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LEGAL ASPECTS OF END-OF-LIFE CARE IN MALAYSIA

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INTRODUCTION

End-of-life ***care*** revolves around the terminally ill patient's quality of ***life***, the dying process and ultimately death. In the modern healthcare setting, death is no longer a definitive matter as pharmacological breakthroughs and advances in technology with regard to ***life*** prolonging therapy and other medical interventions, have blurred the lines between ***life*** and death. Patients who are on ***life*** support for example, are able to live longer, despite no longer possessing cognitive and sensory functions. Thus, ***end-of-life*** issues relate to matters of consideration in the decision-making process in respect of clinical practices and procedures that could lead to the death of a terminally ill patient. This inevitably involves complex ethico-***legal*** dilemmas, which are further compounded by the paucity of proper ***legal*** instruments to address such conflict.

WHAT IS *END-OF-LIFE CARE*?

End-of-life care falls within the wider purview of palliative ***care***. The World Health Organisation defines 'palliative ***care***' as 'an approach that improves the quality of ***life*** of patients and their families facing the problem associated with ***life***-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.[1] Its primary focus is to prevent, diagnose, treat and reduce the severity of symptoms, as well as provide relief to patients suffering from serious or potentially fatal illness, while at the same time assisting patients and their families in the relevant decision-making process.[2] ***End-of-life care*** falls within the spectrum of palliative ***care*** and is applied towards the ***end*** of the disease trajectory. According to the United States National Quality Forum, ***end-of-life care*** applies when a patient's chronic illness is no longer curable and ***life***-prolonging therapies are no longer appropriate indicated or desired.[3] Thus, to put it in simpler terms, ***end-of-life care*** is palliative ***care*** that is delivered when death is imminent.[4]

CURRENT REGULATORY FRAMEWORK ON *END-OF-LIFE CARE* IN *MALAYSIA*

At present, there are no authoritative standards that officially regulate ***end-of-life care*** in ***Malaysia***,[5] and in particular, the management of ***end-of-life*** decisions, which include issues on active euthanasia, withholding and withdrawal of ***life***-sustaining treatment, as well as palliative sedation and terminal sedation. Indubitably, the decision-making process must comply with ***legal*** standards in order to protect the interests of medical practitioners, patients and health ***care*** providers. It is therefore necessary to look into the current ***legal*** position on ***end-of-life*** decisions in ***Malaysia***, which may be determined by examining the existing local statutory provisions and ethical codes. To date, no local judicial decisions on the matter are available, as issues pertaining to ***end-of-life care*** are treated as purely medical decisions and have yet to be brought before the Malaysian courts.

Active euthanasia: Murder of a lesser degree

There is no specific legislation in ***Malaysia*** dealing with acts that amount to euthanasia. Nevertheless, the legality of euthanasia in the Malaysian context can be examined through the existing statutory provisions in the Penal Code, which is the country's main piece of legislation governing criminal offences.

In criminal law, it is axiomatic for the elements of actus reus (the criminal conduct) and mens rea (the guilty mind) to be established in order to prove that a crime has been committed. Thus, it is first necessary to determine whether the deliberate act of a doctor committed with the intention to cause the death of his patient in the case of active euthanasia, would amount to culpable homicide amounting to murder under *s 300* of the Malaysian Penal Code. According to s 300, culpable homicide is murder, if either of the following situations occur:

(a) if the act by which the death is caused is done with the intention of causing death;

(b) if it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused;

(c) if it is done with the intention of causing bodily injury to any person, and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death; or

(d) if the person committing the act knows that it is so imminently dangerous that it must in all probability cause death, or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death, or such injury as aforesaid.

Situations of non-voluntary and involuntary euthanasia would therefore be directly caught under the aforementioned text.[6] However cases of active voluntary euthanasia which involve the victim's consent would appear to fall under exception 5 of *s 300*, which states that: '[c]ulpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death, or takes the risk of death with his own consent.' The effect of this provision is to reduce the liability of the act that caused death to culpable homicide not amounting to murder under *s 299*, which indicates that although the Penal Code regards the value of ***life*** to be highly sanctified, in terms

of blameworthiness, one who kills with the consent of the victim is less culpable than the person who does so without.[7] This appears to have been the intention of the drafters of the Penal Code, who were reluctant to consider homicide by consent in the same light as murder, especially when it was driven by reasons of humanity:

> This type of homicide ought not to be punished severely as murder … In the first place, the motives which prompt men to this offence are generally more respectable than those which prompt men to the commission of murder. Sometimes it is the effect of a strong sense of religious duty, sometimes of a strong sense of honour, not unfrequently of humanity.[8]

It follows that in the Indian Penal Code, which is the model punitive legislation upon which the Malaysian Penal Code is primarily based, active euthanasia is recognised as a situation in which the aforementioned exception would operate.[9]

The element of 'consent' is not expressly defined under the Penal Code, but *s 90* sets out what does not constitute consent:

> (a) if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception;
>
> (b) if the consent is given by a person who, from unsoundness of mind or intoxication, is unable to understand the nature and consequence of that to which he gives his consent; or
>
> (c) unless the contrary appears from the context, if the consent is given by a person who is under twelve years of age.

