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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 8 November 2019

Advance directives in relation to medical treatment and the provision of palliative care services

Purpose

This paper provides background information and summarizes the concerns of members of the Panel on Health Services ("the Panel") and the Joint Subcommittee on Long-term Care Policy ("the Joint Subcommittee") formed under the Panel and the Panel on Welfare Services in the Sixth Legislative Council ("LegCo") on advance directives in relation to medical treatment and the provision of palliative care services.

Background

2. In 2002, the Secretary for Justice and the Chief Justice directed the Law Reform Commission ("LRC") to review the law relating to (a) decision-making for persons who are comatose or in a vegetative state, with particular reference to the management of their property and their affairs and the giving or refusing of consent to medical treatment; and (b) the giving of advance directives by persons when mentally competent as to the management of their affairs or the form of health care or medical treatment which they would like to receive at a future time when they are no longer competent, and to consider and make recommendations for such reform as may be necessary.

3. The Sub-committee on Decision-making and Advance Directives was appointed under LRC in May 2002 to examine and to advise on the present state of the law and to make proposals for reform. In July 2004, LRC issued a Consultation Paper on Substitute Decision-making and Advance Directives in

relation to Medical Treatment,[1] which set out proposals to reform the law relating to the above two aspects of decision-making in relation to medical treatment for persons who were unable to make those decisions at the time of execution of the associated action, for public consultation until end of September 2004. LRC released its Report on Substitute Decision-making and Advance Directives in relation to Medical Treatment in August 2006.[2] It recommended, among others, that the concept of advance directives should be promoted initially by non-legislative means until the community had become more widely familiar with the concept and the use of its proposed model form of advance directive should be encouraged.

4. Having considered LRC's recommendations and recognizing the need to enhance the public's understanding of advance directives; to provide information for those who wished to make such directives; and to strengthen the doctor-patient relationship in the handling of such directives through close communication, the Administration consulted the parties concerned[3] between December 2009 and March 2010 on the introduction of the concept of advance directives as a personal decision.[4] Having regard to the outcome of the consultation, the Administration advised in 2010 that it was more advisable to implement advance directives by way of legislation when there was a greater degree of awareness and consensus over the use of advance directives and that the community was ready for it. Separately, the Hospital Authority ("HA") has put in place since 2010 and 2014 respectively a Guidance for HA Clinicians on Advance Directives in Adults[5] and a set of Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation[6], and updated in 2015 its Guidelines on Life-Sustaining Treatment in the Terminally Ill[7] for reference by clinicians in public hospital setting.

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1 The Consultation Paper can be assessed at LRC's website at https://www.hkreform.gov.hk/en/publications/decision.htm.

2 The Report can be assessed at LRC's website at https://www.hkreform.gov.hk/en/publications/decision.htm.

3 According to the Administration, these parties included public and private hospitals, the medical profession (including the Medical Council of Hong Kong), the legal profession, the healthcare sector, patient groups and non-governmental organizations providing healthcare-related services to patients.

4 The consultation paper can be assessed at https://www.gov.hk/en/residents/government/publication/consultation/docs/2010/AdvanceDirectives.pdf.

5 The Guidance can be assessed at HA's website at http://www.ha.org.hk/haho/ho/psrm/EngcopyAD.pdf. Under the Guidance, an advance directive covers the clinical conditions of being (a) terminally ill; (b) in a persistent vegetative state or a state of irreversible coma; and (c) in other specified end-stage irreversible life limiting condition.

6 The Guidelines (in English version only) can be assessed at HA's website at http://www.ha.org.hk/haho/ho/psrm/CEC-GE-6_en.pdf.

7 The Guidelines can be assessed at HA's website at http://www.ha.org.hk/haho/ho/psrm/HA_Guidelines_on_Life_sustaining_treatement_en_2015.pdf.

5. As stated in its Report on Substitute Decision-making and Advance Directives in relation to Medical Treatment, LRC takes the view that palliative and basic care which is necessary to maintain patient's comfort, dignity, or for the relief of pain should always be provided after the effect of advance directives to not to receive life-sustaining treatment. In 2015, the Food and Health Bureau commissioned The Chinese University of Hong Kong to conduct a three-year research study on the quality of healthcare for the ageing ("the Study") so as to identify barriers and recommend service models for end-of-life care, and to recommend changes (including legislation) if required. At present, palliative care is mainly provided by HA to patients facing terminal illness to improve the quality of care and facilitate a more peaceful dying process. A Strategic Service Framework for Palliative Care[8] was formulated by HA in 2017 to guide the development of its palliative care service in the next five to 10 years. As regards contract homes providing subsidized residential care services for the elderly, they are required by the Social Welfare Department ("SWD") to provide end-of-life care services to render holistic care to elderly residents suffering from life threatening illness and approaching the end of life, and provide support for their carers.

