year-old patient who had suffered a stroke (and was incurable but not terminally ill), the doctor was tried for murder. In summing up for the jury, Devlin J said:

"It did not matter whether [her death] was inevitable and her days were numbered. If her life was cut short by weeks or months it was just as much murder as if it was cut short by years."

Similarly, in R v Cox the defendant, Dr Cox, was a consultant rheumatologist. An elderly terminally ill patient (in severe unremitting pain suffering from rheumatoid arthritis) repeatedly requested that the defendant administer pain relief. He injected a lethal dose of potassium chloride (a toxic substance with no known palliative or curative properties). She died almost immediately and Dr Cox was prosecuted and convicted of attempted murder.

Ah Bun's request may be interpreted as one of voluntary active euthanasia, for example by lethal injection. Administering it, however, would be unlawful. Having a good motive (mercy killing) is irrelevant (though it may be relevant in sentencing), and the consent of the individual whose life is to be ended is no defence either.

a. Active euthanasia versus passive euthanasia

Despite the fundamental principle of the sanctity of life, a doctor's duty to prolong life is not absolute. The law, under certain well-defined and limited circumstances, permits a doctor to assist in the acceleration of the death of a patient (see Part 2). Such practices are now covered by professional guidance such as the Hong Kong Hospital Authority's Guidelines on Life-Sustaining Treatment in the Terminally Ill and the Professional Code of Conduct issued by the Medical Council of Hong Kong.

When it becomes futile to provide life support, a doctor may discontinue medical efforts which would otherwise sustain life. The cessation of life support is known, often with certainty, to end life prematurely. So why does the law allow the cessation of medical treatment resulting in acceleration of death, but not an act which kills a patient?

The distinction between an act and an omission is morally controversial and sometimes appears technical and unconvincing. As Professor Margaret Brazier said, the boundary between passive and active euthanasia might be unclear. She gave a good example highlighting this crucial, yet fine, legal distinction.

"A patient who wishes to die may already be receiving life-sustaining treatment. She is hooked up to a ventilator. She wants her life support withdrawn and to be permitted to die. Intrinsically, her position seems indistinguishable from the patient who instructs her doctor not to ventilate her. However, someone will have to intervene in this scenario, to switch off the ventilator. Will a doctor who does the relevant act risk prosecution for murder or assisting suicide?"

Legal liability in switching off a ventilator and thereby accelerating the death of a hopeless patient who is still alive was considered in Airedale NHS Trust v Bland. There the House of Lords held that
a doctor disconnecting life support at the request of a competent patient did not constitute murder nor was it considered assisting suicide (as discussed in Part 3 of this article), even though removing it hastened death. Lord Goff maintained the legal distinction between an act (as opposed to an omission) being an example of legal recognition of the limits of medicine, and the law allowing nature to take its course.

*5 “At the heart of this distinction lies a theoretical question. Why is it that the doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life support, allows his patient to die may not act unlawfully and will not do so if he commits no breach of duty to his patient? Professor Glanville Williams has suggested ??? that the reason is that what the doctor does when he switches off a life support machine ‘is in substance not an act but an omission to struggle,’ and that ‘the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case’.

*5 I agree that the doctor’s conduct in discontinuing life support can properly be categorised as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive steps to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place. In each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; and as a matter of general principle an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient ???.

*6 *154 The distinction appears, therefore, to be useful in the present context in that it can be invoked to explain how discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. But in the end the reason for that difference is that, whereas the law considers that discontinuance of life support may be consistent with the doctor’s duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony.”

*6 In essence, removing a life support machine is an omission to struggle against an inevitable and imminent death, and absent of a breach of duty, no legal liability results. In such a case, the patient’s death would be regarded as having been caused by the underlying disease, not the removal of the life-support. *155 Although this act and omission distinction has been the subject of much philosophical debate and criticism, it is one which professional medical organisations, including the Medical Council of Hong Kong, endorse. What is controversial is who defines when treatment becomes hopeless and should be ceased.

b. The preferred term: withholding or withdrawing life sustaining treatment

*6 The preceding section provides a brief explanation of the difference in law between an act and an omission, showing why the law strictly prohibits active euthanasia, but under certain circumstances, permits passive euthanasia.

*6 An example of this can be seen in Airedale NHS Trust v Bland. *32 This case involved a patient who was in a permanent vegetative state (PVS), who was alive and not terminally ill. The medical prognosis was unanimous; there was no hope of recovery. The patient was fed artificially by a nasogastric tube, and remained in the same state for a period of three years. The hospital and his parents agreed that it would be appropriate to withdraw the artificial feeding and antibiotic treatment if and when infection appeared. *155 The lack of sustenance would bring an end to the physical functioning of the patient's body within one or two weeks and he would die from starvation. Unsure as to the legality of such a withdrawal, the case came before the court.

*6 The House of Lords unanimously held that a doctor was under no absolute obligation to prolong the patient's life. Medical treatment (including artificial feeding) could lawfully be withheld from an insensate patient with no hope of recovery. Discontinuance of medical treatment under these conditions did not amount to a criminal act. An omission attracted liability only if there was a duty to act, and since treatment was not in the patient's best interests, the doctor was not under a duty to continue to provide treatment. In such a case, the patient would be allowed to die of the pre-existing condition and death would be regarded as caused by the original injury.

