



**CONSULTATION PAPER ON END-OF-LIFE CARE  
LEGISLATIVE PROPOSALS ON  
ADVANCE DIRECTIVES AND DYING IN PLACE**

**THE LAW SOCIETY'S SUBMISSIONS**

The Food and Health Bureau issued a consultation paper on the *Legislative Proposals on Advance Directives and Dying in Place* in September 2019 ("Consultation Paper"). The Law Society studied the Consultation Paper and made the following submissions in response to the questions raised in the Questionnaire attached in Annex D of the Consultation Paper. A set of overall comment is also provided at the end of this Submission.

We are to first respond to the questions in the Consultation Paper (Section A below). Our answers are to be followed by further views and observations on the proposed regime of advanced directives (Section B).

In the course of canvassing views on the consultation questions, we received opposing views on some of the matters raised. These views are well-reasoned and are equally potent and helpful. After deliberation, we consider that both views are relevant to the Bureau in considering the matter. The different views on a particular matter are therefore set out.

Where applicable, the paragraph numbering and abbreviations appearing in this submission below are those used in the Consultation Paper.

**A. RESPONSES TO THE CONSULTATION QUESTIONS**

*Question 1: Do you think that the public at large is ready to accept the concept of advance directives?*

**Law Society's response:**

Agree

*Question 2: Do you think that there should be clear legal provisions for advance directives, or Hong Kong should continue to rely on the common law framework?*

**Law Society's response:**

Agree. Clear legal provisions for advance directives should be enacted.

*Question 3: Do you agree with the fundamental principles set out in paragraph 4.8 [of the Consultation Paper] (i.e. in brief (a) respect a person's right to self-determination; (b) a valid and applicable advance directive can override treatment decisions based on treatment provider's interpretation of patient's best interests; (c) the primary responsibility of a person to keep and to present the original advance directives to treatment providers; and (d) sufficient safeguards to be provided to preserve lives.)?*

**Law Society's response:**

We agree to the fundamental principles under paragraphs 4.8(a) and (b) of the Consultation Paper, i.e.

- (a) "respecting a person's right to self-determination. This means that a mentally competent adult's right to accept or refuse treatment should be respected. In case of a conflict between the wishes of the individual and his/her family members or that of treatment providers, the individual's right to self-determination should prevail;
- (b) a valid and applicable advance directive, which has the same effect as a contemporaneous refusal of treatment by a person with mental capacity, overrides treatment decisions based on treatment provider's interpretation of patient's best interests;"

As for the fundamental principles under paragraphs 4.8(c) and 4.8(d), i.e.

- (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. Under all circumstances where there are any grounds for doubt about the validity or applicability of an advance directive, treatment providers must continue to provide clinically indicated emergency life-sustaining treatments, with

legal protection conferred to treatment providers acting in good faith and with reasonable care."

while we received a "yes" from some members, we note reservations expressed by other members. There are views that clear legal provisions should be enacted on the making of advance directives in order to protect the public, their family members and the health professionals. Similar to the making of Wills and Enduring Powers of Attorneys, an individual should have freedom to choose whether or not he or she wants to make an advance directive. However, once an individual chooses to make an advance directive, the individual should know that he/she will be bound by the legislation which makes the advance directive enforceable.

There are also different views as to whether a compulsory central registration (i.e. an upgraded eHRSS<sup>1</sup>) of the actual advance directive should be put in place.

- (1) There are views that the production of the original advance directive (i.e. para 4.24(a) of the Consultation Document) by the patient or his/her family member is not realistic, given the aging population of Hong Kong, where both the patient and the caregiver could be elderly in which event, they could have senile problems of being, e.g. forgetful;
- (2) A central registration could help avoid challenges to advance directives (i.e. in para 4.24(b) of the Consultation Document). This is because for the purpose of registration, the medical doctor who witnessed the signing of the advance directive is obligated to check the person making the advance directive has the mental capacity and whether he/she is under undue influence before it is to be registered;
- (3) There are an increasing number of singletons, childless divorcees, widows/widowers, and people whose spouse is a dementia patient and whose children are overseas or not readily available. It could be unreasonable to expect the timely production of the original advance directive by the patient's family member.