Deliberations of the Panel and the Joint Subcommittee

6. The Panel and the Joint Subcommittee discussed issues relating to advance directives in relation to medical treatment and the provision of palliative care services at three meetings in 2004 and 2008, and in 2017 respectively. Views from deputations were received at the meeting of the Joint Subcommittee. The deliberations and concerns of members are summarized in the following paragraphs.

Difference between advance directives and euthanasia

7. Members sought clarification from the Administration about the difference between advance directives in relation to medical treatment and euthanasia, given that a prior instruction to not to receive life-sustaining treatment would have the effect of shortening the life of the maker of advance directive. The Administration explained that advance directives were completely unrelated to euthanasia which was an illegal act of direct intentional killing of a person as part of the medical care. No one in Hong Kong could indicate a wish for receiving euthanasia in the advance directive. Healthcare professionals should not act as instructed even if such a wish was expressly requested. Members agreed with the LRC's view of not legislating advance

[8] The Strategic Service Framework can be assessed at HA's website at https://www.ha.org.hk/haho/ho/ap/PCSSF_1.pdf.

directives in relation to medical treatment at this stage, as the concept of advance directives was still little understood in Hong Kong.

Promotion of advance directives

8. Members shared the LRC's view that the Government should play a role in promoting public awareness and understanding of the concept of advance directives in relation to medical treatment, and should endeavour to enlist the support of relevant bodies, such as the Medical Council of Hong Kong and HA, in the campaign. They queried why the Administration did not intend to actively advocate or encourage the public to make advance directives. Some members went further to ask if the Administration would consider requiring all patients planning to undergo operation to make advance directives.

9. The Administration advised that Hong Kong society was not familiar with the concept of advance directives. It would work with HA to consult and disseminate information about advance directives to the healthcare sector, legal profession, patient groups and non-governmental organizations providing healthcare-related services for patients, with a view to enhancing public understanding of the concept and enabling an informed choice by those who wished to make advance directives. The Administration however had no plan to actively advocate or encourage the making of advance directives as it remained voluntary.

Implementation of advance directives

10. Whilst supporting the use of a non-statutory model form of advance directives at this stage, some members pointed out that without the backing of legislation, it was inevitable that disputes might arise between the healthcare professionals and a patient's family members as to the patient's wishes. LRC advised that in such cases, recourse might have to be made to the court. It however believed that the use of a model form which, if completed fully, would offer a clear and unambiguous statement of the patient's wishes and could reduce disputes to a minimum. LRC recommended that the Government should encourage those who wished to make an advance directive to seek legal advice and to discuss the matter first with their family members. Family members should also be encouraged to accompany the individual when he made the advance directive. Some members called on the Administration to take more proactive steps in taking forward the concept of advance directives through legislation at a later stage to ensure that the prior wishes of the makers of advance directive were followed if they were at odds with the wishes of their family members.

11. Concern was raised over the role of doctors in implementing a patient's advance directives. The Administration advised that a doctor's decision should

always be guided by the best interest of the patient. According to relevant professional codes of conduct, 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 execution of the advance directives. In case of insoluble disagreement, the advice of and facilitation by the clinical ethics committee of the hospital concerned should be sought.

12. Members shared the concern of some deputations about the reluctance of public hospital doctors in certifying patients' advance directives or accepting advance directives validly made outside HA. The Administration advised that guidelines were in place to guide HA's clinical teams to handle issues relating to advance directives. Under HA's practice, patients who had their advance directives made outside HA would be invited to also make the advance directive using HA's form in order to reduce the scope of uncertainty and dispute.

13. Members were concerned that emergency rescue personnel, such as ambulance personnel of the Fire Services Department, were currently bound by their empowering ordinances to resuscitate life. Conflict might arise given the absence of clear legislative provisions on the relationship between duties of these personnel and an advance directive in relation to medical treatment. The Administration advised that the Study would, among others, put forth recommendations on how to address the legislative issues on the implementation of advance directives.

