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Legislative Council

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LC Paper No. CB(2)1993/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 8 December 2008, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, JP Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, SBS, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Public Officers attending	:	Items IV and V Professor Gabriel M LEUNG, JP Under Secretary for Food and Health Dr LEUNG Pak-yin Director (Quality & Safety) Hospital Authority Dr Libby LEE Deputising Chief Manager (Patient Safety & Risk Management) Hospital Authority Item IV only Mr Thomas CHAN Deputy Secretary for Food and Health (Health) 2

Dr Sarah CHOI
Principal Medical and Health Officer
Department of Health

Item V only

Miss Gloria LO
Principal Assistant Secretary for Food and Health (Health)

Ms Pauline WONG
Senior Manager (Patient Relations & Engagement)
Hospital Authority

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 5

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2) 7

Ms Sandy HAU
Legislative Assistant (2) 5

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I. Confirmation of minutes
(LC Paper No. CB(2)350/08-09)

The minutes of the special meeting held on 17 October 2008 were confirmed.

II. Information paper(s) issued since the last meeting

2. There was no information paper issued since the last meeting.

III. Discussion items for the next meeting
(LC Paper Nos. CB(2)388/08-09(01) and (02))

3. Members agreed to discuss the following items at the next regular meeting to be held on 12 January 2009 -

(a) Redeployment of Directorate Posts in the Department of Health; and

(b) Progress report on promoting healthy eating among school children.

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4. The Chairman suggested and members agreed to discuss allocation of resources among hospital clusters by the Hospital Authority (HA) in the January 2009 meeting. Under Secretary for Food and Health (USFH) agreed to revert to the Secretariat after the meeting whether the Administration was in a position to discuss the item.

(*Post-meeting note*: At the request of the Administration and with the occurrence of the Chairman, a new item on "Report on First Stage Public Consultation on Healthcare Reform" was added to the agenda for the January 2009 meeting and discussion of the item "Allocation of resources among hospital clusters by HA" was subsequently deferred to the meeting on 9 February 2009.)

IV. Advance directives in relation to medical treatment

(LC Paper Nos. CB(2)388/08-09(03) and (04))

5. USFH briefed members on the concept of advance directives, the recommendations made by the Law Reform Commission (LRC) on advance directives in its report entitled "Substitute Decision-making and Advance Directives in Relation to Medical Treatment" published in August 2006 and the Administration's initial views on LRC's recommendations, details of which were set out in the Administration's paper (LC Paper No. CB(2)388/08-09(03)).

Difference between advance directives and euthanasia

6. Mr IP Kwok-him and Mr Albert HO sought clarification from the Administration as to how advance directive was different from euthanasia, given that a prior instruction to refuse life-sustaining treatment would have the effect of shortening the life of the maker of the advance directive.

7. USFH responded as follows -

(a) an advance directive would only be activated at the point where the individual was terminally ill, or was in a persistent vegetative state or in an irreversible coma, so that he did not have the mental capacity to take part in decisions about his medical care and treatment. A patient who was mentally competent could specify in the directive that when he was in any of the conditions described above and was no longer mentally competent, he could choose not to receive any life-sustaining treatment or any other treatment he had specified in the directive save for basic and palliative care so as to minimise distress or indignity that he might suffer and to spare the healthcare professionals or relatives or both from the burden of making difficult decisions on his behalf;

(b) in the LRC report, life-sustaining treatment meant any of the treatments which had the potential to postpone a patient's death and

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included, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration; and

(c) advance directives were totally unrelated to the illegal act of euthanasia which involved direct intentional killing of a person as part of the medical care being offered. Hence, no one could indicate a wish for performing euthanasia in the advance directive in Hong Kong. Even if such a wish was expressly requested, the healthcare professionals should not act as instructed.

8. Director (Quality & Safety), Hospital Authority (Director (Q&S), HA) supplemented that for advance directive, a case in point was that a mentally competent individual, in anticipation of his entering into a condition such as persistent vegetative state, gave a prior do-not-resuscitate order in the event of cardiac arrest.

