Original Article

Advance directives in Hong Kong: moving forward to legislation

Ben Y. F. Fong[1]^, Hilary H. L. Yee[2]^, Tommy K. C. Ng[2]^

[1]College of Professional and Continuing Education, The Hong Kong Polytechnic University, Hong Kong, China; [2]School of Professional Education and Executive Development, The Hong Kong Polytechnic University, Hong Kong, China

Contributions: (I) Conception and design: All authors; (II) Administrative support: TKC Ng; (III) Provision of study materials or patients: HHL Yee, TKC Ng; (IV) Collection and assembly of data: All authors; (V) Data analysis and interpretation: HHL Yee; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Correspondence to: Hilary H. L. Yee, BSc. School of Professional Education and Executive Development, The Hong Kong Polytechnic University, Hong Kong, China. Email: hilaryee633@yahoo.com.hk.

Background: An advance directive (AD) is a legal statement indicating the form of healthcare the patient would like to receive at a future time when he/she is no longer mentally competent to make decisions. As there are increased concerns to respect the preferences of medical treatment of patients suffering from terminal illnesses, AD receives more attention and recognition in healthcare settings. However, Hong Kong has neither statue nor direst case law on the legal status of AD. A public consultation was therefore launched by the government in 2019. The present study aimed to examine the views towards ADs in response to the proposed legislation.

Methods: Fifty-nine responses were received from questionnaires and the findings formed a protocol and guideline for the focus groups. Twenty-three participants participated in two focus group discussions. A thematic analysis revealed three themes of views towards ADs legislations: public awareness, completion of ADs, and dying in place.

Results: Older and young participants held slightly different views on the acceptance of verbal and written format, and the presence of witnesses of ADs. Overall, participants considered the general public did not have adequate knowledge of AD.

Conclusions: Findings suggested that public education should be enhanced, and guidance and protocols for healthcare professionals were needed after legislation of ADs. In addition, dying in place should also be facilitated while legislative barriers on Coroners Ordinance should be amended.

Keywords: Advance directives (ADs); legislations; public awareness; dying in place

Submitted Dec 16, 2021. Accepted for publication May 12, 2022.
doi: 10.21037/apm-21-3783
View this article at: https://dx.doi.org/10.21037/apm-21-3783

Introduction

From the perspective of many clinicians, death is traditionally considered as a failure and palliation as an act of giving up hope (1). However, prolonging a person's lifespan may also increase the suffering. With the emphasis of quality of life in healthcare, end-of-life (EOL) issues have been increasingly recognised (2). Completion of advance directive (AD) is a part of the advance care planning, which ensures that patients receive medical treatment that is consistent with their "values, goals and preferences during serious and chronic illnesses" (3). A person, when mentally competent, can express a decision regarding place of care, specific medical treatments and life supports by completing the AD (4).

The development of AD is based on the principle of informed consent and a belief in patient's autonomy

---

^ ORCID: Ben Y. F. Fong, 0000-0003-0909-0674; Hilary H. L. Yee, 0000-0001-5508-7797; Tommy K. C. Ng, 0000-0002-7715-9533.

regarding his or her healthcare decisions (5). It has been shown that AD is effective in improving satisfaction of EOL and it also helps to minimise the decisional conflict of healthcare surrogates and hospitalisation (6). By 2018, 15 out of 28 member states of the European Union have enacted specific rules on AD, as well as other developed countries including the United States and Singapore (6,7). Although more than half of the European Union countries have developed law on AD, some countries like Italy, Sweden and Ireland are still in the progress of gaining a social agreement in order to pass an official law on AD (7).

There are studies and research conducted to investigate the perceptions, attitudes and knowledge on AD among Hong Kong people. An early study showed that older adults in nursing homes had a high prevalence for AD and agreed to have treatment to keep them comfortable even if the care might shorten their life (8). Another study conducted in 2011 revealed that elderly participants with chronic diseases accepted the concept of withdrawing life-sustaining treatment in medically futile situations, despite most of them had not heard about AD before (9).

