

Legal recognition of advance refusal needed

The Hong Kong Law Reform Commission issued its Consultation Paper (LRCCP) on 'Substitute Decision-Making and Advance Directives in relation to Medical Treatment' (www.info.gov.hk/hkreform) in July 2004. It rejected giving legal status to advance directives.

An advance directive is a form of 'living will', which outlines the treatment desired when an individual lacks the capacity to make a decision of his own. This is called a living will because it is meant to operate whilst the maker is alive, albeit incapacitated. In view of the increasing treatment interventions now available, there is growing recognition that an individual has the right to refuse what may be considered an unnecessary prolongation of the dying process. Because a living will usually involves the refusal of life-sustaining treatment under certain defined circumstances, it is also called an advance refusal. The author argues that legal recognition of advance refusal is required to protect both doctors, and patients and their family.

It is of interest to note that the LRCCP also suggests that an advance directive can demand all possible available treatment. This is in reality not a real issue because a patient has no right in law to demand medically futile treatment. This legal position has been affirmed in a number of English cases, and is now reiterated in the Hong Kong Hospital Authority Guidelines on Life-sustaining Treatment in the Terminally Ill (The HA Guidelines 2002).

Current legal status of an advance refusal

In Hong Kong, no case law exists regarding the validity of an advance refusal. The validity of an advance refusal in common law is discussed, however, in an English case of *re T*: adult refusal of medical treatment. In that case, Lord Donaldson sets out four criteria for an advance refusal to be both valid and binding:

- (1) The patient has the necessary mental capacity;
- (2) The patient contemplates the actual situation which later arises;
- (3) The patient appreciates the consequences of refusing treatment; and
- (4) The patient is not unduly influenced by another person.

One difficulty with the common law is that it does not stipulate any formal requirements for an advance

refusal. Thus, an oral directive may be both valid and binding. Similarly, a written advance refusal, although not signed, dated, or witnessed, may also be both valid and binding. This may lead to uncertainty and give rise to disputes between a doctor and a patient's relatives over the patient's prior instructions.

Another difficulty with an advance refusal in common law concerns the scope of a directive. A doctor who is required to judge the applicability of an advance refusal in a life-and-death situation is likely to be concerned that legal liability may follow from wrongfully continuing to provide, or withdrawing life-sustaining treatment. For instance, in the case of *Malette v Shulman* (1990, Ontario Court of Appeal) a Jehovah's Witness woman carried a card stating: no blood transfusion in any circumstances. The doctor judged that it was inapplicable in a life-threatening condition after an accident. He proceeded with blood transfusion. The Ontario Court of Appeal held that the refusal was categorical even in a life-threatening condition. Consequently, the doctor was held liable.

In light of these difficulties, the law needs to provide clearer guidance to doctors on the validity of an advance refusal, and thus relieve doctors from any doubt concerning legal liability.

LRCCP recommendations

The LRCCP notes three advantages of legal recognition of advance refusal. These include:

- (1) format and manner of execution to be prescribed by law;
- (2) certainty for the individual and the doctor, thus reducing the likelihood of disputes; and
- (3) enhancing patients' autonomy.

The LRCCP also admits that having surveyed the law in some of the major common law jurisdictions, almost all have provided statutory recognition to advance refusal. It is therefore surprising that the LRCCP rejects legal recognition. Instead, it recommends continuing reliance on the common law as well as promoting the use of a non-statutory model form for advance refusal by the government.

Danger on using a non-statutory model form

The author believes that the use of a non-statutory

model form is insufficient for tackling the current problems. To make things worse, the use of the non-statutory model form may create two misconceptions, either of which may compound the difficulties doctors currently face. First, if the government promotes the use of the non-statutory model form, it may be thought to be the *only* option for making a valid advance refusal, when in fact, other possibilities also exist for making a valid advance refusal under the common law. Second, the non-statutory model form may convey the impression that the scope of an advance refusal is restricted to the withholding or withdrawing of life-sustaining treatment in cases of terminal illness, whereas in fact the common law does not contain this restriction, as may be seen in the case of *Malette v Shulman* above.

More importantly, if we assume that the use of advance refusal can be promoted successfully—whether by virtue of the non-statutory model form or not—then doctors must know to what extent they are obliged to honour an advance refusal, including situations in which the family objects. This, however, is not addressed by the LRCCP.

Legal obligations created by an advance refusal

Where a patient makes a valid advance refusal, it is legally binding and a doctor must comply. There are various approaches that can be taken to clarify a doctor's obligations under the law. For instance, the Singapore Advance Medical Directive Act 1996 provides that a doctor is duty bound to act in accordance with an advance refusal. It further provides that a doctor shall not be subject to civil or criminal liability or to discipline for professional misconduct for a decision made by him/her in good faith and without negligence. Finally, where a doctor has a conscientious objection to carrying out an advance refusal, he is duty bound to take all reasonable steps for

the care of the patient to be transferred to another doctor who does not so object.

Status of family objection

Another crucial issue overlooked by the LRCCP is that by failing to accord legal status to an advance refusal, an individual's right to self-determination is pitched against the weight of the family's views, with doctors potentially in the middle of any dispute arising.

In Hong Kong, the family plays an important role in decision-making in the case of an incompetent adult. However, the HA Guidelines 2002 states that when a patient has lost the capacity to decide, a valid advance directive refusing life-sustaining treatment should be respected. In light of the HA Guidelines 2002, it is vital that the law affirms the same approach, eliminating any possible ambiguities.

Conclusion

The law currently does not specifically cater for advance refusal. Law reform is therefore appropriate first to allow for this possibility, and second, to clarify the obligations of doctors. Legislation needs to include additional provisions, for example, to protect doctors from liability when they act in good faith. It also needs to make clear that advance refusal does not allow for the refusal of basic care (or nursing care) or palliative care.

(This paper was presented at the 11th Scientific Meeting of the Pacific Rim College of Psychiatrists, Hong Kong, 28-31 October 2004.)

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