9. Mr Albert HO remained unconvinced of the Administration's explanation. He said that he could not see how advance directive was different from euthanasia as both involved an end-of-life medical decision making, albeit that the former was in a passive and indirect way.

Promotion of advance directives

10. Ms Audrey EU asked why the Administration did not intend to actively advocating or encouraging the public to make advance directives, which was at variance with the recommendations of LRC. She said that more efforts should be made to step up public education and publicity so that more people would consider making advance directives in advance of any life-threatening traumatic injury or illness. Ms Cyd HO considered it irresponsible of the Administration to disseminate information about advance directives to the public through the relevant professions and organisations.

11. Mr CHAN Hak-kan asked whether consideration would be given to requiring all patients planning to undergo operation to make advance directives to indicate the medical treatments he would or would not want in the event that he became terminally ill, or was in a persistent vegetative state or in an irreversible coma after the operation and was unable to make his wishes known.

12. USFH said that the Administration recognised that people in Hong Kong were not familiar with the concept of advance directives. In the light of this, the Administration would work with HA to consult and disseminate information about advance directives to the healthcare sector, legal profession, patient groups and non-governmental organisations (NGOs) providing healthcare-related services for patients, with a view to enhancing public's understanding of the concept and enabling an informed choice by those who wished to make advance

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directives. Notwithstanding, the Administration did not plan to actively advocate or encourage the use of advance directives as the making of such directives remained a voluntary choice by an individual.

13. Dr PAN Pey-chyou expressed support for the Administration's stance of not actively advocating or encouraging the public to make advance directives because there remained a number of questions which had yet to be resolved in countries that had introduced the concept.

14. Mr Albert CHAN said that the Chinese translation of the term "advance directive" should be drafted in plain language for easy comprehension by the general public. USFH responded that the Administration would be happy to consider any suggestion put forward by members.

Implementation of advance directives

15. Dr PAN asked -

(a) how would the advance directives be kept so as to facilitate access by healthcare professionals concerned as and when necessary; and

(b) whether it would be necessary for individuals making advance directives to obtain written proof from registered medical practitioners that they were of sound mind at the time they made the directive, and if so, the guidelines for such assessments.

16. USFH said that it was important to secure consensus among the relevant professionals and organisations as well as the public before the concept of advance directives could be taken forward. As a first step, the Administration intended to initiate a consultation exercise with relevant stakeholders in the first quarter of 2009. In providing information about advance directives to the public, the Administration would encourage individuals who wished to make advance directives to discuss the matter first with their family members, and would encourage family members to accompany the individuals when they made the advance directives. This would ensure that family members would be aware of the advance directives made and the wish of the individuals could be readily available to the healthcare professionals at the critical moment.

17. Responding to Dr PAN's second question, USFH said that LRC's proposed model form of advance directive required that it be witnessed by two persons, one of whom must be a registered medical practitioner. The witnessing doctor had to explain to the maker of the advance directive of the nature and implications of making the directive.

18. To ensure that the prior wishes of the maker of the advance directive were followed if they were at odds with the wishes of their family members, Mr Albert CHAN said that the Administration should legislate rather than promote advance directives through non-legislative means.

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19. Whilst supporting the concept of advance directives, Mr Albert HO also expressed the view that a non-legislative approach might not provide sufficient protection to the healthcare professionals in implementing a patient's advance directive, particularly when the directive was different from the wishes of the patient's family, or family members held different views as to whether the patient was in one of the three medical conditions for activating advance directive, i.e. terminally ill, in a persistent vegetative or irreversible comatose state. Ms Cyd HO concurred, and urged the Administration to take more proactive steps in taking forward the concept of advance directive through legislation for enactment at a later stage. This could facilitate public discussion on the one hand, and on the other conformed with the LRC's recommendation that the Administration should consider the appropriateness of legislation when the community became more widely familiar with the concept.