We add that if there is a central registration regime,

- (4) there must be clear policy considerations as to whether, absent a valid registration, an advance directive could still have its intended legal effect;
- (5) adequate resources should be committed to the eHRSS to ensure prompt updating and accuracy of the registration system. This is

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<sup>1</sup> Existing Electronic Health Record Sharing System

particularly relevant for compulsory advance directive registration and privacy-sensitive access to stakeholders. There should also be an access control mechanism with a designated advance directive zone in eHRSS where only the patient, the emergency rescue personnel and the “personal care attorney” under the Continuing Powers of Attorney Bill (if enacted), have automatic access.

*Question 4: Do you agree that an advance directive must be made by a mentally competent person who is aged 18 or above to be legally valid?*

**Law Society’s response:**

We have carried out a brief comparative study of a similar age requirements in other countries. See **Annex 1** to this submission.

We ask the Government to consider those age requirements. Subject to this review, we in principle have no objection to the proposed age of 18.

*Question 5: Do you agree that artificial nutrition and hydration should be covered under an advance directive and can be withheld or withdrawn according to the patient’s wish?*

**Law Society’s response:**

Agree

*Question 6: Do you agree 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?*

**Law Society’s response:**

Agree

*Question 7: Legally, there is no limitation for healthy individuals signing an advance directive. Do you agree that the public is sufficiently aware of the*

*pros and cons of making an advance directive when healthy?*

**Law Society's response:**

Many countries including Singapore, UK and Australia allow healthy persons to make their own advance directives. The regulators may make reference to their practices.

If a healthy person is to make an advance directive, a doctor who witnesses the signing of the advance directives should have the duty to ensure that the person is aware of the pros and cons of a healthy person making an advance directive.

*Question 8: Do you agree that a person may revoke or modify an advance directive at any time?*

**Law Society's response:**

A person may revoke or modify an advance directive only when the person has the mental capacity at the time of the revocation and/or the modification.

*Question 9: Do you agree that an advance directive must be made or modified in writing?*

**Law Society's response:**

Agree. A modified advance directive should be treated as a new advance directive and should replace the previous advance directive.

*Question 10: Do you agree that both verbal and written revocation of an advance directive should be accepted?*

**Law Society's response:**

Agree. Furthermore, some members suggest that, although both verbal and written revocation of an advance directive could be accepted, a compulsory central registration should still be established to avoid uncertainty.

If a statutory central registry is to be set up for the registration for advance directives, statutory provisions must be carefully drafted for the central registration system.

*Question 11: Do you agree that a legally-valid advance directive must be witnessed as safeguard?*

**Law Society's response:**

Agree

*Question 12: Do you agree to the proposed arrangement to require 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?*

**Law Society's response:**

Agree

*Question 13: Do you agree that written revocation of advance directive need not be witnessed to avoid imposing unnecessary hurdles?*

**Law Society's response:**

We receive different views from members.

Some consider that witnessing is required in order to ensure that the person revoking the advance directive has the mental capacity to revoke at the time of the revocation and that the person is not revoking an advance directive under undue influence.

The holders of opposite views consider that everyone has right of survival. A revocation means the person involved does not want to abandon his right of survival and that should take his case back to square one when no advance directive has not yet been put in place. In these circumstances witness to a revocation is unnecessary.

*Question 14: Do you agree 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?*

**Law Society's response:**

Disagree. The advance directive of the patient should not be easily displaced by a single family member/carer.

*Question 15: Do you agree to the use of a model form for making advance directives, rather than a statutory prescribed form, to be legally valid?*

**Law Society's response:**

Agree. The use of a non-statutory model form would be helpful for retaining the legal status of advance directives made outside Hong Kong or before the enactment of the new legislation and it will reduce subsequent dispute among his/her family members. Solicitors may help their clients to prepare an advance directive to meet with their individual needs using the model form as the basis.