Palliative care services

14. Members were concerned about the inadequate provision of palliative care beds in public hospitals. They noted with concern that according to a 2015 Quality of Death Index which evaluated the quality and availability of palliative care to adults of 80 countries across the categories of palliative and healthcare environment; human resources; affordability of care; quality of care; and level of community engagement, Hong Kong, which was at position 22, was ranked lower than Taiwan, Singapore, Japan and South Korea which were at positions six, 12, 14 and 18 respectively.

15. According to the Administration, HA had over 350 palliative care beds as at end of December 2017. The overall inpatient bed occupancy rate of the palliative care in HA was around 90% in 2017-2018. HA would further enhance its palliative care services in 2018-2019 by strengthening palliative care consultative service in hospitals; enhancing palliative care home care service through nurse visits; strengthening the competency of nursing staff supporting terminally ill patients beyond palliative care setting through training; strengthening end-of-life care for elderly patients in residential care homes for the elderly; and establishing a centralized multi-disciplinary team at the Hong

Kong Children's Hospital. It should also be noted that as announced in the Chief Executive's 2017 Policy Address, the Administration would consider amending the relevant legislation to give patients the choice of dying in place.

16. On the timetable for the introduction of end-of-life care services by subvented and private residential care homes for the elderly, the Administration advised that SWD would discuss with the operators to enhance training for the staff in this regard.

Recent developments

17. Two written questions concerning advance directives in relation to medical treatment were raised at the Council meetings on 22 and 29 May 2019 respectively. The questions and the Administration's replies are in **Appendices I and II** respectively.

18. A public consultation exercise was launched by the Administration on 6 September 2019 to solicit public views on end-of-life care legislative proposals regarding advance directives and dying in place until 16 December 2019. The Administration will brief the Panel on 8 November 2019 on the public consultation on these proposals.

Relevant papers

19. A list of the relevant papers on the Legislative Council website is in **Appendix III**.

Council Business Division 2
Legislative Council Secretariat
6 November 2019

Appendix I

Press Releases *22 May 2019*

LCQ15: Advance directives in relation to medical treatment
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Following is a question by Dr the Hon Chiang Lai-wan and a written reply by the Acting Secretary for Food and Health, Dr Chui Tak-yi, in the Legislative Council today (May 22):

Question:

An advance directive in relation to medical treatment (advance directive) is a statement (usually in writing) in which a person indicates, when he is mentally competent to make decisions, the form of health care he would like to receive in case he is no longer competent to make decisions. The Law Reform Commission of Hong Kong (LRC) published a report in 2006 putting forward a number of recommendations regarding advance directives, including the one that the person making an advance directive may specify that he does not agree to receive any life-sustaining treatment if he is in any of the following three conditions: being (i) terminally ill, or (ii) in a state of irreversible coma, or (iii) in a persistent vegetative state. The Hospital Authority (HA) formulated a guidance note and prepared a model form on advance directives in July 2010 for patients' reference. Besides, it was mentioned in the 2018 Policy Address that the Government would consult the public in 2019 on arrangements of advance directives and the relevant end-of-life care. In this connection, will the Government inform this Council:

(1) whether it knows (i) the number of valid forms on advance directives received, and the number of cases in which the advance directives as set out in the forms were executed, by healthcare workers in public hospitals, and (ii) the number of patients in public hospitals who produced to healthcare workers advance directives that were not made in accordance with the model form (e.g. advance directives signed under the witness of private doctors), in each year since July 2010;

(2) whether it knows if HA has established a registration system for advance directives; if HA has not, of the reasons for that;

(3) when the Government will launch the public consultation on advance directives and the relevant end-of-life care, and the timetable for the consultation exercise;

(4) whether the Government will make reference to the Patient Right to Autonomy Act in Taiwan and stipulate the following two kinds of conditions of patients as the conditions under which advance directives will become operative: (i) suffering from severe dementia, and (ii) other announced disease conditions of patients or sufferings being unbearable, the disease being incurable and there being no other appropriate treatment options available given the medical standards at the time of the disease's occurrence; and

(5) of the resources allocated in each of the past 10 years by the Government to the research and promotion of advance directives as well as life and death education, and the details thereof?

