For information
in July 2020

Legislative Council Panel on Health Services

Consultation Report on End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place – Moving Forward

PURPOSE

This paper informs Members of the outcome and way forward of the public consultation 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. To gauge public views on legislative proposals in this regard, a public consultation was conducted between 6 September 2019 and 16 December 2019. 30 consultation questions were set out 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 residential care homes for the elderly (RCHEs).

3. The consultation was publicised through Announcement in the Public Interest, advertisements in print media and distribution of leaflet and the consultation document. Representatives of the Food and Health Bureau

(FHB) and the Hospital Authority also appeared on television and radio programmes to explain the issues under consultation to the public.

4. We attended the meeting of the Legislative Council Panel on Health Services (the Panel) on 8 November 2019 and listened to the views of deputations at another meeting of the Panel on 13 December 2019. In addition to public forums co-organised by FHB, we also attended briefings and seminars organised by professional organisations, healthcare staff consultative bodies, patients groups and other non-governmental organisations to explain our proposals and listened to the views expressed by the community.

5. We received 607 submissions from individuals and organisations. There is a clear support from most respondents for the initial proposals on execution details in respect of ADs and amendments to the Coroners Ordinance. Alternative views, such as witness requirements for AD making and revocation, validity proof for AD, statutory prescribed form for Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR), and safeguards for RCHE deaths were raised.

REFINED PROPOSALS AND WAY FORWARD

6. Taking account of the views of the respondents, four major refinements are made to the original proposals –

(a) the role expected of the medical practitioner witness, who should be satisfied that the person making the AD has been informed of the nature and effect of the AD and the consequences of refusing the relevant treatments, would be expressly spelt out;

(b) a second witness would be required for a verbal revocation of an AD reported by a family member or carer;

(c) a statutory prescribed DNACPR form would be used, instead of a non-statutory model form; and

(d) the proposed exemption to the reporting requirement under the Coroners Ordinance in respect of natural deaths in RCHEs in

which the deceased was attended to by a medical practitioner within 14 days of death will only be applicable for persons who have been previously diagnosed as having a terminal illness.

7. Specifically, the refined proposals state 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. Making and modifying an AD must be in writing, while revocation could be done verbally or in written form.

8. When making or modifying an AD, two witnesses with no interests in the estate of the person making the AD are required, one of whom must be a medical practitioner. The medical practitioner should be satisfied that the person has capability to make an advance directive, and has been informed of the nature and effect of the AD and the consequences of refusing the treatments specified in the AD.

9. In respect of revocation, no witness is required for a written revocation. Crossing out and signing onto an AD, and tearing or otherwise destroying by the person who made the AD, or by some person in his/her presence and by his/her direction, could be taken as revoking the AD. For verbal revocation, at least one witness who has no interests in the estate of the person making the AD is required. A second witness is required for the report of verbal revocation made by a single family member or carer.

10. 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, a statutory prescribed DNACPR form would be used. The existing Electronic Health Record Sharing System 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.

11. Relevant empowering ordinances, including the Fire Services Ordinance (Cap. 95) and Mental Health Ordinance (Cap. 136), would be amended so that the administration of ADs would not be hindered.

12. To facilitate dying in place, Coroners Ordinance will be amended to provide that if an RCHE resident who has been diagnosed as having a terminal illness, was attended to by 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.

13. The full consultation report, published on 24 July 2020 is available at https://www.fhb.gov.hk/en/press_and_publications/consultation/190900_eolcare/index.html. The Government would proceed with drafting the relevant legislations, to be supplemented by stepped up efforts on public education on end-of-life care and life and death issues, and training and development of the healthcare, elderly care and emergency rescue workforce.

ADVICE SOUGHT

14. Members are invited to note the content of this paper.

Food and Health Bureau
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