*Question 16: Do you think that the proposed safeguards to ensure validity of an advance directive are sufficient?*

**Law Society's response:**

Some members consider the safeguards are sufficient, but some take the views that there should be additional safeguards. For the additional safeguards, please refer to the reservations we have made in our answers to Question 3 in the above; and the "Further Views" below.

*Question 17: Do you think that the "prespecified 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?*

**Law Society's response:**

We consider that "End-Stage dementia" is not easy to be defined, and have reservation as to whether such should be included in the model form. In any event, if the Government considers that there should be an inclusion of the above, then the list of examples of "other end-stage irreversible life-limiting condition" should specifically include end-stage dementia.

*Question 18: Do you think that the proposed safeguards to ensure the applicability of advance directives are sufficient?*

**Law Society's response:**

Agree

*Question 19: Do you agree to allow emergency rescue personnel to accept advance directives with signed DNACPR<sup>2</sup> forms attached and not attempt CPR<sup>3</sup>?*

**Law Society's response:**

Agree. However, this should not be accepted in an ambulance rescue or on spot rescue.

*Question 20: Do you agree to the use of a model DNACPR form, rather than a statutory prescribed form?*

**Law Society's response:**

We received mixed responses. While some members agree to the above proposal, other members repeat the reservations set out in the answer in Question 3 above.

*Question 21: Do you agree to allow emergency rescue personnel to accept DNACPR form without an advance directive and not attempt CPR for the*

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<sup>2</sup> Do-Not-Attempt Cardiopulmonary Resuscitation

<sup>3</sup> cardiopulmonary resuscitation

*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?*

**Law Society's response:**

Agree

*Question 22: Do you agree that the advance directive document may be recorded in eHRSS?*

**Law Society's response:**

We received mixed responses. While some members agree to the above proposal, other members repeat the reservations set out in the answer in Question 3 above.

*Question 23: Given the possibility of a time lag between the latest status of advance directives and records in eHRSS, eHRSS may not contain the most up-to-date and accurate records. Do you agree to the proposal that storage of advance directive records in eHRSS should be voluntary?*

**Law Society's response:**

While some members agree to the above, other considers that because the witnessing of an advance directive by a doctor is compulsory, the registration of the advance directive by a doctor in eHRSS should also be compulsory; that would minimize uncertainty and future disputes.

To address any privacy concerns, there should be an access control mechanism in eHRSS with a designated advance directive zone where the person can specify who will have access to it, apart from that person and his/her doctors.

The eHRSS system should be kept updated and accurate.

*Question 24: Do you agree 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?*

**Law Society's response:**

Disagree. Please refer to the reservations expressed in the answer to Question 3 in the above.

*Question 25: Do you agree that it is the responsibility of the individual/family to draw the attention of emergency rescue personnel to the existence of an advance directive?*

**Law Society's response:**

While some members agree to the above, other members repeat the reservations expressed in the answer to Question 3 in the above.

*Question 26: Do you agree with the proposed arrangements on liability, i.e. a treatment provider does not incur any civil or criminal liability for carrying out or continuing CPR if, at the time, he/she reasonably believe that a valid and applicable DNACPR form does not exist. Similarly, a treatment provider does not incur any civil or criminal liability for the consequences of withholding or withdrawing CPR from individuals if, at the time, he/she reasonably believes that a valid and applicable DNACPR form exists?*

**Law Society's response:**

While some members agree to the above, other members consider there is a lack of certainty if the carrying out or continuing CPR or DNACPR was to be based on the "reasonable belief" of the treatment provider. There are views that a compulsory central registration of an advance directive which is accessible by the treatment provider should eliminate the uncertainty.

*Question 27: Do you think 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?*

**Law Society's response:**

While some members agree to the above, other members repeat the views expressed in the answer to Question 26 in the above.