Reply:

President,

Under the common law, a patient may, while mentally competent to make decisions, give advance directives (ADs) to specify that apart from receiving basic and palliative care, he/she chooses not to receive any life-sustaining treatment or any other treatment he/she has specified when he/she is in a serious irreversible situation, such as terminally ill, in a state of irreversible coma or in a persistent vegetative state, allowing healthcare professionals to withhold or withdraw futile treatment under specific conditions, which merely postpones his/her death.

The concept of ADs is based on the principle of self-determination by patients, sparing healthcare professionals, the patients' relatives, or both, making difficult healthcare decisions on the patients' behalf, in particular decisions of withholding or withdrawing life-sustaining treatment. In this regard, the Code of Professional Conduct for the Guidance of Registered Medical Practitioners formulated by the Medical Council of Hong Kong has provided guidelines on care for the terminally ill. Where death is imminent, it is the doctor's responsibility to take care that a patient dies with dignity and with as little suffering as possible. When a doctor determines that the treatment for a terminally ill patient is futile, it is legally acceptable or appropriate to withhold or withdraw life-sustaining procedures taking into account the best interest of the patient and the preferences of the patient and his/her family.

My reply to the various parts of the question raised by Dr the Hon Chiang Lai-wan is as follows:

(1) and (2) The Hospital Authority (HA) formulated a guideline together with standardised form on ADs in July 2010. Since August 2012, the Clinical Management System (CMS) has marked the ADs witnessed by HA's doctors as a reminder to assist clinical communication. Currently, doctors can set a reminder on CMS when a patient signs an AD including "Do Not Attempt Cardiopulmonary Resuscitation" in HA, to inform other healthcare professionals that the patient has signed an AD. The number of ADs signed by HA's patients each year since August 2012 is as follows:

Year	Month	Number of ADs signed
2012	From August 21 to December 31	150
2013	From January 1 to December 31	325
2014	From January 1 to December 31	491
2015	From January 1 to December 31	706
2016	From January 1 to December 31	937
2017	From January 1 to December 31	1 395
2018	From January 1 to December 31	1 557
Total number of ADs signed		5 561

HA does not maintain the number of valid AD forms received and the number of cases in which the ADs as set out in the forms were executed. In addition, HA also does not maintain the number of patients in public hospitals who produced to healthcare professionals ADs that were not made in accordance with HA's model form (e.g. ADs signed as witnessed by private doctors).

(3) To allow terminally ill patients more options of their own treatment and care arrangements, the Government will consult the public in the second half of 2019 on arrangements of ADs and relevant end-of-life care.

(4) The ADs of HA currently cover (a) terminally ill; (b) in a persistent vegetative state or a state of irreversible coma; or (c) in other specified end-stage irreversible life limiting condition, which includes patients with irreversible loss of major cerebral function and extremely poor functional status, end-stage renal failure, end-stage motor neuron disease, end-stage chronic obstructive pulmonary disease, etc. Therefore, patients suffering from severe dementia are covered in (c).

Regarding "other announced disease conditions of patients or sufferings being unbearable, the disease being incurable and there being no other appropriate treatment options available given the medical standards at the time of the disease's occurrence", if the concerned situation is an "end-stage irreversible life limiting condition", then it is also covered in (c) above.

The Government and HA will continue to monitor international trend, take into account the needs of patients and engage stakeholders, to review the application of ADs with an open mind. The public consultation on arrangements of ADs and relevant end-of-life care in the second half of this year will cover the related issues.

(5) The Education Bureau (EDB) attaches great importance to life and death education by enhancing students' comprehension of different stages of life and experiences as well as promoting the positive values of cherishing and respecting life. EDB provides continuous curriculum support to schools, including choosing appropriate "life events" themes to produce teaching plans and worksheets, such as "Filial piety shown in grave sweeping in Ching Ming Festival" and "I know how to reflect on the meaning of life", to encourage discussion and sharing among teachers and students, and enhance students' understanding of related topics. EDB also conducts teacher professional development programmes and establishes learning communities to advance teachers' relevant knowledge and skills. Since the expenditure and manpower on developing curriculum, learning and teaching resources along with conducting professional development programmes are subsumed under the recurrent expenditure of EDB, a breakdown of expenditure is not available.