*7 The withholding or withdrawing of life-sustaining treatment, done not in breach of duty, is lawful,
even if it brings about premature death. Effectively, the House of Lords permits passive euthanasia, however, in Hong Kong and in other countries (such as the United Kingdom), the preference is to discuss it using the term "withholding or withdrawing life sustaining treatment"; the word "euthanasia" refers only to active euthanasia.

*7 This terminological preference can be seen in the Professional Code of Conduct issued by the Medical Council of Hong Kong in November 2000 (as recently revised in January 2009). The Medical Council of Hong Kong is the professional regulatory body of all medical doctors in Hong Kong. Its Professional Code of Conduct provides an authoritative guide to doctors practising in Hong Kong. Under the heading “Care for the terminally ill,” at paragraph 34.2, it states the following:

*7 “Euthanasia is defined as ‘direct intentional killing of a person as part of the medical care being offered’. It is illegal and unethical.”

*7 Under paragraph 34.3, it further states that:

*7 “The withholding or withdrawing of artificial life support procedures for a terminally ill patient is not euthanasia. Withholding/withdrawing life sustaining treatment taking into account the patient's benefits, wish of the patient and family, and the principle of the futility of treatment for a terminal patient, is legally acceptable and appropriate.”

*7 *156 These two passages reflect the law on two important points and they are also revealing in two ways. First, there is a distinction between euthanasia on the one hand, and withholding or withdrawing of life sustaining treatment on the other. The definition of euthanasia (as stated in paragraph 34.2) refers to an intentional killing (which is illegal and unethical); whereas withholding or withdrawing of life sustaining treatment is regarded differently (and is considered acceptable under paragraph 34.3). The implication is that in withholding or withdrawing life-sustaining treatment there is no direct intention to kill. Second, although paragraph 34.2 is correct in stating that active euthanasia is illegal, paragraph 34.3 manifests two unwarranted limits. Paragraph 34.3 suggests that: (i) the question of withholding or withdrawing artificial life support is somehow confined to those who are terminally ill; and (ii) that a patient's wishes are to be taken into account (rather than be determinative). Neither of these positions accurately reflects the current legal position. Legally, having artificial life support removed is the right of any competent patient (terminally ill or not). A competent individual's wishes are determinative, not just a matter to be taken into account. This is the law of battery (in the civil law context) which protects a competent adult individual's right to self-determination and bodily integrity. This will be examined further in Part 2.

*8 The Hong Kong Hospital Authority Guidelines on Life-sustaining Treatment in the Terminally Ill (2002) also support the approach of avoiding the term “passive euthanasia” in favour of the term “withholding or withdrawing life sustaining treatment”. Three reasons are cited for such a terminological preference:

*8 (a) ‘Withholding or withdrawing life-sustaining treatment’, if done under appropriate circumstances, is ethically and legally acceptable. This is ethically and legally different from ‘euthanasia’ as defined in the Medical Council Code as ‘direct intentional killing of a person as part of the medical care being offered’. The latter, which some people call ‘active euthanasia’, is illegal around the world except in Holland. To use the term “passive euthanasia” to describe the appropriate withholding or withdrawal of life-sustaining treatment may give people the wrong impression that such a decision is ethically and legally similar to ‘active euthanasia’.

*8 (b) ‘Withholding or withdrawing life-sustaining treatment’ includes widely different situations, ranging from withholding cardiopulmonary resuscitation in a terminally ill malignancy patient, to withdrawing artificial nutrition in a patient in a persistent vegetative state. The former is non-controversial but the latter is very controversial. If the term ‘passive euthanasia’ is used people may relate all discussions about ‘withholding or withdrawing life-sustaining treatment’ to the controversial situation like the latter one.

*8 (c) The term ‘passive euthanasia’ may contain the meaning of ‘an intention to kill’. We support withholding or withdrawing futile treatment; which only prolongs the dying process, but we do not support an intention to kill.”

*8 This author's view is that it is unimportant what label is attached to a certain medical practice. What is important is that there is a clear understanding on what the practice entails: does it involve ending life prematurely, and if so, is it justifiable both morally and legally. However, from a more subtle angle
of naming or labelling, Yu Kam Por argues, and I agree with him, that substituting “passive euthanasia” with “withholding or withdrawing life sustaining treatment” tends to obscure the issue instead of tackling it. Is a competent adult permitted to define whether his life is worth living, and hence permitted to refuse medical treatment?

2. Battery and Trespass to the Person

*8 Euthanasia is illegal. However, under the common law, one does have the right to self-determination and bodily integrity. This right is protected by the law of battery. The general rule here is that non-consensual touching amounts to a trespass to the person. This rule applies equally to any non-consensual medical treatment.

*8 “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault.”

*9 The right to consent to medical treatment also means the right to refuse medical treatment. This right to refuse treatment by a competent patient has been widely framed and it is not dependent on any reasons given justifying such a refusal.

*9 “An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. [This right exists] notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.”

*9 Lord Goff, in Airedale NHS Trust v Bland, made it clear that the right to self-determination overrides the principle of the sanctity of life (or the duty of a doctor to save life).

*9 “it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. To this extent, the principle of the sanctity of human life must yield to the principle of self-determination.”

*9 This right applies to all competent patients irrespective of their medical condition (ie whether they are terminally ill or not). A Jehovah's Witness, for example, may refuse a blood transfusion knowing that it may lead to premature death, even though many non-believers may think that this is an irrational or bad decision.