Consent under the Penal Code therefore connotes that there must be free will on the part of the person in allowing the act to be carried out on his person, together with the knowledge of the material facts relevant to his decision making.[10] In the case of *S Balakrishnan and Another v Public Prosecutor*[11] consent of the victim towards the treatment that caused him the severe injury was one of the defences raised by the appellant. In that case, the victim was subjected to dunking, which formed part of the lesson plan for the Combat Survival Training Course, organised by the Singapore Armed Forces. As a result of the aggravations practised by the instructors in executing the water treatment, the victim suffered from 'near drowning with Acute Respiratory Distress Syndrome'.[12] The appellant argued that the victim had consented to such treatment because he had volunteered to attend the course and therefore by virtue of s 87,[13] no offence had been committed. The court rejected this argument based on two grounds: (1) the claim that the victim had 'volunteered' for the course was refuted by evidence from another witness, since it was a compulsory course for military personnel; and (2) even if the victim had volunteered for the course, the victim's consent would only be valid if he had done so with the knowledge of the treatment that he would have to undergo, and since there was no proof that the victim possessed such knowledge, the contention could not stand. Further, consent requires a mutual understanding between the person carrying out the act and the consenting party.[14] A look into the aforementioned grounds that would vitiate consent under s 90, also draws attention to the fact that in the case of active voluntary euthanasia, criminal liability under s 299 would only come into operation if the patient consenting is mentally sound. A patient who is unable to exercise effective autonomy due to the impairment of his cognitive functions, or is in a state of severe distress emanating from the pain suffered, cannot then be regarded to have given valid consent. The nature and extent of the victim's mental incapacity in rendering him incapable of understanding what he was consenting to, is a matter for the court to decide depending on the circumstances of each case.[15]

Consequently, a doctor who ***ends*** the ***life*** of a patient in ***Malaysia*** may avail himself of exception 5 to *s 300* provided that the elements of consent are fulfilled. The consent of a patient for the doctor to ***end*** or assist in putting an ***end*** to his ***life*** would operate to mitigate the severity of the crime, although the doctor would not be fully exonerated from the liability of his action.

Premised on the foregoing, it follows that the doctor would be liable under s 299 which states that, '[w]hoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury

as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide'. Further, explanation 1 under s 299 provides that '[a] person who causes bodily injury to another who is labouring under a disorder, disease, or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused his death'. This clearly fits the situation of active voluntary euthanasia and a doctor performing such an act can be prosecuted and may be found guilty of having committed the offence of culpable homicide not amounting to murder.[16]

An unsuccessful attempt of a doctor to ***end*** a patient's ***life*** is also treated as a criminal offence under *s 308* of the *Penal Code*.[17] Likewise, in cases of assisted suicide that do not achieve its intended purpose, both the patient and the assisting doctor may find themselves liable under *s 309* for attempt to commit suicide[18] and *s 306* for abetment of suicide,[19] respectively.

Withholding and withdrawal of treatment: The legality of an 'omission'

In the case where a doctor discontinues or withholds ***life***-sustaining treatment from a terminally ill patient, the issue that arises is whether this renders him liable under *s 299*, since under the Penal Code, the word 'act' would also extend to an 'illegal omission', by virtue of s 32.[20] The general rule is that criminal liability is imputed to conduct which consists of a positive act, rather than an omission. The non-criminalisation of omissions is based on concerns of individual autonomy; accordingly, to assign culpability to an omission would not only interfere with a person's fundamental liberty to choose, but it would also be difficult to define the parameters within which a person may be found guilty of an offence, as intentional non-doing may assume different forms and be of varying degrees.[21]

There are however certain types of omissions which constitute exceptions to the general rule and are proscribed under the Penal Code. The purport of s 32 is to make punishable omissions which have caused or intended to cause a proscribed harm in the same way had such harm been committed by positive acts, provided that such omissions were illegal.[22] Thus, an omission would attract criminal liability if it satisfied two elements: (a) it must be illegal under s 43; and (b) a connection must be established between the omission and the harm; in other words, the question that needs to be asked would be: would the harm have occurred had it not been for the conduct of the accused?[23]

The issue is therefore whether the doctor's conduct in not administering further treatment to a dying patient would amount to an illegal omission punishable under the Penal Code. According to s 43, in order for a conduct to be illegal, it would need to fulfill either of the following requirements:

(a) that it is an offence;

Section 40 defines the word 'offence' to denote 'a thing made punishable by this Code'. In this respect, there are no provisions in the Penal Code expressly criminalising the withholding and withdrawal of ***life***-sustaining treatment;

(b) that it is prohibited by law;

This refers to omissions which may not necessarily be proscribed as an offence under the Penal Code, but which are prohibited and regarded as unlawful under other ***legal*** provisions. For example, the conduct of a parent, guardian or caretaker who leaves a child without reasonable supervision and neglects the welfare of that child is prohibited and punishable under *s 33* of the *Child Act 2001*,[24] although it is not tantamount to a crime under the Penal Code. Although the withholding or withdrawal of ***life***-sustaining treatment is not classified as unlawful conduct under any existing law in ***Malaysia***, it is addressed and recognised as a legitimate medical procedure that may be undertaken in prescribed circumstances under the Code of Medical Ethics issued by the Malaysian Medical Association ('CME'), clinical practice guidelines and ICU management protocols. In essence, codes of ethics are imbued with normative authority; they embody the standards of conduct against which members of the profession are judged and are often referred to in considerations of legality.[25] An ethical code functions as a set of agreed imperatives, which may be alluded to in determining the standard of ***care*** in a ***legal*** proceeding.[26] Whether the CME and such guidelines have the force of law and are legally binding on medical practitioners however, is arguable; the CME for instance, contains no indication of such intention or effect, rather referring to it as 'guidelines for the proper conduct of the doctor practising in ***Malaysia***' and that it is not intended to be exhaustive'. In addition, neither is the

CME incorporated into the Medical Act 1971[27] or any other ***legal*** instrument. Therefore, although doctors in ***Malaysia*** are ethically bound by the CME, it might not be entirely accurate to predicate it as a piece of legislation; or