The Elderly Health Service (EHS) of the Department of Health also conducts health talks for elderly persons and their carers on ageing, life and death education and bereavement at residential care homes for the elderly, elderly centres, and the Elderly Health Centres through its multi-disciplinary team of nurses and allied health professionals. From 2009-2018, a total of 1 680 health talks related to these topics were conducted. The expenditure for these activities are covered by the overall provision of the EHS, a breakdown of expenditure is not available.

As mentioned above, HA formulated a guideline together with standardised form on ADs in July 2010. Such information has been made available on the Internet for access by the public. However, HA does not keep count of resources allocated to the research and promotion of ADs.

Ends/Wednesday, May 22, 2019
Issued at HKT 12:30

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~~**DR PRISCILLA LEUNG** (in Cantonese): *Will the Government provide support*~~ *in terms of resources? This is a practical issue as NGOs currently rely on themselves …*

PRESIDENT (in Cantonese): Dr LEUNG, you have already stated the part of your supplementary question that has not been answered.

DR PRISCILLA LEUNG (in Cantonese): *… can the Secretary tell me whether support will be provided in terms of resources instead of merely giving encouragement?*

PRESIDENT (in Cantonese): Secretary, do you have anything to add?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): I think we will continuously discuss with various organizations because it was often the case that during our discussions with them, we found that actually they might not be entirely in need of resources and it was most important that dentists could be recruited to provide assistance. Having said that, we will review the situation in this regard.

PRESIDENT (in Cantonese): Last oral question.

Terminally-ill patients

6. **DR FERNANDO CHEUNG** (in Cantonese): *Regarding the provision of palliative care to terminally-ill patients, as well as their giving advance directives and seeking euthanasia, will the Government inform this Council if it knows:*

(1) the details of the palliative care provided by public hospitals in each of the past five years, including the number of hospital beds, the attendance of the service, the manpower of healthcare workers and social workers involved, as well as the support received by the patients and their family members; whether the Hospital Authority conducted last year any study on improving this type of service;

(2) the number of public hospital patients making enquiries about advance directives in each of the past five years; whether the Government has drawn up a legislative timetable in respect of advance directives; and

(3) the number of public hospital patients seeking euthanasia in each of the past five years, with a breakdown by the disease suffered by the patients and the age group to which they belonged; whether the Government will study enacting legislation to permit the administration of euthanasia?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, Hong Kong is facing an ageing population and rising prevalence of chronic and complicated diseases. A holistic approach in the provision of health care services, therefore, should become more and more important. Such an approach gives terminally-ill patients a greater degree of autonomy to manage their own health as well as the full respect they deserve. In this context, the Government recognizes the need to promote the development of services for the elderly, particularly to strengthen palliative care services for persons facing terminal illness.

Currently, palliative care services in Hong Kong are mainly provided by the Hospital Authority ("HA") led by palliative care specialists, under the specialties of Medicine and Oncology. In the past, palliative care services of HA focused mainly on the care of advanced cancer patients. In the last decade, palliative care services have been gradually extended to cover patients with other diseases, such as patients suffering from end-stage organ failure.

To allow terminally-ill patients more options of their own treatment and care arrangements, the Government will consult the public in the second half of 2019 (i.e. this year) on arrangements of advance directives ("ADs") and relevant end-of-life care.

My reply to the various parts of the question raised by Dr Fernando CHEUNG is as follows:

(1) With the aim to provide holistic care for patients, HA has been providing appropriate palliative care services with a comprehensive service model for terminally-ill patients and their families through a

multi-disciplinary team of professionals, including doctors, nurses, medical social workers, clinical psychologists, physiotherapists and occupational therapists, etc. Palliative care services provided by HA include inpatient, outpatient, day care and home care services and bereavement services, etc.

Currently, palliative care services are provided by HA in all seven clusters to support terminally-ill patients and their families. At present, more than 40 doctors, 300 nurses and 60 allied health professionals (calculated on a full-time equivalent basis) provide the relevant services.

Palliative care inpatient services are mainly for terminally-ill patients with severe or complex symptoms and needs. As at 31 December 2018, HA has over 360 palliative care beds. Besides, if necessary, some terminally-ill patients admitted to other specialties who are in need of palliative care services can also receive treatment from the palliative care teams.

Statistics on utilization of palliative care services in the past five years are at Annex.

To plan and further improve the quality and sustainability of HA's palliative care services as well as to cope with increasing demand, HA has developed the "Strategic Service Framework for Palliative Care" in 2017 to guide the development of palliative care services in the coming five to 10 years and formulate strategic directions for improving adult and paediatric palliative care.