*9 The right of a competent patient to refuse a ventilator can be illustrated in B v An NHS Hospital Trust. In this case, Ms B was a 43-year-old, able and talented unmarried woman. She suffered from an illness (cavernoma -- caused by a malformation of blood vessels in the spinal cord) leading to haemorrhaging and causing her to become a tetraplegic. As a result, she was completely paralysed from the neck down. From February 2001, her life was maintained at the defendant's intensive care unit (ICU) by a ventilator. Ms B requested to have the ventilator removed. In April 2001 she was assessed by two psychiatrists and found to be incompetent (or not of sound mind), and hence the ventilator was not removed. She was later assessed, in August 2001, to be competent by an independent clinician. However, her attending physicians refused to remove the ventilator, advocating instead that she should attend a rehabilitation unit which offered a slim chance of improvement. Ms B rejected this offer and repeated her request for the removal of the ventilator. In January 2002, Ms B commenced proceedings in the English High Court, seeking a declaration that her treatment, by way of the ventilator from August 2001 onwards, was an unlawful trespass.

*10 At the hearing, both parties (Ms B and the hospital) were legally represented, and the court instructed the Official Solicitor to act as Advocate to the Court. The issue before the court was whether Ms B had the capacity to decide on the removal of the ventilator from 8 August 2001, and if so, whether the hospital had been treating her unlawfully. The court heard evidence from Ms B and five other medical witnesses on the point of competence. It concluded that Ms B was competent to make her own decision. Consequently, the treatment in question constituted an unlawful trespass.

*10 This case raised interesting moral and legal questions: was this a case where the doctor, by removing the ventilator, killed Ms B? Or was Ms B exercising her right to self-determination, refusing
the ventilator knowing that death would be inevitable? If so, was Ms B committing suicide and the
doctor assisting in her suicide? The court held that this was a case of a competent patient asserting
her right to self-determination and bodily integrity; removal of the ventilator was neither murder nor
assisting suicide.

Ms B could refuse treatment, effectively bringing about a premature end to her life. However, what
if a paralysed patient wishes to die but is receiving no treatment at all that could be refused or
withdrawn? This brings us to the subject of suicide and assisted suicide.

3. Suicide and Assisting Suicide

Suicide is a self-inflicted, premature and intentional termination of life (eg someone jumping to
their death from a height), and as such it is often unrelated to euthanasia. However, where assistance
is sought in a medical context, it raises the question of physician-assisted suicide. A classic scenario
of medically assisted suicide is where a doctor knowingly prescribes an overdose. The patient then
ends his or her own life by taking the overdose. Here, the final act of ending life rests with the
patient, not with the doctor. However, the doctor arguably has done as much as he or she could to
assist.

In Hong Kong, like many other jurisdictions (such as the United Kingdom and Canada), suicide
ceased to be a crime in 1967. The same is true with attempted suicide. The Offences Against the
Person Ordinance, section 33A provides that:

“The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.”

The removal of criminal stigma attached to those committing suicide raises the concern that the state
(or the law) condones suicide. To address such fears, the Offences Against the Person
Ordinance, section 33B provides that it is a crime for anyone to assist in another's suicide. Section
33B(1) provides that:

“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.”

In November 2007, Ah Bun visited the Faculty of Law, University of Hong Kong. He shared with
the law students his understanding of the law governing suicide and assisted suicide. According to Ah
Bun, if there comes a day when he does not wish to live, it is impossible for him to end his life by
committing suicide. In order to end his life, he will need to be assisted, yet assisting suicide is
unlawful. No one wishes to be involved, nor would he want anyone to bear the criminal sanction for
him. The law on assisted suicide thus discriminates those who are unable to achieve an outcome
which the able-bodied can lawfully achieve. Arguably, the law prohibiting assisted suicide is
discriminatory.

This is a powerful argument indeed. If our legal system values an individual's autonomy and
allows a person to refuse life sustaining treatment (see Part 2), and it also protects an individual's
autonomy to choose death over life by decriminalising suicide, then, arguably, denying those who
cannot commit suicide assistance is an affront to their right to autonomy.

This argument has not been the subject of legal debate in Hong Kong, but it has received
thorough judicial scrutiny in both Canada and the United Kingdom in 1994 and 2001 respectively. The
law prohibiting assisted suicide has been challenged in the United Kingdom in R (Pretty) v DPP. Diane
Pretty suffered from motor neuron disease (MND), a degenerative condition, and she did not have
long to live. She was paralysed from the neck down but was mentally competent. She wanted to
die with dignity and be able to decide when and how she would die. Her husband agreed to help her.
However, section 2(1) of the Suicide Act 1961 imposed a blanket prohibition on assisting suicide.
Diane Pretty sought an undertaking from the Director of Public Prosecutions (DPP) that if her
husband helped her, he would not be subsequently prosecuted. The DPP refused. Diane Pretty
applied for judicial review, seeking a declaration that, firstly, the DPPs refusal was unlawful and
breached, inter alia, her right under the European Convention on Human Rights. The relevant rights
were those under Article 2 (right to life) and Article 8 (right to respect for private life). Secondly, Diane
Pretty sought a declaration that section 2(1) of the Suicide Act 1961, by imposing a blanket prohibition
on assisting suicide, was incompatible with those rights.