*Question 28: Do you agree with the proposed consequential change to the Mental Health Ordinance to remove the potential conflict?*

**Law Society's response:**

Agree

*Question 29: Do you agree that, as a prerequisite to promote dying in place, the relevant provisions of the Coroners Ordinance should be amended to exempt certain deaths in RCHE<sup>4</sup>s from reportable deaths?*

**Law Society's response:**

Agree

*Question 30: Do you think that the proposed safeguard for RCHE residents is sufficient if deaths in RCHEs may be exempted from reportable deaths?*

**Law Society's response:**

Agree. We have carried out a research on a few jurisdictions as to their arrangement for dying in place for the elderly. See **Annex 2** to this submission.

## **B. FURTHER VIEWS: RELATED LEGISLATIVE PROPOSALS**

Apart from the above views, we set out below our further observations on

1. The order of priority for grant in case of intestacy under section 21 of the *Non-contentious Probate Rules* (Cap 10) should be re-considered. Hong Kong is one of the places in the world which enjoys long life expectancy. Dementia unfortunately is relatively prevalent among the elderly. It is likely that the surviving spouse who is the first to have the entitlement to the grant in intestacy will be too elderly or frail to discharge the duty of an administrator. A surviving spouse who is a dementia patient does not even have the mental capacity to sign the Renunciation of Administration so that the second in the order of priority, namely, the children of the deceased, can apply for the grant.

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<sup>4</sup> residential care homes for the elderly

2. Under Part II of Second Schedule to the *Births and Deaths Registration Ordinance* (Cap 174), the informant to register death under section 14 must state, inter alia, “the rank, profession, or occupation of deceased and nationality so far as is known. [If deceased is a child or an unmarried person without occupation or property, the full names and rank or profession of the father will be required (except in the case of illegitimate children); if a wife or widow those of the husband or deceased husband.]” This provision is out-dated and might not survive discrimination challenges. There should be timely updating to render the provision to be gender-neutral.
  
3. The signing of an advance directive touches on the issue of mental capacity. However, the definition regarding mental incapacity under our existing legislation is both outdated and convoluted. For example, see section 2 of the Mental Health Ordinance (Cap 136). (This definition is referred to in both section 2 of the existing Enduring Powers of Attorney Ordinance (Cap 501) and section 1A of the Powers of Attorney Ordinance (Cap 31)). There should be a review of the definition. See for reference section 3 of the UK Mental Capacity Act 2005 which incorporates principles from more recent case law (<https://www.legislation.gov.uk/ukpga/2005/9/section/3>)

**The Law Society of Hong Kong  
3 December 2019**

## Annex 1

### Government Consultation on Advance Directives

Date: Oct 2019

<b>Advance Directive</b>			
<b>Countries</b>	<b>Legislation</b>	<b>Age</b>	<b>Additional Information</b>
Singapore	The Singapore parliament passed the Advance Medical Directive Act in May 1996 to allow Singaporeans who wish to make an AMD to do so. The law came into effect in July 1997.	A person who is not mentally disordered and is <b>at least 21</b> years old may make an AMD.	<p>✓ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- Must be made in the statutory prescribed form and registered with the Registrar of Advance Medical Directive</li> </ul> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- Verbal or written revocation is accepted but must be in the presence of at least one witness.</li> </ul>
UK	The part of the Act relating to advance decisions came into force on 1 October 2007.	Individuals <b>aged 18 or above</b> who are not mentally disordered can make advance directives.	<p>✗ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- Written Down</li> <li>- Signed by the maker</li> <li>- Signed by a witness</li> </ul> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- May be modified at any time and need not be in writing unless such modification is made to include a refusal of life-sustaining treatment</li> </ul>