In fact, since 2018-2019, HA has further enhanced palliative care services provided by the multi-disciplinary team, including strengthening palliative care consultative service in hospitals, enhancing palliative care home care service and strengthening end-of-life care for elderly patients in residential care homes for the elderly ("RCHEs") as well as strengthening the competency of health care staff supporting terminally-ill patients beyond palliative care setting through training. HA will regularly review the demand for various medical services (including palliative care services) and plan

for the development of its services according to factors such as population growth and changes, advancement of medical technology and health care manpower, and collaborate with community partners to better meet the needs of patients.

(2) The Government consulted the public on matters relating to the introduction of the concept of ADs in Hong Kong in 2009. Most of the submissions showed no objection to introducing the concept of ADs by non-legislative means in Hong Kong. HA formulated a guideline together with standardized form on ADs in July 2010. Since August 2012, the Clinical Management System has marked ADs witnessed by HA's doctors as a reminder to assist clinical communication. A total of 5 561 ADs have been signed by HA's patients since August 2012. However, HA does not maintain statistics regarding patients making enquiries on ADs in public hospital.

As mentioned above, the Government will consult the public in the second half of 2019 on arrangements of ADs and relevant end-of-life care. We will study the way forward for ADs in accordance with the results of the consultation.

(3) ADs and euthanasia are not the same. The purpose of ADs is to state explicitly the specific situation where patients can refuse life-sustaining treatment when they are no longer capable to make decision during end-of-life, whereas under the Code of Professional Conduct of the Medical Council of Hong Kong, euthanasia is defined as "direct intentional killing of a person as part of the medical care being offered".

Euthanasia involves a third party's acts of intentional killing, manslaughter, or aiding, abetting, counselling or procuring the suicide of another, or an attempt by another to commit suicide, which are unlawful acts according to the laws of Hong Kong, possibly liable to criminal offence(s) under Offences against the Person Ordinance (Cap. 212).

Euthanasia is a highly complex and controversial issue involving implications on various dimensions, such as medical, social, moral, ethical and legal aspects. Any subject matters concerning life must be treated with care and caution. The Code has made it clear that euthanasia is "illegal and unethical". The Government currently has no plans to carry out any studies or consultations on the issue of legalizing euthanasia. HA also does not maintain statistics regarding patients in public hospital wishing for euthanasia.

Annex

Statistics on Utilization of HA's Palliative Care Services in the Past Five Years

	2014-2015	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019 [Provisional Figures]*
Number of palliative care inpatient and day inpatient discharges and deaths[(1)]	8 254	7 970	7 968	8 176	8 487
Number of palliative care specialist outpatient (clinical) attendances[(1)(2)]	9 449	12 499	13 364	13 372	12 644
Number of palliative care home visits by staff[(3)]	33 199	34 311	40 121	37 925	44 082
Number of palliative care day attendances	12 275	12 231	12 519	12 631	12 181

	2014-2015	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019 [Provisional Figures]*
Number of palliative care bereavement interviews by staff	3 034	3 436	4 192	3 918	3 610

Notes:

(1) The above figures only include palliative care inpatient and outpatient services that are captured by the designated coding in the computer system.

(2) Since 2015-2016, specialist outpatient (clinical) attendances also include attendances from nurse clinics in specialist outpatient setting.

(3) Data definition has been refined since April 2016 to better reflect the workload. Therefore, the statistics before and after April 2016 are not directly comparable.

DR FERNANDO CHEUNG (in Cantonese): *President, every one of us hopes that we can "die pleasantly" with dignity in accordance with our wishes. However, according to some international data such as the Death Quality Index, Hong Kong ranks far behind Taiwan and Singapore.*

The Secretary pointed out in the main reply that there are only 360 palliative care beds at present, whilst more than 40 000 persons passed away in HA hospitals every year. In fact, we are now seriously in lack of palliative care services. Moreover, as not everyone wants to die in a hospital, care and hospice support for terminally-ill patients in the community are hence very important as well. Yet, we learn from the Secretary's main reply that the authorities will only consult the public in the second half of this year on arrangements of ADs, and this is only a very minor part of end-of-life hospice care.

May I ask the Secretary when she will work with other Policy Bureaux to discuss the policy and planning in respect of end-of-life hospice care in a comprehensive manner? As this goes far beyond the portfolio of the Food and Health Bureau, if these services are not linked with welfare or other support systems, we will not be able to make our own choices and die with dignity.