Although the House of Lords was sympathetic to her plight, it held that the DPPs refusal to give
an undertaking was not amendable to judicial review. Further, it held that the right to life in Article 2
protected the sanctity of life (that is, no individual should be deprived of life by means of intentional
human intervention), but it did not include the converse, that is, the right to die or right to assisted
suicide. Consequently, the State might criminalise assisting suicide. On the right to respect for private
life in Article 8, it was held that the right of autonomy was protected; however, that right concerned
exercising autonomy whilst living one's life, and had no bearing on the choice not to live.

*12 It is submitted that the last point is somewhat artificial in the sense that exercising one's autonomy
arguably includes choosing whether and how life is experienced, and that includes whether or not one
wishes to experience a prolonged or painful death.

*12 After failing at the House of Lords, Diane Pretty took her case to the European Court of Human
Rights. Although her case also failed, her argument on Article 8 received a better reception. In Pretty
v United Kingdom the European Court of Human Rights held that Article 8 prohibited interference
with the way in which an individual leads his or her life. The essence of this right was one of
respect of human dignity. Diane Pretty sought to avoid degradation and suffering as her condition
progressed, yet she was prevented from exercising her choice by the law. That was a potential
interference with her right to respect for her private life.

*12 "The very essence of the Convention is respect for human dignity and human freedom; the
Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era
of growing medical sophistication combined with longer life expectancies, many people are concerned
that they should not be forced to linger on in old age or in states of advanced physical or mental
decrepitude which conflict with strongly held ideas of self and personal identity.

*12 The applicant in this case is prevented by law from exercising her choice to avoid what she
considers will be an undignified and distressing end to her life. The Court is not prepared to exclude
that this constitutes an interference with her right to respect for private life as guaranteed under Article
8 (1) of the Convention." 56

*12 However, the European Court of Human Rights held that any such interference with her private
life could be justified on the grounds that it was necessary, in a democratic society, for the protection
of those who might be vulnerable to abuse if assisted suicide was decriminalised. 57

*12 A similar challenge to the law prohibiting assisted suicide took place much earlier in 1994 in
Canada on facts very similar to Diane Pretty. In Rodriguez v British Columbia (Attorney General) Sue Rodriguez was a 42-year-old patient suffering from amyotrophic lateral sclerosis (the most common form of MND). Victims of this disease generally die within 2-3 years of first diagnosis due to the wasting of the muscles used in breathing. Prior to death, victims experience difficulty with speech, chewing and swallowing. Death generally results from starvation or choking. Sue Rodriguez wished to live for as long as possible but avoid future distress and proposed a physician install an intravenous line containing poison which would allow her to end her life at a time of her choosing. However, section 241(b) of the Criminal Code made aiding or abetting a suicide a criminal offence. She argued that this provision was contrary to section 7 of the Canadian Charter of Rights and Freedom (the Charter). Section 7 of the Charter provided that:

*13 “Everyone has the right to life, liberty and security of the person and the right not to be
deprived thereof except in accordance with the principles of fundamental justice.”

*13 Sue Rodriguez argued that section 241(b) was incompatible with section 7 of the Charter in that it
inhibited her in controlling the timing and manner of her death. Although the Canadian Supreme
Court, by a majority of 5:4, dismissed Sue Rodriguez's case, all the judges (except one) recognised
that section 7 of the Charter conferred a right of personal autonomy extending to decisions on life and
death. The case was lost because it was held that the deprivation of the right was in accordance with
the principles of fundamental justice.

*13 Sopinka J delivered the majority judgment, explaining that the crime of assisting suicide was not
limited in its application to the plight of terminally ill patients with whom many people sympathised. A
general prohibition served to protect the old, weak and vulnerable from those who might benefit from
their suicide. Legalisation of assisted suicide might lead to abuse as the line between homicide for
self-gain and assisted suicide was a fine one; homicide for ignoble reasons could easily be disguised
as assisted suicide, hence the need for prohibiting assisted suicide.

*13 McLachlin J delivered a powerful dissenting judgment and took the view that the prohibition
against assisted suicide effectively deprived Ms Rodriguez of the right to decide the time and manner of death, making her a scapegoat for the potential abuse should assisted suicide be legalised. McLachlin J said:

"it does not accord with the principles of fundamental justice that Sue Rodriguez be disallowed what is available to others merely because it is possible that other people, at some other time, may suffer, not what she seeks, but an act of killing without true consent."

McLachlin J was not convinced that legalisation of assisted suicide would devalue life. On the contrary, she took the view that life would be devalued if one could not choose to do what one wanted with one's life. She said:

"One's life includes one's death. Different people hold different views on life and on what devalues it. For some, the choice to end one's life with dignity is infinitely preferable to the inevitable pain and diminishment of a long, slow decline."

McLachlin J further doubted the rationale behind the crime of assisted suicide when it purported to deter murder, rather than assisted suicide. She said that the fear was that unless assisted suicide was prohibited, it would be used as a cloak for murder. However, she questioned how a law which infringed an individual's right could be found to be reasonable and demonstrably justified on the sole grounds that crimes other than those which it prohibited might become more frequent if it was absent.

Although both Diane Pretty and Sue Rodriguez failed in their challenge to the blanket legal prohibition of assisting suicide, their cases clearly showed that, firstly, an individual's autonomy (in controlling when and the manner of one's own death) is at stake, and secondly, it is highly questionable that a blanket prohibition could be justified. In Hong Kong, under section 33B(3) of the Offences Against the Person Ordinance, the Secretary for Justice has the discretion to dispense with prosecution in suitable cases. It has been pointed out, however, that whether or not there will be a dispensation from prosecution is known only after the event. Effectively, there is a built-in uncertainty in the crime of assisting suicide. Arguably, this uncertainty needs to be clarified. More importantly, there is a need to consider whether the law should strike a better balance between enhancing the right to autonomy of those who are unable to end their lives and protecting those vulnerable patients who may be coerced into ending their own lives.