20. USFH responded as follows -

(a) the Administration agreed with the recommendation of LRC that it would be premature at this stage to attempt to formulate a statutory framework and to embark on any legislative process for advance directives, as the concept of advance directives was still little understood in Hong Kong;

(b) at present, the treatment of patients was ultimately subject to the clinical decisions made by the healthcare professionals with reference to the relevant professional codes of conduct. According to the Professional Code and Conduct for the Guidance of Registered Medical Practitioners (the Professional Code and Conduct) issued by the Medical Council of Hong Kong (MCHK) and, in the case of those working in the public sector, the Guidelines on Life-sustaining Treatment in the Terminally Ill (the Guidelines) issued by HA, a patient's right of self-determination should prevail over the wishes of his relatives in case of conflict and a doctor's decision should always be guided by the best interest of the patient; and

(c) to date, the Hong Kong courts had not made any judicial decisions in relation to advance directives. However, substantial case laws had been developed in other common law jurisdictions that a valid advance directive made by a patient prevailed over the wishes of his family members.

21. Mr CHAN Hak-kan asked whether the attending doctor would take the wishes of the patient's family into account if they objected to the withholding or withdrawing of life-sustaining treatment as instructed by the patient in his advance directive. Ms Audrey EU also queried whether there needed to have a third party other than the attending doctor to trigger the advance directive.

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22. USFH said that according to the existing Professional Code and Conduct and the Guidelines, the healthcare team had to maintain close communication with the family on the medical conditions of the patient and wherever possible, forge consensus with the family in the consideration of whether to withhold or withdraw life-sustaining treatment. If there was disagreement between the healthcare team and the patient's family which could not be resolved despite repeated communication, the advice of and facilitation by the clinical ethics committee of the hospital concerned should be sought. USFH further said that the Food and Health Bureau was consulting the Labour and Welfare Bureau on the other part of LRC's report regarding the proposal to change the definition of "mentally incapacitated persons" under the Mental Health Ordinance (Cap. 136).

23. Mr Albert HO queried whether the final decision on the withholding or withdrawing life-sustaining treatment of a maker of advance directive rested with the attending doctor and, in the case of disputes with the patient's family, the clinical ethics committee of the hospital concerned.

24. Director (Q&S), HA advised that the common practice in overseas countries was to save the patient's life in the first instance should the wishes of the family were at odds with the patient's prior wishes or instructions. Given that the concept of advance directives were little understood in Hong Kong, the Administration would first consult and solicit inputs of the relevant professions and organisations on the contents of information about advance directives to be provided to the public, and any necessary guidelines that might need to be provided to the relevant professionals in this regard.

25. The Chairman said that to his understanding, implementation of advance directive was to a certain extent, formalising the existing practice of the no active resuscitation (NAR) order. Dr PAN Pey-chyou remarked that an advance directive would remain valid unless being revoked by the maker. However, a fresh NAR order had to be made each time the patient was admitted to the hospital.

26. Mr Albert CHAN said that it was regrettable that the Administration's paper failed to shed any light on the mechanism to be put in place by the Administration to handle the problem when the patient's family objected to the instructions contained in the patient's advance directive. Mr Albert HO and Ms Audrey EU held the view that as the issue of advance directive was related to end-of-life medical decision making, the Administration should include in its consultation exercise the details of the procedures for implementing advance directives, so as to enhance the public's understanding of the concept.

Conclusion

27. In closing, the Chairman said that the Administration should take into account the concerns expressed by members when taking forward the concept of advance directives. To facilitate future discussion, the Chairman requested the Administration to provide after the meeting a table setting out the concept of advance directives and euthanasia, the proposed implementation details of

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advance directives and the Administration' stance on legislation.

(*Post-meeting note*: The Administration's response was issued to members vide LC Paper No. CB(2)941/08-09(01) on 23 February 2009.)

V. Enhancing quality patient care - beyond incident reporting and complaint management in Hospital Authority
(LC Paper Nos. CB(2)388/08-09(05) and (06) and CB(2)411/08-09(01) and (02))

28. USFH briefed members on the approaches and measures of HA to further enhance service quality and patient safety in public hospitals, details of which were set out in the Administration's paper (LC Paper Nos. CB(2)388/08-09(05) and (06)).