(c) that it furnishes a ground for civil action;

The scope of civil liability under this provision encompasses both tortious wrongs and breach of contract.[28] Under common law, a person is under a ***legal*** duty to act if he stands in a certain status with the other party, and failure to properly exercise such duty would render such person liable for civil negligence.[29] In other words, an omission may amount to an offence if the person is under a duty to act and fails to fulfil it. Likewise, no person should be held liable for the consequences of his omission if he was not legally bound to act.[30] It is worth noting that the civil standard of negligence has been judicially recognised to be equivalent to the standard of negligence in criminal cases.[31]

In applying the above rule to the withholding or withdrawal of ***life***-sustaining treatment, it must first be established that there existed a ***legal*** duty on the part of the doctor to carry out and/or continue further treatment. The recognition that a doctor owes a ***legal*** obligation to his patient is an age-old concept that dates back to ancient writings on medical jurisprudence, identified to be as early as the Code of Hammurabi,[32] which states once a doctor undertakes to treat to a patient, a ***legal*** relationship exists between the two parties, which gives rise to a duty to provide proper medical treatment and ***care*** to the patient. In terms of a decision to withhold or withdraw ***life*** support therapy from a terminally ill patient, this is made on the basis of medical futility and/or the request of the patient or family members (in the case of an incompetent patient). In view of the foregoing, two inferences may be deduced:

(a) In cases where the treatment would no longer benefit the patient, or would cause the patient further burden and discomfort, the doctor ceases to be duty-bound, since he is not ethically and legally obliged to provide futile treatment which would not be in the best interests of the patient. It is important to reiterate that although a doctor is required to take reasonable steps to keep a patient alive, he is not under an obligation to keep the latter alive at all costs.[33] These principles on the extent of a doctor's duty of ***care*** have been judicially laid down in common law, for example in the leading case of [34] Consequently, when no ***legal*** duty exists, its omission ie, the discontinuance of ***life***-sustaining treatment will not attract liability. It is to be noted that a doctor still owes a duty towards ensuring that the patient is accorded the comfort and ***care*** that he needs during the final stage of his ***life***, which is exercisable by way of proper palliative ***care***. The dying process takes place naturally, and the patient eventually dies due to the underlying illness and not the withholding or discontinuance of treatment;

(b) Individual autonomy is an ethical right which is imbued in and protected by both civil law and criminal law. In the health ***care*** setting, it is an established principle that the right to self-determination prevails over sanctity of ***life*** when the patient is in a position to partake in the decision-making process concerning his treatment. Thus, the patient's consent must be obtained when administering treatment, and likewise, a refusal must also be complied with, irrespective of the adverse consequences. Failure to adhere to a patient's refusal of treatment would attract civil liability for trespass to person and the criminal offence of assault, and therefore conversely, by implication, a doctor cannot be held culpable for doing the opposite ie, respecting the patient's wishes to not carry out or stop medical treatment. It follows that the contention that such ***end-of-life*** decision could constitute a ground for civil action is one which would be difficult to sustain, due the above reasons.[35]

In sum, since it is established in common law that a doctor ceases to be under a duty to carry out and/or continue further treatment in the above circumstances, the above discussion provides credence to the submission that it is unlikely that withdrawal or withholding of treatment would therefore amount to an offence punishable under Malaysian law, as it does not in the first instance, fulfill the requirements of an illegal omission.

Palliative and terminal sedation: the application of the doctrine of double effect

Under the double effect principle, an act that has both good and bad effects is ethically permissible if it fulfils the following conditions:

(1) the act itself is good;

(2) the act is performed with the intention of achieving the good effect without intending the bad effect, although the later was foreseen prior to the act being undertaken;

(3) the good effect is not obtained by means of the bad effect; and

(4) there is a proportionately grave reason for permitting the bad effect.[36]

Palliative sedation fulfils the requirements in that (1) the administration of sedatives in itself is a good act as it is done with the aim of relieving pain or suffering, which is the good effect; (2) death being the bad effect, although foreseen, is not intended; (3) death is not the means to relief of pain or suffering; and (4) the principle of proportionality is exercised taking into consideration the condition, needs and consent of the patient. There is broad consensus however, that the notion that heavy sedation would accelerate the dying process of the terminally ill patients is unfounded and may have been overemphasised.[37] Analyses conducted by experts such as Sykes, Thorns and Fohr provide evidence showing that there is little basis in the claim that administering opioid analgesics at the ***end of life*** shortens the ***lives*** of patients,[38] thus, lending credence to the argument that it is unnecessary to invoke the doctrine of double effect to justify palliative sedation. Therefore, premised on the findings that carefully monitored and proportionate amounts of sedatives do not operate to hasten the dying process, it is argued that such intervention would not attract the ***legal*** consequences under *ss 300* and *299*. In terms of terminal sedation which involves the withdrawal of artificial nutrition and hydration, the deductions in the preceding paragraphs would apply, on the basis that such ***end-of-life*** decision is considered to be analogous to other ***life*** support therapy which may be withheld and withdrawn.[39]

However, in cases where medical intervention may indeed involve death as a foreseeable but unintended consequence, the doctrine of double effect would still apply as an ethical justification for such conduct, particularly in deciding what would be in the patient's best interests. In terms of criminal liability, it is submitted that a situation involving the application of double effect may be exempted by virtue of certain provisions under Chapter IV of the Penal Code, which deal with special defences. It is to be noted that unlike exception 5 of *s 300* which if proven, reduces the gravity of the offence and mitigates the punishment (from that of murder to culpable homicide not amounting to murder), the special defences, if successfully pleaded, would result in exonerating the accused.