4. Physician-Assisted Suicide and Euthanasia Globally and in Hong Kong

As mentioned earlier, the Hong Kong law on euthanasia and physician-assisted suicide is similar to those in many common law jurisdictions which have not specifically tackled the issues of physician assisted suicide and euthanasia in their legislation. There are only three jurisdictions in the world, the Netherlands, Oregon and Belgium that have done so.

The Netherlands has debated the subject of physician assisted suicide as well as voluntary euthanasia for many years and had a "half-way house" experience for about 20 years. This half-way house meant that, although in Dutch law euthanasia remained illegal and was a criminal offence, doctors who carried it out would not be prosecuted provided they complied with certain requirements. This exemption from criminal liability is now codified in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act which took effect on 1 April 2002. It legalises both physician assisted suicide as well as voluntary euthanasia under certain well defined situations. The Ministry of Health, Welfare and Sport published its evaluation report on the legislation on May 2007. It concluded that:

"All things considered, the law has achieved its objectives well, generally speaking. The frequency of euthanasia and assistance in suicide has decreased and the percentage of cases reported has increased; there does not seem to be any question of a slippery slope with regard to life terminating, either with or without the request of the patient. Therefore, there is very little incentive for actual substantive law or policy amendments."

However, according to Mason and McCall Smith, the Dutch experience has shown that there are problems and it should not be treated as a paradigm for future law reform.

In the United States, the State of Oregon has legalised physician assisted suicide by the Death with Dignity Act 1997. The law allows a terminally ill patient to end life through voluntary self-administered lethal medications, expressly prescribed by a physician for that purpose. The
The Death with Dignity Act 1997 has been in place for almost a decade, and the Department of Human Services issued its 9th Annual Report in March 2007. The Report provides interesting insights on how the law has been working. For instance, it found that since the law was passed, as at 2007, a total of 292 patients have died under the Act. The annual figures have been steady and there has been no significant increase from year to year. In 2006, 65 prescriptions for legal medications were written, however only 35 patients took the medications. As in prior years, it was more likely that participants had cancer (87 per cent) and had more formal education (41 per cent had at least a baccalaureate degree). Patients who died in 2006 were slightly older (median age 74 years) than in previous years (median age 69 years), and most patients died at home (93 per cent). As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (96 per cent), decreasing ability to participate in activities that made life enjoyable (96 per cent) and loss of dignity (76 per cent). The report found that more participants in 2006 were concerned about inadequate pain control (48 per cent) than in previous years (22 per cent).

In the United Kingdom, the most recent attempt to legalise assisted suicide was initiated by Lord Joffe when he proposed a Private Members' Bill called the Assisted Dying for the Terminally Ill Bill. The Bill was closely modelled on the abovementioned Oregon law. Its preamble says: “to enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make provision for a person suffering from a terminal illness to receive pain relief medication.” It was defeated in May 2006.

Closer to Asia, the State of Northern Territory, Australia enacted the Rights of the Terminally Ill Act in 1995, which provided for both physician assisted suicide and euthanasia for those who were terminally ill. The Act came into force on 1 July 1996. However, it was repealed by the Commonwealth Euthanasia Laws Act 1997.

In Hong Kong, as mentioned at the beginning of this article, Ah Bun wrote a letter to the Legislative Council on 15 March 2004 outlining his own plight and requesting euthanasia. He also asked the Legislative Council to debate the issue of legalising euthanasia in Hong Kong.

As a result of Ah Bun's letter, the Legislative Council Panel on Health Services, held a meeting on 19 April 2004, ostensibly, to discuss the issue.

The agenda of the meeting stated that, “The Chairman sought members' views on the above letter from a quadriplegic patient requesting members to debate on the issue of legalising euthanasia in Hong Kong.” The Chairman then advised that:

“the issue of legalizing euthanasia in Hong Kong had been debated by the Legislative Council (LegCo) during the motion debate on ‘Treatment of Terminal Patients’ at the Council Meeting on 2 May 2001??? As the motion debate was negatived, Dr Lo [Wing-lok] was of the view that there was no need to embark on another debate on the issue of legalizing euthanasia in Hong Kong.”

The motion debate (on 2 May 2001) on the "Treatment of Terminal Patients" was moved by Dr Lo Wing-lok (a representative of the medical profession). The motion stated that:

“That, as the treatment of terminal patients has aroused considerable controversy in various places over the world, and a country has already introduced legislation to decriminalize euthanasia and bring it under regulation, while some other places have legislated for a total prohibition of euthanasia, this Council urges the Government to attend to the treatment of terminal patients in Hong Kong and to study the need to establish a regulatory mechanism.”

As mentioned, the motion debate was negatived. However, a careful examination of the motion debate revealed that the focus was on the treatment of terminally ill patients (although Ah Bun is not a terminally ill patient). Further, the then Secretary for Health and Welfare (Dr E K Yeoh) said, during the debate, that "the treatment of terminal patients has indeed been a standing topic of study by the Government for many years." He concluded that, "we have already got appropriate measures on the practice of withdrawing life-sustaining treatment to safeguard people's autonomy as well as rights to treatment."