29. Mr Albert HO and Mr Andrew CHEUNG commended HA for its efforts in improving the complaint system and the handling of sentinel event. To enhance the independence and impartiality of HA's complaint management system, Mr Albert HO said that consideration could be made to enlisting greater participation of medical experts from private practice or overseas in the complaint system and reviewing the controversial complaint cases on a regular basis.

30. Director (Q&S), HA advised that at present, all complaints would be handled and responded to directly by the respective hospitals/clinics in the first instance, as complaints were generally most effectively handled at the point of service delivery. Complainants who wished to put forward further views or were not satisfied with the handling/outcome of his complaint could file an appeal with HA's Public Complaints Committee (PCC), which comprised medical experts and lay members from different sectors of the community including patient groups, for a review. It should be noted that there were also other well-established complaint redress avenues in Hong Kong, such as the Ombudsman, the Legislative Council and MCHK. Director (Q&S), HA added that to facilitate effective monitoring and further enhance service quality, HA would proactively gauge patient's views and experience on HA's services through the Patient Satisfaction Survey (PSS) to be launched in mid 2009.

31. Mr Albert HO was of the view that a medical misadventure fund should be set up to provide compensations to victims of medical blunders in order to avert the need for them to go through the very cumbersome legal proceedings, which had been a great pressure on both the medical blunders and HA staff. Ms Audrey EU also considered that a medical injuries compensation board, similar to the existing criminal injuries compensation board, should be set up to provide ex-gratia payments to victims suffering injuries as a result of medical incidents. USFH said that the Administration would take note of the suggestions.

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32. Mr Andrew CHEUNG cast doubt on the independence of PCC to handle complaints in a fair and impartial manner, as its members were all appointed by HA. To ensure that complaints targeting at health service would be properly handled, he urged the Administration to study the needs of setting up an independent statutory office of the health service ombudsman to receive complaints concerning medical incidents of HA hospitals/clinics and private health services delivery institutions, as was the case in many other countries. Without violating the principle of professional autonomy, this body should be vested with investigatory power and could commission medical experts from overseas to provide independent advice on complaints on a need basis.

33. USFH responded that to assure the independence and representativeness of PCC, only three out of the 23 members of PCC were members of the HA Board. The two-tier complaint system of HA and the other complaint redress avenues mentioned in paragraph 30 above had been effective in handling complaints on medical services over the years. There was no need to set up another statutory body to handle these complaints as this would lead to duplication of efforts and cause confusion to the public about the interface between the various avenues. USFH further pointed out that at present, members of the public who considered that a healthcare professional had breached the professional conduct could lodge complaints to MCHK or other relevant healthcare professional regulatory bodies. If a new complaint body was to be set up as proposed with the powers to investigate all types of medical complaints including that of a doctor's conduct, this might erode the autonomy of the healthcare profession. There was also no similar independent complaint body for other professions such as lawyers, accountants or architects, which had their respective self-regulated bodies.

34. Ms Cyd HO said that the creditability of the existing mechanism for handling complaints concerning medical incidents had been questioned by the public. She cited the investigation on the medical incident of a wrong breast biopsy specimen of a patient at North District Hospital in July this year to illustrate that medical professionals had been defending one another under the current mechanism. Ms HO asked whether the Administration had studied the reasons why the public had no confidence in the ability of the mechanisms to handle complaints and investigations on adverse medical incidents fairly and independently with a view to rebuilding public's confidence in this regard.

35. USFH responded that the investigation panel appointed to investigate the incident mentioned by Ms HO in paragraph 34 above had made a number of recommendations on prevention of similar incidents. The case had also been dealt with in accordance with the prevailing HA human resources policy and established disciplinary mechanism. USFH added that based on his past experience while being a frontline medical personnel in the public sector, he believed that the public at large had confidence in the public health care system and the mechanism for handling complaints and reporting incidents in HA. To enhance public understanding, HA would continue to release the annual report of PCC and the half-yearly report on sentinel events.

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36. Ms Audrey EU expressed concern about the small number of appeal cases found to be substantiated. For example, out of the 2 483 complaint cases received in 2007, the total number of cases taken to PCC was 258 cases, and only 8 out of the 218 cases concluded by PCC in 2007 were found to be substantiated. She asked whether the Administration had compared the above figures with those in countries having established an independent office of health service ombudsman.