One such relevant provision is s 81 which deals with exceptions based on necessity. According to s 81, '[n]othing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property'. The purport and context of this provision is similar to and represents the principle of double effect in that it adopts the approach of balancing the harm between two different outcomes. This is manifested in illustration (a), where the captain of a steam vessel on the verge of an inevitable collision with a boat carrying 20 to 30 passengers, and in an attempt to evade such incident, incurs the risk of possibly running down another boat with two passengers on board, will be able to avail himself of the defence of necessity, if the latter does in fact occur.[40] This is however subject to the captain's intention, which is another corresponding element that needs to be proven under both the common law doctrine of double effect and s 81.[41] Under the Penal Code, the definition of 'good faith' is set out in s 52: 'Nothing is said to be done or believed in good faith which is done or believed without due ***care*** and attention'. Medical interventions are essentially carried out by doctors for the benefit of the patient and devoid of any criminal intent, despite the fact that it is foreseeable that such action might cause harm to the patient, including death. Although what constitutes 'good faith' is fairly subjective; it is suggested that this requires the person to demonstrate that not only did he have a good intention, but that he exercised reasonable ***care*** and skill as required in the discharge of such duty.[42] In this regard, the personal characteristics and circumstances of the person committing the act will be considered;[43] applying this to the context of medical interventions, the doctor's knowledge and skills, clinical ***aspects***, and compliance to prescribed protocol would therefore be relevant.

Although the management of ***end-of-life*** decisions would most likely fulfil the mental element required to invoke the defence of necessity, an issue that could arise would be as to what would qualify within the ambit of 'other harm' under s 81. According to the explanation to s 81, whether the harm to be prevented or avoided justified or excused the risk of doing the act is a question of fact.[44] The Penal Code however, does not limit the scope of this defence to any particular type of harm, whether perceived or inflicted.[45] Thus, although there has yet to be a local judicial decision interpreting the relevant provision within the context of ***end-of-life*** decisions, this may present a possible window for ***end-of-life*** decisions such as palliative and terminal sedation to be included under the purview of the protection accorded under this provision, since they are carried out for the purpose of alleviating the patient's pain

and suffering. Under the common law, necessity has been pleaded in several cases concerning medical treatment, although the applicability of such a defence remains obscure in situations involving ***end-of-life*** decisions. In *R v Bourne*[46] for instance, the decision of the doctor to perform an abortion on a 14-year old adolescent who had been violently raped was justifiable on the ground of preserving the girl's ***life*** and alleviating the physical anguish and mental suffering that she would endure if she were to get pregnant. In this case, the judge impliedly made out a case of necessity, instructing the jury that the doctor, based on reasonable grounds and with adequate knowledge, believed he was doing the right thing and that he had done so in good faith for the sole purpose of saving the ***life*** of the girl, pursuant to which the jury passed a verdict of acquittal. In *F v West Berkshire Authority and another (Mental Health Act Commission intervening)*[47] necessity was raised as one of the defences by the House of Lords in issuing a declaration that it was lawful under common law for a patient who was mentally disabled to be sterilised. The court held that the doctrine of necessity provided justification for a doctor, to admit treatment in the best interests of a patient who was unable to provide consent. Lord Goff in his judgment, laid down the two basic requirements applicable in such cases of necessity: '(a) there must be a necessity to act when it is not practicable to communicate with the assisted person; and (b) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person'.[48] It was held that in this case, the sterilisation would be in the best interests of the patient, as her mental condition did not make it possible for her to cope with the pregnancy and matters relating thereto, without causing her both physical and mental anguish. In the recent case of *R (on the application of Nicklinson and another) v Ministry of Justice R (on the application of AM) v Director of Public Prosecutions*,[49] which did involve a form of ***end-of-life*** decision ie, assisted suicide, one of the arguments put forth by the applicants at the Court of Appeal level, was that of necessity. The argument was consequently dismissed by the court on two grounds: (a) it was inappropriate for the court to admit the defence of necessity in such a complex and controversial case, and it should be left to the legislature to decide on such matter. The judicial process was not one which enabled judges to deal properly with 'the range of conflicting considerations and procedural requirements which a proper regulation of the field required';[50] and (b) it would go against the intention of legislature to develop a defence of necessity for cases of assisted suicide, when it is expressly clear that the latter was proscribed as a serious criminal offence.[51] In other cases apart from that of active euthanasia, ***end-of-life*** decisions have been held to be justifiable on the basis of the autonomy of a competent patient, and the principle of best interests when the patient has diminished capacity, rather than that of necessity.[52]

If the patient has consented to such medical intervention, s 88 may accordingly be invoked to exculpate the doctor from liability. The provision makes it clear that, '[n]othing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm.' Further, the illustration under s 88 provides an example that directly addresses medical interventions: 'A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under a painful complaint, but not intending to cause Z's death, and intending in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence'.

In the case of an incompetent patient who has not signified any consent prior to his or her incapacity, the second exception to s 92[53] may be of relevance. The operation of the provision has the effect that a person who causes any harm to another person in good faith, even without the former's consent, does not commit an offence, provided that it is done to prevent death or grievous hurt, or to cure any grievous disease or infirmity.[54] There is however ambiguity whether this would be applicable in an ***end-of-life*** setting, where it would be futile to prevent the dying process from progressing, and where the aim is no longer to cure but to provide adequate and competent palliative ***care*** to the patient.[55]

ANALYSIS OF CURRENT *LEGAL* STANDARDS

In terms of ***legal*** standards, there are currently no local statutory provisions or judicial decisions laying down principles governing the conduct of doctors in ***end-of-life*** decision making. The Penal Code lies on the other ***end*** of the spectrum; being punitive law, it solely deals with criminal liability, and even then, it does not specifically list active euthanasia and withholding or withdrawal of ***life*** support therapy as an offence. The earlier discussion on the relevant provisions of the Penal Code in the preceding paragraphs is primarily based on inferences drawn from the text of the statute, including their respective explanations and illustrations, as no judicial interpretations of such provisions have been made by the Malaysian courts in the context of ***end-of-life*** decisions.