Studies conducted in Hong Kong in recent years showed higher acceptance of AD. For instance, Chung *et al.* found that out of 1,067 participants who were aged over 30, more than 900 of them had not heard about AD but 60.9% of them indicated they would make their own AD (1). A more recent study found that although 80% of the 2,002 participants in the study had heard about AD, only 0.5% had made the AD, showing a low completion rate (5). The participants agreed that people should be mentally prepared and there should be effective communication with healthcare professionals to discuss about the completion of AD (5). The study also highlighted that enhancement of public awareness and education of family in making decision on AD and their involvement were of utmost importance (5).

Despite the increasing interest, AD is still not well known among people in Hong Kong and there are no legal implications (10). Currently, patients are relying on the general requirement for their consent to receiving medical treatment under the common law to make validly-made AD and refusing life-sustaining treatment. As there are no legal implications, family members have the right against the signed AD made by the patient when being mentally competent. The legislation work of AD in Hong Kong is in slow progress, even after two public consultations in 2009 and 2019. The government had recognised the potential advantages of AD and issued the first public consultation on AD in 2009 (11). After the consultation, a standard form of AD was issued by the Hospital Authority (HA) with a detailed guideline for clinicians. By 2018, there were only 5,561 AD made with HA in Hong Kong (12). Another public consultation was conducted in 2019 and the government had responded by stating that the drafting of the bill for AD legislation would be proceeded in the next term of the Legislative Council, which would be 2022.

To gauge the responses to the AD public consultation in 2019, the aim of the study was to examine the views and awareness towards legislation of AD in Hong Kong. To our knowledge, there are no studies conducted in Hong Kong comparing the views on AD legislation between older and young university students. In addition, as everyone can be a caregiver and may play an important role in EOL communication for family members, healthy participants who had not made an AD before was targeted in this study in order to obtain their concerns and insights for the AD draft bill in the next Legislative Council in 2022. We presented the following article in accordance with the COREQ reporting checklist (available at https://apm.amegroups.com/article/view/10.21037/apm-21-3783/rc).

Methods

Study design and participants

The study employed both quantitative and qualitative methods to explore the attitudes and awareness of AD in Hong Kong. Recruiting by internal mass emails, participants were students and staff from the School of Professional Education and Executive Development of The Hong Kong Polytechnic University (PolyU SPEED). A total of 2,600 emails were sent to recruit students and staff who had not made an AD before. Respondents were also invited to participate in focus group discussion. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The present study followed The Code of Ethics for Research Involving Human Subjects of PolyU SPEED. Since all participants had given informed consent and no intervention like test or exercising programme were involved, no further ethical approval was required. All participation was voluntary, without any reimbursement provided.

Data collection

The quantitative phase involved an online questionnaire conducted between September and November of 2019.

The questionnaire was adopted from the consultation document "Public Consultation on End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place". The questionnaire, in both English and Chinese versions, consisted of 30 questions (13) (Appendix 1). The electronic version of consultation document was attached to the email for participants to go through before answering the questionnaire. Participants were required to answer 30 questions by selecting "Yes" or "No".

In the qualitative phase, a checklist of consolidated criteria for reporting qualitative research was followed (14). Questions with neither predominantly "Yes" or "No" answers were selected from the results of the questionnaire to form the question protocol and guideline for group discussion to obtain more details about public acceptance of AD and verbal and writing documentation of AD. A semi-structured interview guide was developed based on the questions in the consultation document. Two focus group discussions were conducted in Cantonese on 31 October 2019 and 4 November 2019 in a classroom in PolyU SPEED. Participants gave informed consent and the interviews were audiotaped. All participants did not disclose their names and were given a participant number (i.e., participant 1, participant 2 …) during the discussions. At the beginning of each focus group interview, the objectives and purposes of the research were explained by a moderator. One male and one female researcher who had experiences in conducting focus group discussion, were present, acting as note-takers and monitoring the discussion time. The moderator ensured that no new information was generated in a question before moving to the next question.