Countries	Legislation	Age	Additional Information
<p>States in Australia: Queensland, Victoria, Tasmania, Northern Territory, South Australia, Australian Capital Territory, New South Wales, Western Australia</p>	<p>The laws regarding advance directives, powers of attorney, and enduring guardianships vary from state to state.</p> <p>National Framework for Advance Care Directives- Endorsed by the Australian Health Ministers' Advisory Council at its 4 March 2010 meeting.</p> <p><a href="https://www.dementia.org.au/files/start2talk/5.0.4.1%20AHMAC%20framework.pdf">https://www.dementia.org.au/files/start2talk/5.0.4.1%20AHMAC%20framework.pdf</a></p>	<p>It must be made and signed by a person <b>18 years</b> or over who has been certified as having capacity;</p> <p>It must be in the form prescribed by regulation; and</p> <p>It must be witnessed by an eligible witness.</p>	<p>Queensland</p> <p>✘ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <p>- Must be written and may be made using a recommended form.</p> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <p>- Only written revocation is accepted, and a witness is recommended but not required.</p> <p>Australia has two types of Advance Care Directives:</p> <p><u>Common Law Advance Care Directives</u> which are recognised by the common law (decisions made by judges in the courts) and generally must be followed. These types of Directives exist in all states and territories except Queensland.</p> <p><u>Statutory Advance Care Directives</u> which are governed by state and territory legislation. These types of Directives exist in all states and territories <b>except New South Wales and Tasmania.</b></p>

Countries	Legislation	Age	Additional Information
Provinces in Canada: British Columbia and Ontario	<p>The Advance Care Planning in Canada: A National Framework and Implementation Project was initiated in 2008.</p> <p>An Advance Directive is a new legal document in <b>British Columbia</b> as of September 1, 2011, when the Health Care Consent and Care Facility Admission Act was amended.</p> <p>The <b>Guide to Advance Care Planning</b> has been developed by the government of Ontario as part of Ontario's Strategy for Alzheimer Disease and Related Dementias, which was released in September 1999. (A Guide to Advance Care Planning)</p>	<p>British Columbia:            It must be made and signed by a person <b>19 years</b> or older (an adult) in order to make an Advance Directive.            You must also meet the capability requirements.</p>	<p>✗ Statutory central registry</p> <p>Ontario</p> <p><b><u>Making an advance directive:</u></b></p> <p>To be valid, the document must:</p> <ol style="list-style-type: none"> <li>i. be signed by the maker voluntarily, of his own free will;</li> <li>ii. be signed by the maker in the presence of two witnesses;</li> <li>iii. be signed by the two witnesses in front of the maker.</li> </ol> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <p>- A patient may change/revoke an advance directive that is not a power of attorney for personal care by making oral statements, by communicating his wishes by alternative means, by making a new statement of wishes in writing. The patient does not need to execute a "revocation".</p>

Countries	Legislation	Age	Additional Information
Netherland	Article 450 of the WGBO[3] of 1994 contains a paragraph which can be interpreted as referring to advance directives.	To make a valid advance directive, a person <b>must be aged 16</b> or over and have the necessary capacity to do so. (Article 450 of the WGBO of 1994 )	<p>✗ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- In writing</li> <li>- identity of the make must be certain</li> <li>- Older than 16 years old and competent</li> </ul> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- Patients may retract or modify an advance directive at any time.</li> </ul>
India	On 09 March 2018, the Supreme Court of India passed a landmark Judgment [Common Cause (A Regd. Society) v. Union of India and Another (Writ Petition (Civil) No. 215 of 2005).] permitting adults of sound mind to leave advance directives regarding the end of life treatment they wish to receive and the kinds of treatment that they do not wish to receive.		<p>✓ Statutory central registry</p> <p>Subject to the provisions contained in clause (a) of sub-section (1) of section 91, every Board shall maintain an <b>online register of all advance directives</b> registered with it and make them available to the concerned mental health professionals as and when required.</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- A valid advance directive must be executed in writing and, in much the same manner as a will, must be witnessed by two witnesses. The document must have</li> </ul>