He made it clear that euthanasia is illegal in Hong Kong. On society's sentiment on euthanasia, he said that:

“We note that in the past professional bodies and community organizations have expressed
opposing views on amending legislation to sanction euthanasia. We however have not seen a clear consensus among the general public. Related community surveys show that there is still some confusion in some concepts pertaining to this issue and there is still room for deeper discussion in society.”

*16 There is indeed confusion over what is meant by “euthanasia” or “<foreign language>”. This is apparent when, a year earlier, on 26 January 2000, the then Secretary for Health and Welfare (Dr E K Yeoh), responded to Ms Emily Lau's question regarding the practice of euthanasia in Hong Kong. He said that:

*16 “The Government has studied the issue of euthanasia which has been a subject of public debate in many other countries.”

*16 Ms Emily Lau asked him a very simple question.

*16 “I should like to ask the Secretary whether the hospitals or doctors in Hong Kong would approve of this practice: Supposing a patient is seriously ill and reckons that he could not live much longer. When this patient is still conscious, could he write and sign any instructions telling the doctors concerned that he would not wish to have his life prolonged, and asking them not to apply to him any resuscitation procedures should he fall unconscious? Could the Secretary inform this Council whether the people of Hong Kong have now the freedom to choose to live in dignity or to choose to end their lives in dignity?”

*16 His response was clear at first; however, it was followed by confusion between life sustaining treatment and euthanasia. He said:

*16 “In the case mentioned by Miss Lau just now, the patient is terminal and has indicated his wish to cease medical treatment. Under such circumstances, normally doctors will respect the wish of their patients. If any patients should indicate their wishes to not receive any medical treatment, we would cease treatment according to their wishes. Generally speaking, however, we would endeavour to make the patients concerned have a better understanding of their conditions first. As a matter of fact, there are many ways to take care of patients with terminal illness. Our colleagues responsible for hospice care service are strongly opposed to the concept of euthanasia. In their opinion, the pains suffered by many patients could be minimised by means of medical treatments; as such, patients really should not ask for euthanasia just because of the pains they suffer.”

*17 On whether the government would consult the public on whether euthanasia should be allowed, he replied that:

*17 “There has been very limited discussion on euthanasia as I have defined today. I believe there needs to be much more informed discussion on the subject and we will facilitate the discussion.”

*17 What is interesting to note is that, despite the government's own admission that there was still some conceptual confusion and there needed to be much more informed discussion on the subject of euthanasia, Ah Bun's request that the Legislative Council debate the issue of legalising euthanasia was dismissed on the basis that there was no need to embark on another debate. Consequently, since Ah Bun's request, no debate has taken place. The only positive response by the government has been that on 25 June 2004 a report of the Panel on Welfare Services was submitted to the Legislative Council. It backed the provision of better support and assistance for paralysed patients living in the community.

*17 In sum, the debates in the Legislative Council prior to Ah Bun's case have been impeded by terminological or conceptual confusion. This confusion may be ameliorated somewhat with the publication of professional guidance such as the Hong Kong Hospital Authority's Guidelines on Life Sustaining Treatment in the Terminally Ill and the Professional Code of Conduct issued by the Medical Council of Hong Kong (discussed in Part 1). Nonetheless, what is clear is that much of the discussion: (i) has concentrated on the withdrawal of life-sustaining treatment in the context of those who are terminally ill; (ii) was initiated by the medical profession, such as the Hong Kong Hospital Authority and the Hong Kong Medical Council; and (iii) the government acknowledges that there needs to be much more informed discussion on the subject of euthanasia.

*17 The debate on euthanasia has been reignited with the publication of the Law Reform Commission of Hong Kong's Report on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment in 2006. This Report recommended that an adult of sound mind should be able to state in
advance on a model form whether they wish life-sustaining treatment to be withdrawn should he or she become terminally ill or enter a permanent vegetative state. The Report ruled out the option of enacting legislation giving such an advanced refusal legal status. However, it recommended, inter alia, that advance directives not be given legislative status, but that a model form of advance directives be promoted widely.

*17 The Report's recommendations, although unrelated, have been associated, rightly or wrongly, with euthanasia. For example, it has been reported that the Alliance of Patients Organization objected to the Report's recommendations, seeing it as no different from euthanasia and suspecting that it was a cost-cutting measure. **96** Others, such as the Direction Association for the Handicapped, worried that legalising euthanasia might put pressure on the sick and the handicapped to commit suicide, as they might worry about becoming a burden to society and their families. **99** The Society for the Promotion of Hospice Care opposes euthanasia, arguing that more resources should be placed on developing palliative care. **100**

*18 It was recently reported that a 77-year-old stroke patient, <<foreign language>>, also wanted euthanasia. He sent letters to the Department of Social Welfare and the Hospital Authority but received no reply. **101**

*18 It is not the intention of this article to discuss the arguments for and against physician assisted suicide or euthanasia; it is sufficient to note that proponents to changing the law argue that patients must be able to decide for themselves and they should not have to endure unbearable pain "for the good of society as a whole". **102**

*18 Opponents to changing the law may adhere to the belief that killing is wrong. Others are concerned that any exception to the law protecting the sanctity of life, even if it were tightly worded with stringent safeguards, will devalue life -- that "certain kinds of life are not worth living". **103** It may also lead to abuse whereby subtle or not-so-subtle pressure is put on the vulnerable to consider euthanasia or assisted suicide. Others are concerned that changing the law may detract from the need to improve the palliative care and support provided for those who need it. A related concern is that opening the door to one category of patients (eg those who are terminally ill) may mean that eventually other categories of patients would be allowed to ask for euthanasia or assisted suicide. Others are concerned that any change to the law may fundamentally change the role of the doctor from someone who cures or cares to someone who can kill.