Data analysis

All recorded discussions were transcribed verbatim and input to Qualitative Data Analysis (QDA) Miner 5 of Provalis Prosuite by two researchers. Notes taken during discussion sessions were also compared. Following the six phases of analysis by Braun and Clarke [2006] (15), the two researchers read the transcripts of two focus group discussions repeatedly to familiarize the contents and to identify principal messages and keywords from the transcripts. Thematic analysis was conducted, and initial codes were developed inductively from the data set (15). The researchers carried out the coding independently, and each created code was compared, discussed and tested in detail. The researchers organized different codes and collated the relevant data into potential categories and themes. They then reviewed the identified themes and categories in detail and revised them to ensure consistency where necessary. They also discussed the data coding to avoid and resolve variance in interpretation between them.

Results

In total, 59 eligible responses were received from the questionnaires. More than 70% of 59 participants agreed that the public at large was ready to accept the concept of AD and there should be clearer legal provisions for AD. More than 80% participants thought that the objective of an AD was to minimise distress or indignity when the patient was suffering from an irreversible illness. 90% of the participants agreed that an AD must be witnessed, and a person could revoke or modify an AD at any time. The results of each question are presented in the Appendix 1.

In the qualitative part of this study, 10 questions without obvious majority of "Yes" or "No" responses in the questionnaire were selected as the questions protocol in focus group discussion. In addition, Question 1 of the questionnaire was used to start with the discussion and Question 10 was also included in the question protocol to ask participants about the format of AD. Question 13 was chosen to allow participants to discuss about possible hurdles when amending an AD. Hence, a total of thirteen questions were selected to form the question protocol of the focus group discussion.

Twenty-three participants were assigned into two groups and each focus group lasted for approximately 60 minutes. Grouped by age, the first group consisted of older participants aged from 50 to 65 years, while the second group had young participants aged from 20 to 25 years. 11 participants of the first focus group comprised one male and ten female students of the Diploma in Active Ageing programme of PolyU SPEED (DAA group). Participants of the second focus group included 12 undergraduate students in Health Studies of PolyU SPEED, with seven females and five males (Health Studies group). All participants completed the focus group discussions.

Three themes were generated, namely "Public awareness", "Completion of AD", and "Dying in place". Under the theme "Completion of AD", four categories were resulted, namely "Verbal or written format", "Witnesses", "Information storage", and "Resuscitation". *Table 1* presented the themes and categories, with example of quotes.

Table 1 Theme of “Public awareness”, “Completion of AD”, and “Dying in place” with examples of direct quotes