Accordingly, there is an evident lacuna in the Malaysian regulatory system with regard to the proper governance of

end-of-life decisions. ***Malaysia***, having been under British colonial rule in the 19th and 20th Centuries, inherits much of its ***legal*** system from the common law in England. The prevailing influence of the laws of England is codified in s 3 of the Malaysian Civil Law Act 1956. Section 3 states that Malaysian courts shall apply the common law of England and rules of equity where no provision on the matter has been made by any written law in ***Malaysia***.[56] Therefore, common law principles particularly in England are persuasive and constitute a significantly relevant source for Malaysian judges to refer to in order to plug the existing gap on the subject of ***end-of-life*** decisions.

To this ***end***, it has been suggested that if a case of withholding or withdrawal of treatment were to be brought before the courts, the common law principles laid down in the dicta of cases such as *Airedale NHS Trust v Bland*[57] could be applied to ascertain the ***legal*** position of such conduct.[58] This brings to light another issue; in view of the current development and increasing demands in ***end-of-life care***, addressing the legality of ***end-of-life*** decisions as and when they may be referred for judicial consideration may run the risk of being counterproductive, as highlighted in *Nicklinson*.[59] There is accordingly a need for the country's policymakers to formulate a more effective mechanism to allow for ethico-***legal*** implications to be anticipated and dealt with in advance rather than *post factum*.[60]

It must further be noted that the application of English law in ***Malaysia*** is limited to the extent that 'the circumstances of the States of ***Malaysia*** and their respective inhabitants permit and subject to such qualifications as local circumstances render necessary'.[61] Hence, the racial and religious demography in ***Malaysia*** constitutes a pertinent factor that requires due consideration. Ethical guidelines and ***legal*** standards on ***end-of-life*** decisions must therefore take into account the values and perspectives of the different communities, particularly since it concerns an area that involves a lot of sensitivity. The CME acknowledges the effects of ***Malaysia***'s diverse cultural composition on local medical practice and mentions this briefly in s I. The other reference made to religion is under appendix I, by highlighting several principles of medical ethics under Chinese culture and Ancient Indian medicine. The Islamic perspective on professional ethics is indicated in the reproduction of the 'Oath of a Muslim Physician',[62] but no specific bioethical principles are laid down in the CME. Further, some general information on religious rituals during the dying process are set out in the Handbook of Palliative Medicine in ***Malaysia***,[63] although religious perspectives on ***end-of-life*** decisions are not explored in detail.

Guidance on religious viewpoints with regard to ***end-of-life*** decisions in ***Malaysia*** must therefore be found in other documents. The ethical principles for Islamic medical ethics, for example, are contained in the Islamic Code of Medical and Health Ethics,[64] in which arts 61 and 62 lay down the Islamic perspective on euthanasia and the approach taken towards termination of futile treatment and palliative sedation. On the local front, a religious edict issued at the 97th Discourse of the National Fatwa Committee for Islamic Affairs ***Malaysia*** adopted a similar position in reiterating the prohibition on active euthanasia, and the permissibility of withdrawal of definitive treatment if the patient no longer has any hope for recovery,[65] although this was expressly restricted to PVS patients. Apart from the above, other religious directives properly addressing the ethics of ***end-of-life*** decisions have yet to be contrived.

LEGISLATING MEDICAL LIABILITY

To reiterate, the legality of euthanasia in ***Malaysia*** is impliedly indicated by the provisions of the Penal Code. Nevertheless, although active euthanasia would amount to a criminal offence, there remains ambiguity in determining the legitimacy of certain ***aspects*** of medical practices within the framework of the Malaysian ***legal*** system. The paucity of local case law regarding the matter further augments the uncertainty as to how the letter of the law should be judicially interpreted when it comes to ***end-of-life*** decisions.

Section 299 of the Penal Code: An indirect prohibition of active euthanasia

Although active euthanasia is not expressly interdicted as a specific felony under the Penal Code, the purport of exception 5 of *s 300*, substantiated by the intention of its drafters, operates to proscribe this controversial form of ***end-of-life*** decision as an act of culpable homicide not amounting to murder under *s 299*. This ***legal*** position of active euthanasia accordingly stands in conformity with the stance taken by all of the major religious groups in ***Malaysia***,[66] and it is difficult to see how this current status could be considered in a different context, considering the level of impact and influence that religion has on the country's legislative process.[67] Thus, on the whole, the

preceding discussions on active euthanasia from the Malaysian perspective attest to the view that it is highly unlikely that the country would be receptive to legalising active euthanasia at any given time in the future, and accordingly this ***legal*** provision, although indirect, is currently sufficient to prohibit such an act.

Special defences in the Penal Code: Plugging the gap on withholding and withdrawal of treatment and terminal sedation

The dearth of specific ***legal*** provisions regulating the liability of and providing safeguards to doctors in ***Malaysia*** inevitably begs the conspicuous question, is it therefore necessary to have a law to address the prevalent ethical and ***legal*** dilemmas in ***end-of-life*** decisions? The Penal Code is the only piece of local legislation that confers a certain level of protection for doctors, in that it does not appear to proscribe the withholding and withdrawal of ***life***-sustaining therapy, as opposed to active euthanasia, and its provisions on special defences may, to a certain extent, be invoked to exculpate a doctor whose course of action is consistent with good medical practice and done for the benefit of the patient. However, it must be noted that there remains ambiguity in how the exact wordings of ss 81 and 92 will be interpreted by the courts to cover medical situations involving a patient whose death is imminent, whereby curative treatment is no longer possible and the prevention of death is no longer the aim. It is suggested that this warrants the need for clearer ***legal*** provisions to be drafted and put into effect, which will serve to protect doctors from criminal liability in the performance of their duties in an ***end-of-life*** ***care*** setting.