Countries	Legislation	Age	Additional Information
			<p>been signed by the executor of their own free will and without any coercion and must be registered with the appropriate authorities specified in the Supreme Court judgment. The advance directive must also specify the name of a guardian or close relative who will act as the surrogate of the executor in the event the executor becomes incapable of taking a decision.</p> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <p>Revocation, amendment or cancellation of advance directive 8. (1) An advance directive made under section 6 may be revoked, amended or cancelled by the person who made it at any time.</p> <p>(2) The procedure for revoking, amending or cancelling an advance directive shall be the same as for making an advance directive under section 6.</p> <p><a href="https://mhca2017.com/index.php/act/chapter-iii-advance-directive">https://mhca2017.com/index.php/act/chapter-iii-advance-directive</a></p>

Countries	Legislation	Age	Additional Information
Germany	On 18 June 2009 the Bundestag passed a law on advance directives, applicable since 1 September 2009.	The law also makes explicit that only an adult ( <b>18 years or above</b> ) can establish an advance directive.	<p>✗ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- The law states that advance directives are <b>only valid in writing</b>. According to x126 of the German Civil Code, a written statement must always be signed by hand; this formal requirement is also satisfied by the often-used checkbox forms as long as it includes the patient's signature. Notarisation is not necessary. A verbal statement, although not recognised as an advance directive, is still of legal value.</li> </ul> <p>In determining a patient's will, a verbal statement is recognised either as an expression of preferred treatment, when referring directly to a specific treatment in question, or as a clear sign of the presumed will of the patient.</p> <p><a href="https://pdfs.semanticscholar.org/dfdf/fa38bc79620aeaf3d0f7bbd07394f8f688ba.pdf">https://pdfs.semanticscholar.org/dfdf/fa38bc79620aeaf3d0f7bbd07394f8f688ba.pdf</a></p> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- It should of course be</li> </ul>

Countries	Legislation	Age	Additional Information
			possible to withdraw or amend an advance directive at any time provided that the person with dementia has the necessary capacity to do so.
Italy	On 14 December 2017, Italian Senate officially approved a law on advance healthcare directive that came into force on 31 January 2018.	<b>18 years old or above</b>	<p>✗ Statutory central registry</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- In an advance care directive, the maker can write either or both:</li> <li>- an instructional directive with legally binding instructions about future medical treatment you consent to or refuse</li> <li>- a values directive which documents his values and preferences for his medical treatment decision maker to consider when making decisions for you.</li> </ul> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- It is always possible modify, revoke and reconfirm it.</li> </ul>

Countries	Legislation	Age	Additional Information
USA	<p>The laws governing advance directives vary from state to state.</p> <p>The most common types of advance directives are the living will and the durable power of attorney for health care (sometimes known as the medical power of attorney).</p>		<p>✓ Statutory central registry</p> <p>The US Living Will Registry has been storing advance directives since 1996. The Registry electronically stores the documents, and makes them available to hospitals and health care providers. Registrants are contacted every year to remind them to update their personal and emergency contact information, and to confirm that their advance directive has not been changed or revoked.</p> <p><b><u>Making an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- The maker will need 2 (two) witnesses to his signature. The witness must sign the Advance Directive Form and also write his/her initials beside the maker's signatures. The witnesses in effect confirm that the maker has signed the document in their presence and in the presence of each other.</li> </ul> <p><b><u>Modifying or revoking an advance directive:</u></b></p> <ul style="list-style-type: none"> <li>- Advance health care</li> </ul>

<b>Countries</b>	<b>Legislation</b>	<b>Age</b>	<b>Additional Information</b>
			directives can always be changed if/when your wishes or circumstances change.