Theme	Category	Examples of direct quotes
Public awareness	N/A	“*I have never heard of AD until my church organized a talk about that. The audience also said it was their first time to know what AD is*” (older participant from DAA group)
		“*I think it is similar to organ donation in some way, that people know about AD but with only very few of them actually make an AD*” (younger participant from Health Studies group)
Completion of AD	Verbal or written format	“*Verbal revocation should be invalid as there are chances of misunderstanding when conveying the Messages*.” (older participant from DAA group)
		“*Perhaps a video tape recording could be added as evidence to prove the patient was acting on his/her own will*.” (younger participant from Health Studies group)
		“*There should be a formal format and requirement of contents to direct people to write and sign an AD. If no formal structure to guide people in making AD, it may lead to difficulty for doctors or medical personnel to read the AD*.” (younger participant from Health Studies group)
		“*When the situation is very urgent and there is limited time to find a statutory prescribed form, I think a model from should still be legally valid under doctor’s approval and witnessing*.” (older participant from Health Studies group)
	Witnesses	“*Without a witness, other family members may argue that the changes on the AD are not according to the will of that patient*.” (older participant from DAA group)
		“*A witness has no right to oppose or revoke the AD anyway, so a witness is not required*.” (younger participant from Health Studies group)
		“*Sometime there is insufficient time to find a suitable person to witness the process of revocation. The requirement of a witness at that moment would cause inconvenience*.” (younger participant from Health Studies group)
	Information storage	“*A centralised system should be developed to allow both hospital medical team and ambulance to have access to information of AD*.” (older participant from DAA group)
		“*An AD card similar to the organ donation card, can be put inside the wallet*.” (younger participant from Health Studies group)
		“*E-signature should be allowed when making or amending an AD, just like what the banks are doing*” (younger participant from Health Studies group)
	Resuscitation	“*The current law requires emergency rescue personnel to perform CPR under all circumstances. Therefore, a central system that allows both rescue personnel and medical teams to access information, including AD and DNACPR of the patient, could avoid unnecessary resuscitation that violates the will of the patient*.” (younger participant from Health Studies group)
Dying in place	N/A	“*RCHE is a home to elderly and patient’s will to die in place (i.e., RCHE) should be respected. The attending doctor should have confirmed the last stage of condition of the patient when he/she was approaching death in RCHE. So the report to Coroners Ordinance should be exempted*”. (older participant from DAA group)
		The *law states that once the RCHE resident had been attended by a registered medical practitioner within 14 days before death, reporting to the Coroner is not required. However, most RCHE would protect themselves by sending the patient to the hospital*”. (younger participant from Health Studies group)

AD, advance directive; DAA, Diploma of Active Ageing; CPR, cardiopulmonary resuscitation; DNACPR, do not attempt cardiopulmonary resuscitation; RCHE, residential care homes of elderly

Public awareness

Both groups shared similar views on the public awareness of AD. Participants generally thought public acceptance of AD was high, but the public was unfamiliar with the actual concept of AD. Participants from the Health Studies group said they only had an overall concept of AD, but not in detail. Half of the participants from the DAA group mentioned that they did not know about AD until they had someone close to them being recommended to make AD by doctors. A participant from the Health Studies group stated that the situation was similar to organ donation in some way, that very few people actually made an AD.

Completion of AD

Verbal or written format

Both groups emphasised the important role of doctors in certifying the patient as being fully conscious, and physically and/or mentally capable of signing the AD. The DAA group tended to agree that AD should be made in writing and could be modified, just like a will. They explained that a written AD would be the physical evidence to show that the patient had signed the AD. They disagreed with the acceptance of a verbal revocation, because there would be arguments as there was no actual evidence to prove that it was really the wish of the person concerned.

The young participants of the Health Studies group suggested that both verbal and written formats should be accepted as long as the doctors knew that the patient was fully conscious when signing an AD. Two participants suggested to develop an electronic system to store the signed AD. Another participant suggested to add a video tape recording as evidence to prove the person was acting on his/her own will.

Regarding the written form, participants in both groups agreed to adopt both model form and statutory prescribed form as being legally valid. A participant from the Health Studies group pointed out that a formal format could clearly guide people in making an AD and doctors and medical personnel could easily read the AD. Another participant suggested that a model form should still be legally valid under doctor's approval and witnessing under a very urgent situation.

Witnesses

Participants in DAA group held mixed views on whether one or more witnesses should be required in the revocation of AD. They thought the presence of witness could provide stronger proof that the person had signed or revoked the AD on his/her will, to convince family members. However, some participants argued that involving more stakeholders would create hurdles when the patient suddenly wanted to modify the AD.

Participants in the Health Studies held a different point of view that they thought a witness should not be required when an AD had to be revoked. They stated that the person who made the AD should have already understood clearly the nature of AD, with the explanation by his/her attending doctor. A participant mentioned that a witness is not required as a witness should not has the right to oppose or revoke the AD anyway. Another young participant added that it was possible that there is insufficient time to find a suitable person to witness the process of revocation, therefore requiring a witness would cause inconvenience.