Although ethical codes and guidelines present a more malleable form of regulatory instrument to cope with the advancements in medicine, the UK experience has shown that the existence of comprehensive ethical guidance still require ***legal*** backing and affirmation in the form of legislation, as pointed out by the courts in the cases of *Bland* and *Nicklinson*. In both decisions, the judiciary's limitations to address issues on ***end-of-life*** decisions were reiterated; a court of law was not the most appropriate forum to decide on the legitimacy of moral issues of such a contentious nature. Accordingly, the need for legislature to step in and address such matters was emphasised, as this would allow for the views of different segments of society to be heard and considered, rather than it being confined to the individual opinions of the presiding judges. In addition, the legislative process would provide opportune access to expert opinion on a much wider scale, compared to the confines of court procedure.

CONCLUSION

Evidently, there is a compelling need for a regulatory framework to be constructed in respect of ***end-of-life*** ***care*** in ***Malaysia***. In order for an effective ***end-of-life*** ***care*** pathway to be in place, it must be supported by a proper ***legal*** framework that addresses the ethical and ***legal*** implications, in order to provide better direction and assurance to health ***care*** professionals on the legitimacy of their actions. Although currently there are initiatives by various non-governmental organisations and medical societies in providing written directives on practical ***aspects*** of ***end-of-life*** ***care***, the development of a regulatory system in such area has yet to reach its fullest extent. The foregoing discussion demonstrates that the provisions of the Penal Code are equivocally positioned and are not drafted to provide adequate protection or affirmation on the ethicality of ***end-of-life*** decisions. Although the relevant common law principles may be applied to assist judges to develop judicial standards and fill in the lacuna in the law, the more pragmatic approach is for policymakers to legislate and enhance the necessary ***legal*** instruments to address the ethico-***legal*** conflicts prevalent in ***end-of-life*** ***care*** in ***Malaysia***.

[1] World Health Organisation, *National Cancer Control Programmes: Policies and Managerial Guidelines*, (2nd edn, World Health Organisation 2002) 84.

[2] Robin B Rome and et al, 'The Role of Palliative ***Care*** at the ***End of Life***' (2011) The Ochsner Journal 11 (4) 348.

[3] National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice* ***Care*** *Quality: A Consensus Report* (National Quality Forum, 2006) 3.

[4] Cher N. I. Cherny, 'ESMO Takes a Stand on Supportive and Palliative ***Care***' (2003) Annals of Oncology 14 (9) 1335.

[5] Rini Vella, 'Raising Palliative ***Care*** Standards in ***Malaysia***' (Ehospice, 18 November 2015) *https://ehospice.com/international_posts/raising-palliative-**care**-standards-in-**malaysia**/* accessed 8 February 2018.

[6] The punishment for the offence of culpable homicide amounting to murder is death. This is set out under Penal Code (Act 574) *s 302*. An attempt to commit murder is also an offence. Penal Code *s 307* states that '[w]hoever does any act with such intention or knowledge and under such circumstances, that if he by that act caused death he would be guilty of murder, shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine; and if hurt is caused to any person by such act, the offender shall be liable to imprisonment for a term which may extend to twenty years'. Further, subsection (2) of the same provision provides that 'when any person offending under this section is under sentence of imprisonment for ***life*** or for a term of twenty years, he may, if hurt is caused, be punished with death'.

[7] Stanley Meng Heong Yeo, Neil A. Morgan and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, LexisNexis 2015) 577.

[8] Ratanlal R, Thakore DK and Thakker CK, *Ratanlal & Dhirajlal's Law of Crimes: A Commentary on the Indian Penal Code, 1860* (24th edn, Bharat Law House 1998) 1346.

[9] See *ibid*, 1347.

[10] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, Lexis Nexis 2015) 558.

[11] *S Balakrishnan and Another v Public Prosecutor* [2005] 4 SLR(R) 249; [2005] SGHC 146.

[12] *Ibid* [44].

[13] Singapore Penal Code (Cap 224) s 87 states the following:

Act not intended and not known to be likely to cause death or grievous hurt, done by consent

Nothing, which is not intended Nothing, which is not intended to cause death or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person above eighteen years of age, who has given consent, whether express or implied, to suffer that harm; or by reason of any harm which it may be known by the doer to be likely to cause to any such person who has consented to take the risk of that harm.

[14] Kheng Lian Koh, C.M.V Clarkson, and N.A Morgan, *Criminal Law in Singapore and **Malaysia**: Text and Materials* (Malayan Law Journal, 1989) 149.

[15] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, Lexis Nexis 2015) 565.

[16] Punishment for culpable homicide not amounting to murder is stipulated under Penal Code *s 304* which states that:

Whoever commits culpable homicide not amounting to murder shall be punished —

(a) with imprisonment for a term which may extend to twenty years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death; or

(b) with imprisonment for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death.

[17] Penal Code *s 308* provides, '[w]hoever does any act with such intention or knowledge and under such circumstances that if he by that act caused death he would be guilty of culpable homicide not amounting to murder, shall be punished with imprisonment for a term which may extend to three years, or with fine, or with both; and if hurt is caused to any person by such act, shall be punished with imprisonment for a term which may extend to seven years, or with fine, or with both'.

