Submission to Panel Of Health Services, LegCo; on Legislative Proposals on Advance Directives and Dying in Place

- **By The Hong Kong Anti-Cancer Society (4 Dec 2019)**

With reference to the subject proposal published by the Food & Health Bureau in September this year, we think that the public at large is ready to accept the concept of advance directives. Of course, further public education should be performed by the Government, in collaboration with stakeholders in the NGO sector; to increase their understanding on the matter.

We think that there should be clear legal provisions for advance directives.

We agree with the fundamental principles as appeared in the proposal, briefly: (a) respecting a person's right to self-determination; (b) a valid and applicable advance directive overrides treatment decisions based on treatment provider's interpretation of patient's best interests; (c) a person should have the primary responsibility of keeping an advance directive and of ensuring that the original copy shall be presented to treatment providers as proof of a valid advance directive; and (d) sufficient safeguards should be provided to preserve lives.

We also support the proposal in the following aspects:

- "that an advance directive must be made by a mentally competent person who is aged 18 or above to be legally valid";
- "that artificial nutrition and hydration should be covered under an advance directive and can be withheld or withdrawn according to the patient's wish";
- "that the primary objective of an advance directive should be for advance refusal of life-sustaining treatments to minimise distress or indignity when the patient faces a serious irreversible illness";
- "that a person may revoke or modify an advance directive at any time";
- "that an advance directive must be made or modified in writing";
- "that a legally-valid advance directive must be witnessed as safeguard";
- that there should be "two witnesses for making and modifying an advance directive, one of whom must be a medical practitioner, and both witnesses should not have an interest in the estate of the person making the advance directive";
- that a model form for making advance directives be used, rather than a statutory prescribed form, to be legally valid;
- that the proposed safeguards to ensure validity of an advance directive and the applicability of advance directives are sufficient;
- "that the "pre- specified conditions" in the proposed non-statutory advance directive model form should cover: (a) terminal illness, (b) persistent vegetative state or a state of irreversible coma and (c) other end-stage irreversible life-limiting condition, or any conditions as pre-specified by the person";
- that emergency rescue personnel be allowed to accept advance directives with signed DNACPR forms attached and not attempt CPR;
- that a model DNACPR form be used, rather than a statutory prescribed form; furthermore, emergency rescue personnel be allowed to accept DNACPR form without an advance directive and not attempt CPR for the reason that there is consensus between the healthcare team and

family members that this is in the best interests of the patient who is unable to make an advance directive;
- that the advance directive document may be recorded in eHRSS on a voluntary basis;
- the proposed arrangements on liability of the treatment provider (as in Section 4.8 of the proposal);
- "that medical professionals should also be exempted from disciplinary proceedings for professional misconduct for a decision made by him/her in good faith and with reasonable care";
- the proposed consequential change to the Mental Health Ordinance be made in order to remove the potential conflict;
- "that as a prerequisite to promote dying in place, the relevant provisions of the Coroners Ordinance should be amended to exempt certain deaths in RCHEs from reportable deaths";
- "that the proposed safeguard for RCHE residents is sufficient if deaths in RCHEs may be exempted from reportable deaths".
- "that it is the responsibility of the individual/family to draw the attention of emergency rescue personnel to the existence of an advance directive". Indeed, we think that the emergency rescue person should not be responsible for that, otherwise he has to ask /check for the existence of an advance directive whenever he encounters a critical patient which is not practical.

However, we could not quite agree with the following aspects of the proposal:

- "that the public is sufficientlyaware of the pros and cons of making an advance directive when healthy". We do not think that the public has sufficient in-depth knowledge on the matter; especially those of a lower educational level. Therefore we suggest that much more public education is required by the Government to promote the genuine understanding of the pros and cons of making an advance directive;
- "that both verbal and written revocation of an advance directive should be accepted". We think that only written advance directive should be accepted; in order to safeguard mis-communication between different parties involved; and to ascertain the certainty of such decision by the patient whose mental/health condition might be changing from time to time.
- "that written revocation of advance directive need not be witnessed to avoid imposing unnecessary hurdles". We think that only written revocation should be accepted; since only written advance directives are accepted; in order to safeguarding revocation under undue influence, it should be witnessed by a doctor or an unrelated 3rd party.
- "that, when a single family member/carer reports that the patient has verbally revoked his/her advance directive before becoming mentally incapable, a second witness is not required before the treatment provider considers the advance directive is no longer valid". We do not agree with this point for similar reasons to the 2 points immediately above.
- "that the original advance directive document should still be required as proof of a valid advance directive, even when an advance directive record could be found in eHRSS". We think that this is an unnecessary hurdle for respecting the patient's choice when such advance directive had been made and recorded in eHRSS.