Information storage

Both groups had mentioned the importance of having a central system to store the information of AD. They commented that carrying an original hardcopy of AD all the time would be inconvenient. Some participants pointed out that there would be doubts on the validity of AD if the hardcopy was soiled or partly fragmented. Participants suggested to have a centralised system to allow both hospital medical team and ambulance to have access to the information of AD, and an AD card can be put inside the wallet.

Resuscitation

Participants also discussed how to handle a patient designated for 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' and without an AD during emergency. Participants in DAA group thought that the healthcare team should have the professional knowledge to explain the decision of not performing cardiopulmonary resuscitation (CPR) was in the best interest of the patient. Participants in Health Studies group also suggested that a central system that allows both rescue personnel and medical teams to access AD and DNACPR information of the patient could avoid unnecessary resuscitation that violates the will of the patient.

Dying in place

To facilitate the planning of AD and avoid repeated admissions to hospitals for elderly living in Residential

Care Homes of Elderly (RCHE), participants of both groups agreed to amend the current Coroners Ordinance. Participants in Health Studies group pointed out the flaws of the current law, and that the report to Coroners Ordinance should be exempted when an attending doctor confirmed the last stage of condition of the patient living in RCHE. Participants also pointed out that most RCHE did not have adequate manpower or facilities to take care of elderly residents during the EOL stage and to facilitate dying in place. There was a need to formulate better measures to promote AD and dying in place in Hong Kong.

Discussion

This study had collected opinions on the legislative proposals on AD and dying in place, in response to the public AD consultation document of 2019. Participants considered AD as a good approach and the public at large was ready to accept the concept. The results showed that the older and young participants held slightly different views on the acceptance of verbal and written, and the presence of witnesses. Regardless of the age, participants considered that the general public did not have adequate knowledge of AD. In this digital age, participants suggested to store AD information in a centralised system and granting access to medical team and emergency rescue personnel.

Participants agreed that the acceptance of AD was higher compared to years ago, but the general public in Hong Kong were still insufficiently aware of the pros and cons of AD. Findings from a study showed an inadequacy in the promotion of AD to the public had caused a lack of awareness and familiarity with it (5). As receiving adequate information and knowledge about AD were found to affect completion of AD, earlier public education in promoting the concept could empower patients to make their own healthcare preference (5,16,17). In addition, discussion about AD among patients and medical professionals should be held in time, not at the late stage of life. Powers [2020] suggested education of AD should be integrated into the public health approach to increase public engagement in EOL issues, and stimulate discussion of AD (18). Apart from enhancing public education, guidance and protocols for concerned healthcare professionals, not restricting to those in oncology or palliative care, were also needed to be improved. This could facilitate better decision-making process and communication between medical professionals and patient's family members, and most importantly the patients themselves (19).

Participants in this study regarded the attending doctors as being responsible to ensure that the AD was applicable to the patient and the patient was fully conscious when signing an AD. However, different medical cases or scenarios could put the clinicians under pressure. Therefore, it is also important to safeguard the responsibility of service providers, and healthcare professionals should be exempted from disciplinary proceedings for professional misconduct for a decision made in good faith and for reasonable care. The healthcare workforce should have the knowledge to decide whether an AD is clear and has not been withdrawn, and applicable to the person who has pre-specified conditions (20). Patients and their carers would rely on the suggestions of treatment option by clinicians and it is important to ensure clinicians are equipped with AD knowledge and communication skills to initiate AD-related discussion (21). Hence, policies should clearly outline the roles and responsibilities of the relevant healthcare workforce with regards to AD (4).