[18] Penal Code s 309 reads, '[w]hoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year or with fine or with both'.

[19] According to Penal Code s 306, '[i]f any person commits suicide, whoever abets the commission of such suicide shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine'.

[20] Penal Code s 32 stipulates, '[i]n every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions'.

[21] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, Lexis Nexis 2015) 70.

[22] Ratanlal, Thakore, and Thakker, *Ratanlal & Dhirajlal's Law of Crimes: A Commentary on the Indian Penal Code,1860* (24th edn, Bharat Law House 1998) 98.

[23] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, Lexis Nexis 2015) 81.

[24] (Act 611).

[25] See Malcolm H Parker, 'Normative Lessons: Codes of Conduct, Self-Regulation and the Law' (2010) *The Medical Journal of Australia* 192 (11) 658–660.

[26] See L Skene, 'A ***Legal*** Perspective on Codes of Ethics' M Coady and S Bloch (eds) in *Codes of Ethics and the Professions* (University of Melbourne Press 1996) 112-13.

[27] (Act 50).

[28] See Ratanlal, Thakore, and Thakker, *Ratanlal & Dhirajlal's Law of Crimes: A Commentary on the Indian Penal Code,1860* (24th edn, Bharat Law House 1998) 146; Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in **Malaysia** and Singapore* (2nd edn, Lexis Nexis 2015) 73-74.

[29] See Richard Card, Jill Molloy, and Rupert Cross, *Card, Cross & Jones Criminal Law* (22nd edn, Oxford University Press 2016) 44-46.

[30] Ram Chandra Nigam, *Law of Crimes in India: Principles of Criminal Law* (Asia Publishing House 1965) 43.

[31] This principle was laid down in *Ng Keng Yong v Public Prosecutor* [2004] 4 SLR(R) 89 [84].

[32] Andrew A. Sandor, '***Legal*** Duties of Physicians' (1951) Calif Med 74 (5) 385.

[33] *R (on the application of Burke) v General Medical Council* [2004] All ER (D) 588 (Jul) [106].

[34] *Airedale NHS Trust v Bland* . [1993] 1 All ER 821. The case concerned one Anthony Bland, a victim of the disaster at the Hillsborough Football Stadium who suffered irreversible damage to his cerebral cortex which rendered him to be in a persistent vegetative state. He was fed artificially and mechanically with a nasogastric tube and showed no cognitive response to his surroundings. All his natural bodily functions had to be operated with nursing intervention, requiring four to five hours of nursing attention by two nurses daily. After three and a half years of remaining in this condition, a court declaration was sought by Bland's attending doctor to cease further treatment, which involved extubation ie, withdrawal of artificial nutrition and hydration and withholding of antibiotic treatment in case of infection. The declaration was based on a clinical assessment by medical experts that there was absolutely no hope of recovery for Bland and thus, any medical intervention would be futile and not in the best interests of the patient.

[35] Prof. Dr. Norchaya Talib avers that it is unforeseeable that civil actions would be taken against doctors in such cases and to consider withholding and withdrawal of treatment as civil wrongs would be untenable — see Norchaya Talib, *Euthanasia: A*

Malaysian Perspective (Sweet & Maxwell Asia 2002) 82-84; Norchaya Talib, '***Legal*** and Ethical Issues in the ***Care*** of Terminally Ill Patients' (2012) Journal of Health and Translational Medicine 9 (1) 93-94.

[36] Rita L Marker, '***End-of-Life*** Decisions and Double Effect: How Can This Be Wrong When It Feels So Right?' (2011) National Catholic Bioethics Quarterly 11 (1) 101.

[37] See for instance Nigel Sykes and Andrew Thorns, 'The Use of Opioids and Sedatives at the ***End of Life***' (2003) The Lancet Oncology 4 (5) 313; Thomas A. Cavalieri, 'Ethical Issues at the ***End of Life***' (2001) Journal of the American Osteopathic Association 101 (10) 621; Rita L Marker, '***End-of-Life*** Decisions and Double Effect: How Can This Be Wrong When It Feels So Right?' (2011) National Catholic Bioethics Quarterly 11 (1) 110.

[38] See Nigel Sykes and Andrew Thorns, 'The Use of Opioids and Sedatives at the ***End of Life***' (2003) The Lancet Oncology 4 (5); SA Fohr, 'The Double Effect of Pain Medication: Separating Myth from Reality' (1998) Journal of Palliative Medicine 1 (4) 315–328.

[39] Siow Yen Ching, '***End-of-Life*** ***Care***' in Richard B.L Lim and Diana Katiman (eds) *Handbook of Palliative Medicine in* ***Malaysia*** (Malaysian Hospice Council 2015) 69.

[40] Penal Code s 81, illustration (a) states:

A, the captain of a steam vessel, suddenly and without any fault or negligence on his part, finds himself in such a position that, before he can stop his vessel, he must inevitably run down a boat B, with 20 or 30 passengers on board, unless he changes the course of his vessel; and that, by changing his course, he must incur risk of running down a boat, C, with only two passengers on board, which he may possibly clear. Here, if A alters his course without any intention to run down the boat C, and in good faith for the purposes of avoiding the danger to the passengers in the boat B, he is not guilty of an offence, though he may run down the boat C, by doing an act which he knew was likely to cause that effect, if it be found as a matter of fact that the danger which he intended to avoid was such as to excuse him in incurring the risk of running down the boat C.

[41] According to some authors, Penal Code *s 81* embodies both justificatory necessity ('the lesser of two evils' approach) as well excusatory necessity (where judicial compassion for the person committing the wrongful act is exercised). See Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in* ***Malaysia*** *and Singapore* (2nd edn, Lexis Nexis 2015) 657–660.

