For discussion
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LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES
End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place

PURPOSE

This paper briefs Members on the public consultation launched on 6 September 2019 by the Food and Health Bureau (FHB) on end-of-life care legislative proposals regarding advance directives (ADs) and dying in place.

BACKGROUND

2. ADs and dying in place are important arrangements for respecting the choice of a person who is approaching end-of-life. An AD may be described as "a statement, usually in writing, in which a person indicates when mentally competent what medical treatment he/she would refuse at a future time when he/she is no longer mentally competent", whereas dying in place usually means spending the final days at the place of choice of a patient, be it at home, in residential care homes for the elderly (RCHEs) or nursing homes, and not necessarily a hospital.

3. AD was first introduced for public discussion through the 2004 public consultation paper and 2006 report "Substitute decision-making and advance directives in relation to medical treatment" by the Law Reform Commission of Hong Kong (LRC). In response to LRC's report, FHB issued a consultation paper in 2009 titled "Introduction of the Concept of Advance Directives in Hong Kong" to consult stakeholders on the relevant issues. The majority of views received at the time were in support of the adoption of a non-legislative approach to promote ADs in Hong Kong first, and then consideration of whether legislation is appropriate when there is greater awareness in society. The Government recommended at the time that guidance should be developed for the medical and other relevant professions on the making and handling of ADs.

4. In 2010, the Hospital Authority (HA) issued the "Guidance for HA Clinicians on Advance Directives in Adults". Upon revision in 2014, a

new category "other end-stage irreversible life-limiting condition" was added to the scope set out by LRC. Also in 2014, HA extended the Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) to seriously ill non-hospitalised patients. Under the latest Guidelines, a specific DNACPR form for non-hospitalised patients can be signed by doctors in charge of a patient when there is a valid and applicable AD refusing cardiopulmonary resuscitation (CPR), or when a DNACPR decision is made through an explicit advance care planning process for minors or incompetent adults without an AD in defined categories of seriously ill patients with end-stage irreversible diseases. Since 2012, an increasing trend in the number of ADs (with a refusal to CPR) signed by HA patients each year has been observed, increasing from 325 in 2013 to 1 557 in 2018.

5. Currently, Hong Kong has neither statute nor direct case law on the legal status of ADs. We are relying on the general requirement for the patient's consent to receiving medical treatment under the common law to make validly-made ADs refusing life-sustaining treatment legally binding.

6. On the other hand, while dying at home or in RCHEs has both been identified as options for dying in place in different surveys of elderly people, the death reporting requirements are significantly different between the two. Under the Coroners Ordinance, when a person dies **at home** due to natural cause, there is no requirement to report to the Coroner, if he/she was diagnosed as having terminal illness before his/her death or if he/she was attended to by a registered medical practitioner during his/her last illness within 14 days prior to his/her death. However, all cases of deaths due to natural causes **in RCHEs** must be reported to the Coroner via the Police, irrespective of whether the person had been diagnosed with terminal illness or whether the person had been attended to by a registered medical practitioner during his/her last illness within 14 days prior to his/her death. If necessary, an investigation by the Police and forensic pathologist and a post-mortem examination will follow. While the requirement under the Coroners Ordinance provides important safeguards for RCHE residents, it also poses a serious disincentive for RCHEs to allow elderly residents to die on their premises.

PUBLIC CONSULTATION

7. The public consultation on end-of-life care legislative proposals regarding AD and dying in place was launched on 6 September 2019. 30 consultation questions have been set out to gauge public views on the

Government's proposal to –

(a) codify the current common law position in respect of an AD and to increase safeguards attached to it;

(b) remove legislative impediments to implementation of ADs by emergency rescue personnel; and

(c) amend the relevant provisions of the Coroners Ordinance (Cap. 504) to facilitate dying in place in RCHEs.

8. Specifically, the Government proposes that any mentally competent person who is aged 18 or above could make an AD on a model form, refusing life-sustaining treatment under pre-specified conditions. No restriction is imposed on when a person could modify or revoke an AD, as long as he/she is mentally capable and not under undue influence. We propose that making and modifying an AD must be in writing, while revocation could be done verbally or in written form. To ensure the validity of an AD, two witnesses with no interest in the estate of the person making the AD are required, one of whom must be a medical practitioner. No witness is suggested for revocation.

9. Furthermore, a person with an AD would have the primary responsibility of keeping the AD and of ensuring that the original copy shall be presented to treatment providers as proof of a valid AD. To facilitate an AD being followed outside the hospital setting, the use of a model DNACPR form is suggested. The existing Electronic Health Record Sharing System (eHRSS) should be considered for storing records of ADs and DNACPRs on a voluntary basis. Proper safeguards will be afforded to treatment providers in that a treatment provider will not incur any civil or criminal liability for carrying out or continuing a treatment if, at the time, he/she reasonably believes that a valid and applicable AD does not exist. Similarly, a treatment provider does not incur any civil or criminal liability for the consequences of withholding or withdrawing life-sustaining treatment from individuals if, at the time, he/she reasonably believes that a valid and applicable AD exists. The same safeguard is applicable to DNACPR forms.

10. Currently, ambulance personnel of the Fire Services Department are bound by the Fire Services Ordinance (Cap. 95) to assist any person who appears to need prompt or immediate medical attention by resuscitating or sustaining his life, while under the Mental Health Ordinance (Cap. 136), a doctor or a dentist may provide life-sustaining

treatment to a mentally incompetent person without consent in urgent or non-urgent situation if the doctor or dentist considers that the treatment is necessary and in the best interests of the person, notwithstanding whether there exists a valid and applicable AD. To avoid these legislation impeding the implementation of ADs, we propose to also amend the relevant empowering ordinances to state that a valid and applicable AD shall prevail.

11. To facilitate dying in place, we are to consider amending the Coroners Ordinance to provide that if an RCHE resident (regardless of whether he/she was diagnosed as having a terminal illness) who has been attended to be a registered medical practitioner within 14 days prior to death and a medical practitioner makes a final diagnosis and determines the cause of death, the reporting requirements to the Coroner should be exempted.

12. The full consultation document is available at https://www.fhb.gov.hk/en/press_and_publications/consultation/190900_eolcare/index.html. The deadline for submission of views is 16 December 2019. We will decide on the way forward after consolidating and analysing the views received from the public consultation.

ADVICE SOUGHT

13. Members are invited to note the content of the consultation document and express views on the legislative proposals in respect of ADs and dying in place.

Food and Health Bureau
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