There are potentially arguments on whether changes on AD are really the will of the patients, as verbal statement alone may not be strong enough to convince family members. Thus, the format of revocation and the presence of witnesses are important concerns. Being different from the young group in this study, the older participants would only consider written format of AD as being valid. Taking other countries as references, Singapore and United States accept verbal and written AD revocation, subject to the presence of witnesses (22,23), while the law in Australia states that only written revocation of AD is accepted (22). To minimise unnecessary hurdles, both verbal and written formats of revocation should be accepted as valid, but the verbal format must be witnessed by clinicians. An important feature of implementation of AD is information storage. To prevent the missing of original copy of AD and fragmentation of it, participants agreed that an original copy of AD was not required but the information of AD should be stored in a centralised system, like the Electronic Health Record Sharing System (eHRSS). Ideally the system should be accessible by designated healthcare professionals and emergency rescue personnel to allow for appropriate medical treatment in a timely manner or to avoid overtreatment. Such arrangement also has the potential benefits such as increasing the accuracy of communication and achievement of preventative care goals in advance care planning (24,25). On the other hand, there could be potential differences between the original copy of AD and electronic version due to the time gap, change of mind or updating process. A well designed system should help to keep AD information up-to-date and be easy to use (25).

Dying in place should also be supported in order to facilitate the implementation of AD. Some people feel most comfortable and less medicalized when dying in a preferred place as compared to those who die in a hospital setting or intensive care unit (26). It has been reported that home death is associated with higher quality of death compared to hospital death (1,27,28). There are others who prefer palliative care unit as the preferred place of death, subject to the provision of necessary support in the dying phase (20). However, the current Coroners Ordinance demands all deaths in RCHE be reported to the Coroner, regardless of whether the person is diagnosed as having terminal illness, or has been attended by a medical practitioner. This is a barrier for people to die in place of their choice and planning in AD.

Therefore, it is suggested to amend the requirements such that when residents living in RCHE have once attended by a registered medical practitioner, and having been considered a terminal case within 14 days prior to death, their subsequent deaths should not be required to report to the Coroner. In this connection, healthcare setup and facilities in RCHE have to be enhanced to support the arrangements for dying in place. It has been reported that staff in nursing homes have experienced helplessness in the face of suffering, confusion, and communication problems during the provision of EOL care (29). Hence, to support dying in place in RCHE, training and education to staff with the knowledge about EOL issues and dying process, and management of symptoms are needed (29). More discussion on the provision of quality EOL care services in institutions will be required in the society.

This study has a number of limitations. First, the sample size was small and the age groups included were only limited in aged from 20 to 25 years and from 50 to 65 years. Second, participants in the focus groups were all educated and may have different views towards EOL issues compared to those who are less educated. The gender included in the focus group discussion was also imbalanced, resulting in a gender bias. Therefore, the results may not precisely reflect views of other age groups or those who have different educational background. Participants in this study had not made an AD before so they did not have actual experience in situations where an AD was needed to be signed. Therefore, the actual difficulties and barriers would not have been reflected. Although the current study reflects that most participants accept ADs, this topic is still relatively new in Hong Kong. Thus, research with a larger sample size and wider age groups is needed to generate more data.

Conclusions

AD can be an advance refusal of life-sustaining treatments to minimise distress or indignity when an individual is facing a serious or irreversible illness, facilitating the quality of EOL. Response of the Hong Kong Government to the consultation in 2019 was an important milestone in the development of EOL care. Although the present study reflected that AD had received more attention and the acceptance of AD was higher, most participants had pointed out that the general public was still unfamiliar with the detail information of AD. The different views towards the format of AD and presence of witnesses suggested that a legislation on AD was vital to provide a clear concept for the public, as well as protocol for healthcare professionals to assist in preparation of AD planning. To facilitate data storage and implementation of AD, an electronic health system to align and share information of AD and care plans is needed to ensure the synchronization of care preferences. The proposed legislation on AD is expected to remove current legal impediments, and to better respect personal choice of medical treatment in EOL care with legal protection. Meanwhile, education programme in the community should be conducted in order to raise people's awareness on AD. Challenges and barriers are inevitable in the legislative work, but with the collaboration between various government departments and stakeholders, the final draft bill in the next Legislative Council in 2022 would be a big step forward to AD legislation in Hong Kong.