[42] Ratanlal, Thakore, and Thakker, *Ratanlal & Dhirajlal's Law of Crimes: A Commentary on the Indian Penal Code,1860* (24th edn, Bharat Law House 1998) 151.

[43] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in* ***Malaysia*** *and Singapore* (2nd edn, Lexis Nexis 2015) 570.

[44] The Penal Code s 81 explanation states that '[i]t is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm'.

[45] Stanley Meng Heong Yeo, Neil A. Morgan, and Wing Cheong Chan, *Criminal Law in* ***Malaysia*** *and Singapore* (2nd edn, Lexis Nexis 2015) 664.

[46] *R v Bourne [1938] 3 All ER 615*.

[47] *F v West Berkshire Authority and another (Mental Health Act Commission intervening) [1989] 2 All ER 545*.

[48] *Ibid* 565.

[49] *R (on the application of Nicklinson and another) v Ministry of Justice (Director of Public Prosecutions and another, interested parties) (CNK Alliance Ltd and another, intervening) [2013] 133 BMLR 46*. The case concerned one Tony Nicklinson who suffered a catastrophic stroke, which rendered him completely paralysed, save for movement of his head and eyes. For many years, he had wanted to ***end*** his ***life*** but could not do so without assistance. Mr. Nicklinson applied to the court in the first instance for a declaration it would be lawful for a doctor to kill him or to assist him in terminating his ***life***, or, if that was refused, a

declaration that the current state of the law in such matter was incompatible with his right to a private ***life*** under European Convention of Human Rights art 8. His application was eventually dismissed at all levels of appeal.

[50] *Ibid* [60].

[51] *Ibid* [64]. This contention was not pursued further when the case was appealed to the Supreme Court.

[52] *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 866. See Norman L Cantor, 'Deja vu All over Again: The False Dichotomy between Sanctity of ***Life*** and Quality of ***Life***' (2005) Stetson Law Review 35, 87.

[53] Penal Code s 92 states:

Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit:

Provided that this exception shall not extend to:

(a) the intentional causing of death, or the attempting to cause death;

(b) the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity;

(c) the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than the preventing of death or hurt;

(d) the abetment of any offence, to the committing of which offence it would not extend.

[54] Penal Code s 89 is a similar provision to s 92, but is applicable to the case of children under the age of 12 and persons of unsound mind, where consent is provided by their guardian or those legally responsible for their ***care***.

[55] See Norchaya Talib, *Euthanasia: A Malaysian Perspective* (Sweet & Maxwell Asia 2002) 80–81.

[56] Civil Law Act 1956 (Act 67) s 3(1) states:

(1)Save so far as other provision has been made or may hereafter be made by any written law in force in ***Malaysia***, the Court shall:

(a) in Peninsular ***Malaysia*** or any part thereof, apply the common law of England and the rules of equity as administered in England on the 7 April 1956;

(b) in Sabah, apply the common law of England and the rules of equity, together with statutes of general application, as administered or in force in England on 1 December 1951;

(c) in Sarawak, apply the common law of England and the rules of equity, together with statutes of general application, as administered or in force in England on 12 December 1949, subject however to subparagraph (3)(ii):

Provided always that the said common law, rules of equity and statutes of general application shall be applied so far only as the circumstances of the States of ***Malaysia*** and their respective inhabitants permit and subject to such qualifications as local circumstances render necessary.

[57] *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

[58] See Norchaya Talib, *Euthanasia: A Malaysian Perspective* (Sweet & Maxwell Asia 2002) 92–95.

[59] *R (on the application of Nicklinson) v Ministry of Justice; R (on the application of AM) v Director of Public Prosecutions* [2014] UKSC 38.

[60] See Avraham Steinberg, 'Medical Ethics' in *Encyclopedia of Jewish Medical Ethics: A Compilation of Jewish Medical Law on All Topics of Medical Interest* (Vol I, Feldheim Publishers 2003) 399.

[61] Civil Law Act 1956 s 3 proviso.

[62] Being of Malay origin is almost always considered synonymous with being a Muslim. Under the Malaysian Federal Constitution Art 160: ' 'Malay' means a person who professes the religion of Islam, habitually speaks the Malay language, conforms to Malay custom and: (a) was before Merdeka Day born in the Federation or in Singapore or born of parents one of whom was born in the Federation or in Singapore, or is on that day domiciled in the Federation or in Singapore; or (b) is the issue of such a person'.

[63] Richard B.L Lim and Diana Katiman (eds), *Handbook of Palliative Medicine in **Malaysia*** (Malaysian Hospice Council, 2015).

[64] The Islamic Code of Medical and Health Ethics (endorsed at the International Conference on Islamic Code of Medical Ethics in Egypt in 2004) is based on the *Islamic Code of Medical Ethics* (issued by the Islamic Organisation for Medical Sciences and endorsed at the First International Conference on Islamic Medicine in Kuwait in 1981).

[65] National Fatwa Council for Islamic Religious Affairs ***Malaysia***, 'The Ruling on Euthanasia or Mercy Killing' *http://e-smaf.islam.gov.my/e-smaf/fatwa/fatwa/find/pr/10289*.

[66] Fadhlina Alias, 'An Ethico-***Legal*** Study on ***End-of-Life*** Decisions in ***Malaysia***: The Need for A Comprehensive Regulatory Reform, (PhD diss., International Islamic University ***Malaysia***, 2019).

[67] Shamrahayu Abdul Aziz, 'Some Thoughts on the Relationship between Law and Religion in ***Malaysia***' (2009) 1 CLJ(A) xix.

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