37. Director (Q&S), HA advised that the subject of the complaints received was not only related to medical services, but also included other areas such as staff attitude, administrative procedures, environment, etc. The main reason why so few cases were considered substantiated by PCC was due to the fact that a great majority of complaint cases had been properly dealt with by the hospitals/clinics concerned without having to resort to PCC. Director (Q&S), HA further pointed out that it was difficult to compare the complaint statistics with those in other countries because of the differences in the mechanisms for handling medical complaints. He assured members that all complaint cases were considered on their own merits and that all complaint cases were dealt with independently, fairly and impartially.

38. Ms Audrey EU asked whether there was any performance pledge in respect of the handling of request for the provision of the patient's medical records upon the occurrence of adverse medical incident. USFH responded that requests for the provision of medical records under the patients' consent would be dealt with expeditiously as far as practicable. The performance target for processing such request was within 40 working days.

39. Dr PAN Pey-chyou declared that he was HA employee. He pointed out that the implementation of the first-tier complaint system had added to the already heavy workload of frontline healthcare staff, as they had to spend a lot of time and efforts to resolve the complaints. He urged HA to provide greater support to frontline staff in this regard. Dr PAN also expressed concern that frontline staff often bore the blame for medical errors under the Sentinel Event Policy. He said that some sentinel events, such as the death of a patient who committed suicide during home leave, could hardly be totally preventable. In some other cases, it was difficult to identify whether it was system factors, such as lack of human resources and training, rather than human factors, that caused the happening of the sentinel events.

40. USFH advised that apart from the total of 2 483 complaints, HA had at the same time received 26 332 appreciation in 2007, which affirmed the service quality of the staff of HA. USFH said that in line with the international trend of promoting higher transparency, the implementation of the Sentinel Event Policy was intended to encourage staff to report sentinel events so that lessons could be learnt from the events to prevent similar medical incidents from happening in the future. The emphasis was on the promotion of a learning culture rather than putting blame on staff. HA would on one hand render support to staff involved in medical incidents and on the other instigate disciplinary action where

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necessary under a "Just Culture". USFH continued to say that apart from maintaining the prevailing mechanism for handling individual complaints and reporting sentinel events, HA had planned to roll out two initiatives, viz a patient satisfaction survey and a pilot project of hospital accreditation, as the new initiatives for pursuing the change from reaction to pro-action to further improve service quality and patient safety.

41. Director (Q&S), HA supplemented that HA had consulted staff of all hospital clusters before implementing the Sentinel Event Policy in October 2007, and responses from staff were generally positive. It was noted that some frontline staff had different views on the need to report suicide case while the patient was on home leave. Notwithstanding, it was of value to identify the root causes of such cases to prevent the occurrence of similar incidents in the future through various system and process improvements.

42. Dr LEUNG Ka-lau asked whether information disclosed by the frontline staff to the investigation panel was subject to legal professional privilege under the Sentinel Event Policy. He said that it was important for HA to provide an undertaking to ensure that the communications between the frontline staff and the investigation panel would be privileged from disclosure unless the Court so directed, so as to ensure the provision of all necessary information by the staff involved in the incident, and protect the staff from being sued by the patient concerned.

43. Director (Q&S), HA responded that appropriate level of confidentiality would be applied to the root cause analysis report to protect the identity of patients and staff concerned. In line with the existing practice for the investigation of all adverse medical incidents, HA would first seek legal opinion before providing any confidential information so requested. He added that there was no cause for concern that frontline staff would refrain from providing complete and accurate information to the investigation panel, as a series of training on effective root cause analysis had been provided to frontline staff upon the implementation of the Sentinel Event Policy.

44. In closing, the Chairman urged the Administration to consider pursuing the suggestion of members that an independent body should be set up for the handling of medical complaints, and providing greater support to frontline staff in the implementation of the complaint management and incident reporting systems.

VI. Any other business

45. There being no other business, the meeting ended at 10:40 am.

Council Business Division 2
Legislative Council Secretariat
23 June 2009