Acknowledgments

The authors would like to thank the staff and students of PolyU SPEED, and students of the Diploma in Active Ageing for the participation and support of this study.
Funding: The work described in this paper was fully supported by a grant from the Research Grants Council of the Hong Kong Special Administrative Region, China (Project Reference No. UGC/IDS24/18).

Footnote

Reporting Checklist: The authors have completed the COREQ reporting checklist. Available at https://apm.amegroups.com/article/view/10.21037/apm-21-3783/rc

Data Sharing Statement: Available at https://apm.amegroups.com/article/view/10.21037/apm-21-3783/dss

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at https://apm.amegroups.com/article/view/10.21037/apm-21-3783/coif). BYFF reports receiving funding from Research Grants Council of the Hong Kong Special Administrative Region, China (Project Reference No. UGC/IDS24/18), Research Grants Council of the Hong Kong Special Administrative Region, China (Project Reference No. UGC/IDS24/18). The other authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The present study followed The Code of Ethics for Research Involving Human Subjects of PolyU SPEED. Since all participants had given informed consent and no intervention like test or exercising programme were involved, no further ethical approval was required.

References

1. Chung RY, Wong EL, Kiang N, et al. Knowledge, Attitudes, and Preferences of Advance Decisions, End-of-Life Care, and Place of Care and Death in Hong Kong. A Population-Based Telephone Survey of 1067 Adults. J Am Med Dir Assoc 2017;18:367.e19-27.
2. Hinderer KA, Lee MC. Chinese Americans' attitudes toward advance directives: An assessment of outcomes based on a nursing-led intervention. Appl Nurs Res 2019;49:91-6.
3. Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage 2017;53:821-832.e1.
4. Coffey A, McCarthy G, Weathers E, et al. Nurses' knowledge of advance directives and perceived confidence in end-of-life care: a cross-sectional study in five countries. Int J Nurs Pract 2016;22:247-57.
5. Chan CWH, Wong MMH, Choi KC, et al. Prevalence, Perception, and Predictors of Advance Directives among Hong Kong Chinese: A Population-based Survey. Int J Environ Res Public Health 2019;16:365.
6. Kim E, Lee KS. Factors associated with willingness to complete advance directives in older adults. Geriatr Nurs 2021;42:1042-7.
7. Rodado EP, Sanchez DP, Grifo MG. Advance Directives. Comparison of current legislation within the European Union. Spanish J Legal Med 2021;47:66-73.
8. Chu LW, Luk JK, Hui E, et al. Advance directive and end-of-life care preferences among Chinese nursing home residents in Hong Kong. J Am Med Dir Assoc 2011;12:143-52.
9. Ting FH, Mok E. Advance directives and life-sustaining treatment: Attitudes of Hong Kong Chinese elders with chronic. Hong Kong Med J 2011;17:105-11.
10. Kawakami A, Kwong EW, Lai CK, et al. Advance care planning and advance directive awareness among East Asian older adults: Japan, Hong Kong and South Korea. Geriatr Gerontol Int 2021;21:71-6.
11. Food and Health Bureau. Introduction of the concept of advance directives in Hong Kong [internet]. 2009 [cited 2021 Nov 1]. Available online: https://www.fhb.gov.hk/download/press_and_publications/consultation/091223_advance_directive/ad_consultation_paper_en.pdf
12. Legislative Council of the Hong Kong Special Administrative Region of China. Advance healthcare directives of patients [Internet]. 2021 [cited 2021 Nov 4]. Available online: https://www.legco.gov.hk/research-publications/english/essentials-1819ise07-advance-healthcare-directives-of-patients.htm
13. Food and Health Bureau. End-of-life Care: Legislative proposals on Advance Directives and Dying in Place [Internet]. 2019 [cited 2021 Nov 5]. Available online https://www.fhb.gov.hk/download/press_and_publications/consultation/190900_eolcare/e_EOL_care_legisiative_proposals.pdf
14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care 2007;19:349-57.
15. Braun V, Clarke V. Using thematic analysis in psychology.