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, I thank Dr Fernando CHEUNG for his supplementary question. In fact, it has been our long-standing goal to give terminally-ill patients a greater degree of autonomy to manage their own health as well as the full respect for their dignity. Therefore, just now I have mentioned in the main reply that while there are only 300-odd beds at present, HA already developed the "Strategic Service Framework for Palliative Care" in 2017 to formulate strategic directions for this in the hope of improving continuously the various services, including adult and paediatric care, in the next 5 to 10 years. Certainly, the legislative procedures in respect of ADs and the consultation exercise to be conducted are only part of our overall care for terminally-ill patients, whereas many other parts are also involved.

As a matter of fact, we have been striving to enhance the existing work of the hospitals or RCHEs, whilst additional resources have been allocated to improving the service model and strengthening multi-disciplinary services. Looking ahead, we will also continue to review the various services, taking into account factors such as population growth and changes, advancement of medical technology and health care manpower in the meantime, and provide more services having regard to the demand of terminally-ill patients. Factors of particular importance to palliative care are: First, provision of multi-disciplinary services; second, collaboration with community partners. Rightly as Dr CHEUNG has said, many patients may not want to die in a hospital, some of them would rather die at home or in other institutions, which is a better choice for them. Therefore, the mission of our services is to equip health care personnel with the competence to handle such cases, to understand the service model of providing multi-disciplinary services in its entirety, and to provide better care for patients and their family members, while enabling family members of the patients to assist the patients in going through this difficult time.

MR LEUNG YIU-CHUNG (in Cantonese): *President, although the Secretary indicated that consultation on ADs would be conducted, the problem lies in the fact that the Secretary has refused to conduct a review of or consultation on euthanasia. May I ask the Secretary, why an extensive consultation on the legalization of euthanasia cannot be conducted when the consultation on ADs is ongoing? We all know that many people around the world are willing to seek euthanasia recently, and the number of them is ever-increasing. Such being the case, would it not be more desirable if the Government can give patients the*

opportunity to make a choice? Therefore, may I ask the Secretary direct whether she will conduct an extensive consultation on the legalization of euthanasia during the consultation exercise on ADs or in the future?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, I thank Mr LEUNG for his views. As I have said just now, euthanasia is indeed a very complicated and controversial issue involving implications on medical, social, moral, ethical and legal aspects, as well as on various dimensions. Therefore, we would treat the care for terminally-ill patients or any subject matters concerning life with care and caution, especially because euthanasia is illegal and unethical under the existing laws of Hong Kong. The Code has also made it clear that euthanasia is illegal and unethical.

For this reason, we hope that the upcoming consultation will focus on examining issues related to ADs, as HA has already introduced some practices on ADs albeit legislation is yet to be enacted, and patients or their family members have all along raised requests in this respect. Under such circumstances, we believe the arrangements of ADs have developed to a relatively mature state. Certainly, during the upcoming consultation exercise, some people will present to us their views on other aspects in addition to ADs, such as end-of-life care, and we will gather the views on this aspect for consideration. However, we will focus on ADs in the upcoming consultation exercise.

PRESIDENT (in Cantonese): Mr LEUNG Yiu-chung, which part of your supplementary question has not been answered?

MR LEUNG YIU-CHUNG (in Cantonese): *I was asking whether she would conduct an extensive consultation on euthanasia during this consultation exercise or in the future.*

PRESIDENT (in Cantonese): Mr LEUNG, I think the Secretary has already answered your supplementary question. Yet, Secretary, do you have anything to add?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): I do not have anything particular to add. We do not plan to carry out a review or consultation on the legalization of euthanasia in this consultation exercise.