*18 "I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat (or the green scrub) of a healer, concerned only to relieve my pain and restore me to health, or the black hood of the executioner. Trust between patient and physician is simply too important and too fragile to be subjected to this unnecessary strain." **104**

Conclusion

*18 "Death is disconcerting for medical science because it is often seen as a type of failure." **105**

*18 Since Ah Bun's letter to the Legislative Council on 15 March 2004, his condition has improved tremendously. In October 2008, it was reported that Ah Bun asked to leave the Queen Mary Hospital with a view to moving back into his parents' home. **102** He does not want to end his life anymore. It is pertinent to ask, however: should there be such a right if and when a competent person wants assistance to end his or her life?

*18 Currently the law prohibits assisted suicide and euthanasia. However, a competent person has the legal right to refuse medical treatment which may bring about premature death. In other words, the withholding or withdrawing of life-sustaining treatment is permitted not because there is any specific statutory recognition of this right, but rather via an application of a general legal principle that non-consensual medical treatment amounts to trespass to the person.

*19 How practically valuable is such a right? As can be seen in the English case of B v An NHS Hospital Trust, **107** even if a patient has a legal right, there may be many practical obstacles to its enjoyment. First, there is the question of competence (which is the gatekeeper of self-determination or autonomy). Second, as in the case of Ms B, is the issue of enlisting assistance. At the conclusion of the judgment, President Dame Elizabeth Butler-Sloss noted that the dedication of the ICU staff in preserving life actually added to the difficulties of Ms B. She said:
Ironically this excellent care has to some extent contributed to the difficulties for the Hospital. Ms B has been treated throughout in the ICU in which the medical and nursing team are dedicated to saving and preserving life, sometimes in adverse medical situations. As Dr C said, they are trained to save life. The request from Ms B, which would have been understood in a palliative care situation, appears to have been outside the experience of the ICU in relation to "173 a mentally competent patient. It was seen by some as killing the patient or assisting the patient to die and ethically unacceptable."

The court made it clear that the impasses between Ms B and the team at the ICU were such that the hospital ought to assist effectively. As the hospital failed to do so, the burden then rested on Ms B to initiate proceedings to vindicate her right. More importantly, the court issued guidelines for future cases like this for hospitals to follow in the future. Essentially, they provide that where there is disagreement regarding competence, the hospital should seek independent outside expertise, and that the patient should be part of the process. Where a doctor is unable to disconnect a ventilator, there is a duty to find another who will do so. If all else fails, the hospital should make an application to the High Court or seek the advice of the official solicitor.

What this means for people like Ms B is that her right to bodily integrity is only protected by an adequate access to the legal system. However, if a person, like Ah Bun now, is no longer dependant on a ventilator or any other life sustaining treatment, any assistance in ending life would be in the form of assisted suicide or euthanasia. Both are illegal.

Prior to Ah Bun’s case, much of the discussion on euthanasia was initiated by the medical profession. They focused on withholding life-sustaining treatment of the terminally ill. A competent patient’s right to self determination was secondary. Ah Bun’s case raises issues beyond the cessation of treatment of those who are terminally ill, or of relieving dying patients from the overzealous captivity of modern medical technology. His case poses the poignant questions, does a competent adult have a right to define his or her life as not worth living, what constitutes a dignified death, and to what extent may society prohibit those who are handicapped in ending their life from being assisted in suicide? Compared to the fight for a right to die -- as seen in the case of Pretty v United Kingdom and Rodriguez v British Columbia (Attorney General) -- the social and legal debate is still at its infancy. As such, Ah Bun is a maverick. He has pushed the debate further than anyone has done before.

As the government has stated that there needs to be much more informed discussion on the subject of euthanasia, it is submitted that the more appropriate approach would be for the Law Reform Commission to be engaged in producing a thorough consultation paper which leads us out of the quagmire, and ahead.

2. ><<foreign language>>, Ming Pao, 20 Apr 2004.
3. ><<foreign language>>, Ming Pao, 25 Dec 2004. A patient on diaphragmatic pacing is breathing on his own. Over time the patient may get stronger and may not require it. ><<foreign language>>, Ming Pao, 3 May 2007.
4. ><<foreign language>>, Ming Pao, 14 Jun 2006.
7. Lord Goff in Airedale NHS Trust v Bland said, “euthanasia --actively causing his death to avoid or to end his suffering” [1993] 1 All ER 821 p 867.


15. See Part 4.


17. The defendant was acquitted. See the double effect doctrine and cases of terminal sedation, Mason and McColl Smith (see n 14 above), p 634.


20. Dr Cox was treated rather leniently. He received a one year suspended sentence and was reprimanded by the General Medical Council. His name was retained on the Medical Register. His employer agreed to reinstate him provided that he worked under the supervision of a senior consultant.