## Annex 2

<b>Dying in Place</b>	
Singapore	<p>✘ facilitate dying in place</p> <p>-Latest statistics from the Singapore Demographic Bulletin show that though most Singaporeans have expressed the wish to die at home, many do not.</p> <p>-Dr Chong Poh Heng, medical director of HCA Hospice Care, the largest provider of home hospice care in Singapore, said: "The greatest barrier that prevents people from dying at home now is the <b>social support that caregivers need. Caregivers are generally not equipped, mentally or technically, to care for them at home. They lack the confidence or assurance to do so.</b>"</p> <p><a href="https://www.straitstimes.com/singapore/health/new-project-launched-to-support-terminally-ill-patients-who-want-to-die-at-home">https://www.straitstimes.com/singapore/health/new-project-launched-to-support-terminally-ill-patients-who-want-to-die-at-home</a></p>
UK	<p>In 2016, almost half of all deaths in England (46.9%) occurred in hospital; <b>nearly a quarter of deaths (23.5%) occurred in people's own home</b>; 21.8% of deaths occurred in care homes, that is residential and nursing homes;5.7% of deaths occurred in a hospice.</p> <p>The trend over recent years has been a reducing proportion of deaths in hospital, and an increasing proportion of deaths to occur in care homes and private homes. In 2004, 57.9% of deaths occurred in hospital.</p> <p>In the UK, a study showed the main reasons for 52% of participants not achieving their preferred place of death were:</p> <ul style="list-style-type: none"> <li><u>-uncontrolled pain and complex symptoms</u></li> <li><u>-inability to guarantee 24-hour care in the community</u></li> <li><u>-delayed discharge from hospital; and</u></li> <li><u>-rapid deterioration and the concerns of relatives.</u></li> </ul> <p>(Damanhuri, D., 2014. What factors influence the terminally ill patient referred to the hospital specialist palliative care team in a NHS hospital,</p>

Dying in Place	
	not achieving their preferred place of death? A critical evaluation. BMJ Support Palliative care, 2014 March 4 Supp 1: A 54-55.)
Australia	<p>✗ facilitate dying in place</p> <p>In Australia, survey results have shown that people did not die in their preferred place because of:</p> <ul style="list-style-type: none"> <li>-patient and carer preferences</li> <li>-rapid and unexpected deterioration in patient condition</li> <li>-certain types of terminal conditions that require a level of palliative care hospitals are best equipped to provide the limited availability of carers and other health-care services; and an inability to manage at home.</li> </ul>
Canada	<p>✓ facilitate palliative home care services</p> <p>Most Canadians (75%) want to die at home, and a new report by the Canadian Institute for Health Information (CIHI) reveals that people who access palliative home care services in their last year of life are 2.5 times more likely to do so.</p>
Taiwan	<p>✓ facilitate hospice palliative care system</p> <p>Taipei, Oct. 6 (CNA) Taiwan is the best place to die in Asia, according to the 2015 Quality of Death (QOD) Index compiled by the Economist Intelligence Unit (EIU), leaping from 14th to sixth place on the index comparing end-of-life care in 80 countries.</p> <p>Taiwan's sixth place makes it the highest Asian country on the list. In a society where talk of death is usually taboo, the integration of community engagement for palliative care education and the encouragement of talking about death through the use of mainstream and social media have helped Taiwan successfully increase public awareness of palliative care, according to the EIU.</p> <p>Taiwan is one of the first few countries in the world to <b>introduce a hospice palliative care system</b>. In 2000, it passed the Hospice and Palliative Care Act, which provides its citizens with the right to issue do-not-resuscitate instructions.</p>

## Dying in Place

USA

✓ Acute care hospital / nursing homes

Studies have shown that approximately 80% of Americans would prefer to die at home, if possible. Despite this, 60% of Americans die in acute care hospitals, 20% in nursing homes and only 20% at home.

A minority of dying patients use hospice care and even those patients are often referred to hospice only in the last 3-4 weeks of life.

However, not every patient will want to die at home. Dying at home is not favored in certain cultures (due to cultural taboos) and some patients may wish not to die at home, out of concern that they might be a burden on the family. Still, it is clear that fewer patients are dying at home than want to do so (<https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/>)