PROF JOSEPH LEE (in Cantonese): *President, we are now discussing issues relating to terminally-ill patients, part of which involves palliative care services. In fact, it has been clearly stated in the Annex to the Secretary's main reply that home visits are very important when speaking of palliative care services, especially if the Government intends to encourage and promote "dying-in-place". I have this question for the Secretary. In the past five years, the number of home visits has increased by almost 10 000 times but her health care team only consists of 300 nurses, who are also tasked with attending to the 360 palliative care beds. Does the Secretary know the number of patients that each nurse has to take care per home visit? In addition, will the Secretary allocate additional resources to enabling the nurse team to cope with the increasing number of households in need of home visit services?*

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, I thank Prof LEE for his supplementary question. In fact, Prof LEE is right, we have all along been enhancing our palliative care services, such as extending or deepening the coverage of palliative care services, including the gradual strengthening of services in the community such as the establishment of Community Geriatric Assessment Teams ("CGATs"), which is also aimed at enhancing the support for terminally-ill patients in RCHEs. As regards home visits by nurses, this is one of the expanded services with a view to improving home-based palliative care. We need to train health care personnel so that they can take care of these patients beyond the palliative care setting (i.e. in the household setting), and they must possess some special skills as well.

I do not have the number of home visits made by each nurse on hand right now, but we understand that if there is a demand for this service—As I said earlier, HA had already reviewed and formulated strategies and would gradually study the development directions of the services on this aspect, taking into account the needs and the current circumstances, particularly the health care manpower. If home visits are welcomed by patients and are quality services, we will certainly provide the necessary resources to meet the requests of HA for developing this service.

PRESIDENT (in Cantonese): Prof Joseph LEE, which part of your supplementary question has not been answered?

PROF JOSEPH LEE (in Cantonese): *How much additional manpower will HA deploy to conduct home visits?*

PRESIDENT (in Cantonese): Secretary, do you have anything to add?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, Prof LEE, we do not have specific figures at present, since HA will raise proposals on various services with us on a yearly basis, and we will then provide the necessary resources. We have yet to receive information in this respect in the meantime, but as I said just now, if HA has a need in this regard, we will certainly provide resources.

DR HELENA WONG (in Cantonese): *President, I hope the Government can tell us, while HA developed the "Strategic Service Framework for Palliative Care" in 2017, there are only 360 palliative care beds now ... in fact, what plans does the Secretary actually have, and when can the number of these beds be increased? How many beds are we currently short of? How will the Secretary allocate and deploy resources to improving the existing palliative care services in hospitals? Particularly, if the patients choose to die in a hospital or at home, what palliative measures are provided by the authorities to enable them to die comfortably?*

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, I thank Dr WONG for her question. The existing palliative care inpatient services are mainly for terminally-ill patients with severe or complex symptoms and needs. Dr WONG is right in saying that HA has 360 palliative care beds presently. Yet, palliative care services may not necessarily be provided in hospitals, whilst some terminally-ill patients will of course be admitted to other specialties in the light of their clinical needs. If these patients need palliative care services, we can make arrangements for them to receive treatment in this respect.

As for other services, HA has actually allocated additional resources to improving the service model and enhance these multi-disciplinary services in recent years, including the expansion of the scope of services, and the gradual strengthening of the services provided by CGATs from 2015-2016 onwards, as well as arranging for collaboration between the palliative care teams and RCHEs.

DR HELENA WONG (in Cantonese): *The Secretary has not answered whether there are plans to increase the number of palliative care beds.*

PRESIDENT (in Cantonese): Secretary, do you have anything to add?

SECRETARY FOR FOOD AND HEALTH (in Cantonese): President, we will certainly review various health care services, taking into account factors such as population growth and changes, advancement of medical technology and health care manpower, and palliative care services are of course included. After understanding the patients' needs, we will provide resources to meet such needs upon request by HA. More importantly still, we will collaborate with community partners as well.

PRESIDENT (in Cantonese): Oral questions end here.

WRITTEN ANSWERS TO QUESTIONS

Use of mobile phones by motorists while driving

7. **MR CHAN KIN-POR** (in Chinese): *President, it is not uncommon to see traffic accidents which were caused by drivers of vehicles for hire via telephone getting distracted as a result of their communicating with customers on mobile phones while driving. In 2017, traffic accidents caused by inattentive driving resulted in 5 735 casualties. In this connection, will the Government inform this Council:*

Appendix III

Relevant papers on advance directives in relation to medical treatment

Committee	Date of meeting	Paper
Panel on Health Services	19.7.2004 (Item VI)	Agenda Minutes
	8.12.2008 (Item IV)	Agenda Minutes
Joint Subcommittee on Long-term Care Policy	12.12.2017 (Item II)	Agenda Minutes CB(2)1449/17-18(01)
Research Office of the Information Services Division of the Legislative Council Secretariat	6.6.2019 *	Essentials entitled "Advance healthcare directives of patients"

* *Issued date*

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