23. Lord Mustill found the distinction, ethical or legal, artificial ([1993] 1 All ER 821, p 885). He said that, “The conclusion that the declarations can be upheld depends crucially on a distinction drawn by the criminal law between acts and omissions, and carries with it inescapably a distinction between, on the one hand what is often called ‘mercy killing’, where active steps are taken in a medical context to terminate the life of a suffering patient, and a situation such as the present, where the proposed conduct has the aim for equally humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life. The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable. By dismissing this appeal I fear that your Lordships’ House may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen. Still, the law is there and we must take it as it stands.”

24. Brazier and Cave (see n 13 above), p 487.


26. [1993] 1 All ER 821.

27. [1993] 1 All ER 821, pp 867-868.


30. See the Hong Kong Hospital Authority’s Guidelines on Life Sustaining Treatment in the Terminally Ill (Hong Kong Hospital Authority,


33. Emphasis added.

34. See also the Hong Kong Government's definition of euthanasia: “a deliberate act with the primary intention of ending the life of an individual, as part of the medical care offered.” It “does not apply to withholding or withdrawal of resuscitation procedures or life prolonging treatment for the terminally-ill patients.” See Hong Kong Hansard, 26 Jan 2000, p 3598, http://www.legco.gov.hk/yr99-00/english/counmtg/hansard/000126fe.pdf (visited 5 Mar 2009).


36. Ibid, App II.

37. Ibid, p 866.


41. Ibid, p 866.

42. Ibid, p 652-653.

43. The court awarded notional damages of 100 in recognition of the technical battery committed in treating Ms B against her wishes.

44. Vacco v Quill 521 US 793 (1997, Supreme Court of the United States).

45. In common law, suicide was seen as a form of felonious homicide that offended both God and the King's interest in the life of his citizens. Thus, until 1823, English law provided that the property of the suicide be forfeited and his body placed at the crossroads of two highways with a stake driven through it. However, given the practical difficulties of prosecuting the successful suicide, most prohibitions centred on attempted suicide, see Rodriguez, Sopinka J.

46. [2002] EWHC 429 HC.

47. Para 2.


49. The court awarded notional damages of 100 in recognition of the technical battery committed in treating Ms B against her wishes.


52. South China Morning Post, 29 Nov 2007.

53. [2002] 1 All ER 1.


60. Section 33B(3) of the Offences Against the Person Ordinance provides that, "No proceedings shall be instituted for an offence under this section except with the consent of the Secretary for Justice".


62. In 2002, Belgium legalised active euthanasia. Switzerland decriminalised assisted suicide in 1942, see Mason and McCall Smith (above n 14), p 614.


64. Ibid.

65. Art 293 of the Act amends the Penal Code to read as follows: "(1) A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine ??? (2) The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care ??? and who informs the municipal autopsist of this ???". For more of the Dutch experience, see Mason and McCall Smith (n 14 above), p 605.


67. Ibid.


69. Mason and McCall Smith (see n 14 above), pp 606-608; see also Peter Singer, Rethinking Life and Death (London: OUP, 1994); Margaret Battin, "Voluntary Euthanasia and the Risk of Abuse: Can We Learn Anything from the Netherlands?"(1992) 20 Law, Medicine and Health Care 133.


73. “Unbearable suffering” means suffering whether by reason of pain or otherwise which the patient finds so severe as to be unacceptable and results from the patient's terminal illness; and “suffering unbearably” shall be construed accordingly.

74. “Terminal illness” means an illness which, in the opinion of the consulting physician, is inevitably progressive, the effects of which cannot be reversed by treatment (although treatment may be successful in relieving symptoms temporarily) and which will be likely to result in the patient's death within a few months at most.
“Assisted dying” means the attending physician, at the patient’s request, either providing the patient with the means to end the patient’s life or if the patient is physically unable to do so ending the patient’s life.


See n 1 above.


Ibid.

Ibid. emphasis added.


Emphasis added.

Ibid, p 5095(emphasis added).

Ibid, p 5097(emphasis added).

Ibid, p 5096.

Ibid, p 5097(emphasis added).


Ibid, p 3600.

Ibid, p 3601(emphasis added).

Ibid, p 3599(emphasis added).


As noted by Tse Chun Yan and Samantha Pang, the term “euthanasia” can embrace forgoing lifesustaining treatment or palliative care. See Tse Chun Yan and Samantha Pang, “Euthanasia and Forgoing Life-sustaining Treatment in the Chinese Context”, in Cecilia Chan (ed), Death, Dying and Bereavement: a Hong Kong Chinese Experience, p 169.

As noted Tse Chun Yan and Samantha Pang, “Euthanasia and Forgoing Life-sustaining Treatment in the Chinese Context”, in Cecilia Chan (ed), Death, Dying and Bereavement: a Hong Kong Chinese Experience, p 169.


98. “Right-to-die proposal is morally wrong, say patient's groups”, South China Morning Post, 17 Aug 2006.

99. “Legalising euthanasia 'may pressure weak'”, South China Morning Post, 12 Aug 2007. According to Dr Doris Tse Man-wah, the department of medicines and geriatrics of Caritas Medical Centre, Hong Kong has only about 20 specialists in palliative care.

100. “Legalising euthanasia ‘may pressure weak’”, South China Morning Post, 12 Aug 2007; “Care groups call for end to debate over euthanasia”, South China Morning Post, 28 Jul 2007. However, as correctly pointed by Mason and McCall Smith (see n 14 above), p 605, such a measure is unlikely to end to call for euthanasia.


104. Mason and McCall (see n 14 above), p 618.

105. Montgomery (see n 13 above), p 459.


107. [2002] EWHC 429 HC.

108. Para 97.
