For information

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES

Advance Directives in relation to Medical Treatment: Supplementary Information

Introduction

At the meeting on 8 December 2008, the Administration was requested to provide a table setting out the concepts of advance directives and euthanasia, the proposed implementation details of advance directives and the Administration's stance on legislating for advance directives.

Advance directives and euthanasia

2. As mentioned in LC Paper No. CB(2)388/08-09(03) prepared for the above meeting, advance directives are totally unrelated to euthanasia. They are two distinct concepts which cannot be compared with each other.

3. Advance directives concern the principle of a patient's autonomy which allows him to decide, when being conscious, the form of health care he would like to have in a future time when he is no longer mentally competent. An individual who makes an advance directive will usually make a written statement to specify that, when he is terminally ill[1], in a state of irreversible coma or in a persistent vegetative state, he does not agree to receive any life-sustaining treatment or any other treatment he has specified save for basic and palliative care, or to specify the withholding or withdrawal of futile treatment[2] which merely postpones his death.

4. Euthanasia involves a third party's unlawful acts of intentional killing, manslaughter, or aiding, abetting, counselling or procuring the suicide of another, or an attempt by another to commit suicide. According to the existing *Professional Code and Conduct for the Guidance of Registered Medical Practitioners* of the

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[1] In the medical field, "terminally ill" generally refers to patients who suffer from advanced, progressive, and irreversible disease, and who fail to respond to curative therapy, having a short life expectancy in terms of days, weeks or a few months.

[2] According to HA's *Guidelines on Life-sustaining Treatment in the Terminally Ill*, "futility" can be viewed in the strict sense of physiologic futility when clinical reasoning or experience suggests that a life-sustaining treatment is highly unlikely to achieve its purpose. The decision is normally made by the healthcare team. However, in most other clinical situations where futility is considered, the decision involves balancing the burdens and benefits of the treatment towards the patient, and asking the question of whether the treatment, though potentially life-sustaining, is really in best interests of the patient. To establish this broader sense of futility, the healthcare team, the patient and family will seek to build a consensus in making the decision.

Medical Council of Hong Kong, euthanasia is defined as "direct intentional killing of a person as part of the medical care being offered". Euthanasia is neither medically ethical nor legal in Hong Kong. Hence, no one in Hong Kong can indicate a wish to perform euthanasia in his advance directive. Even if a person expressly requests for such an illegal behaviour to be conducted, healthcare professionals should in no way act as instructed. Any person who is involved in euthanasia will be suspected to have committed the above offences.

5. To illustrate the concept of advance directives, a table comparing the differences between having and not having made an advance directive when a patient is in any of the three conditions described in paragraph 3 above is at **Annex**.

Proposed implementation details of advance directives

6. At the meeting, we informed Members of our plan to consult hospitals, healthcare sector, legal profession, patient groups and non-government organisations providing healthcare-related services to patients on preparing relevant information on advance directives, the forms and methods of making and withdrawing them, the guidelines for healthcare practitioners and other professionals, as well as other relevant matters in the first quarter of this year. We will decide on how to formulate and provide implementation details on advance directives after thorough consultation with various sectors. The Law Reform Committee (LRC) has also made recommendations on the approaches to implement advance directives in its report entitled *Substitute Decision-making and Advanced Directives in Relation to Medical Treatment* (available for download at http://www.hkreform.gov.hk/en/publications/rdecision.htm). Members may wish to make reference to the report.

Legislation on advance directives

7. As explained in the paper submitted to the Panel, as Hong Kong people are not yet familiar with the concept of advance directives, we share LRC's view that it is not the appropriate time to implement advance directives through any form of legislation. In fact, for the same reason, when the LegCo Panel on Health Services discussed LRC's consultation document on 19 July 2004, Members also shared LRC's view that legislation should not be made on advance directives at this stage.

Food and Health Bureau
February 2009

Annex

**Comparison between
having and not having made an advance directive
when a patient is no longer mentally competent to make a decision**

	Having made an advance directive	**Not having made an advance directive**
When a patient is still mentally competent to make a decision	● The patient has chosen to make an advance directive to indicate the form of healthcare he would like to receive in the future when he is no longer mentally competent.	● The patient has not indicated the form of healthcare he would like to receive in the future when he is no longer mentally competent.
When a patient is not mentally competent to make a decision (i.e. he is terminally ill, in a state of irreversible coma or in a persistent vegetative state)	● The doctor will make clinical decisions with reference to the relevant professional codes of conduct and provide the patient with medical treatment in the best interest of the patient. ● If the doctor maintains that any medical treatment will be futile, he may, with reference to the advance directives, withhold or withdraw any life-sustaining treatment or any other treatment the patient has specified save for basic and palliative care. The doctor will also explain to the patient's family the advance directive made by the patient and the doctor's decision thus made.	● The doctor will make clinical decisions with reference to the relevant professional codes of conduct and provide the patient with medical treatment in the best interest of the patient. ● If it is impossible to ascertain the wish of the patient, and the doctor considers that withholding or withdrawing life-sustaining treatment is in the best interest of the patient, the doctor will usually consult the patient's family, explain to them his suggestions and seek the family's understanding of his clinical decision.
In case of conflict between the patient's family and	● A patient's right of self-determination should prevail over the wishes of	● Although a doctor's decision should always be guided by the best interest

	Having made an advance directive	**Not having made an advance directive**
the doctor	his family. ● Avoid disputes between the doctor and the patient's family over the form of healthcare to the patient. ● Help alleviate the plight of the family in face of the death of the patient.	of the patient, disputes often arise between the doctor and the patient's family over the form of healthcare to the patient when the wish of the patient cannot be ascertained.
Results	● Minimising distress and indignity that the patient may suffer; sparing the healthcare professionals or family or both from the burden of making difficult decisions on behalf of the patient; and avoiding disputes between the healthcare professionals and the relatives.	● The wish of the patient may not be honoured. ● If the disparity of views between the doctor and the patient's family remains unresolved for a long time, the distress that the patient suffers may be prolonged, and disputes or litigation may arise.