Qual Res Psychol 2006;3:77-101.
16. Leong SM, Tam KI, Che SL, et al. Prevalence and Predictors of Willingness to Make Advance Directives among Macao Chinese. Int J Environ Res Public Health 2021;18:7942.
17. Jang Y, Park NS, Chiriboga DA, et al. The Knowing-Doing Gap in Advance Directives in Asian Americans: The Role of Education and Acculturation. Am J Hosp Palliat Care 2017;34:874-9.
18. Powers JS. Promoting advance directive discussions. Palliat. Med. Hosp. Care Open J 2020;6:e3.
19. Kwok YL, Leung WM. Advance directives in Chinese patients with cancer: A retrospective study in a single palliative care unit. J Pain Manag 2018;11:31-40.
20. Tse CY. Advantages of legislation for advance directives in Hong Kong and areas of concern for clinicians. Hong Kong Med J 2021;27:309-11.
21. Sutherland R. Dying Well-Informed: The Need for Better Clinical Education Surrounding Facilitating End-of-Life Conversations. Yale J Biol Med 2019;92:757-64.
22. The Law Society of Hong Kong. Consultation paper on end-of-life care legislative proposals on advance directives and dying in place [Internet]. 2020 [cited 2021 Nov 4]. Available online: https://www.hklawsoc.org.hk/-/media/hkls/pub_e/news/submissions/20191203.pdf?rev=a6a6f1ea12cc4fa89a8254c632ec33f6
23. Justia Advance directives and living wills forms: 50-state resources[internet]. 2021 [cited 2021 Nov 3]. Available online: https://www.justia.com/estate-planning/estate-planning-probate-forms-50-state-resources/forms-for-advance-directives-living-wills/#kansas
24. Lemon C, De Ridder M, Khadra M. Do Electronic Medical Records Improve Advance Directive Documentation? A Systematic Review. Am J Hosp Palliat Care 2019;36:255-63.
25. Portz JD, Lum HD, Bull S, et al. Perceptions of Patient Portal Use for Advance Directive Documentation among Older Adults with Multiple Chronic Conditions. J Soc Work End Life Palliat Care 2020;16:238-49.
26. Woo RK, Kwok AO, Tse DM. Preferred place of care and death among the terminally ill: Asian perspectives and implications for Hong Kong. In: Fong B, Ng A, Yuen P. editors. Sustainable Health and Long-Term Care Solutions for an Aging Population 2018:277-93. IGI Global.
27. Gomes B, Calanzani N, Koffman J, et al. Is dying in hospital better than home in incurable cancer and what factors influence this? A population-based study. BMC Med 2015;13:235.
28. Kinoshita H, Maeda I, Morita T, et al. Place of death and the differences in patient quality of death and dying and caregiver burden. J Clin Oncol 2015;33:357-63.
29. Cagle JG, Unroe KT, Bunting M, et al. Caring for Dying Patients in the Nursing Home: Voices From Frontline Nursing Home Staff. J Pain Symptom Manage 2017;53:198-207.

Cite this article as: Fong BYF, Yee HHL, Ng TKC. Advance directives in Hong Kong: moving forward to legislation. Ann Palliat Med 2022;11(8):2622-2630. doi: 10.21037/apm-21-3783

Appendix 1

The results of the questionnaire from consultation document "Public Consultation on End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place".

Food and Health Bureau. End-of-life Care: Legislative proposals on Advance Directives and Dying in Place [Internet]. 2019 [cited 2021 Nov 5]. Available from https://www.fhb.gov.hk/download/press_and_publications/consultation/190900_eolcare/e_EOL_care_legisiative_proposals.pdf.

Questions	Yes	No
(1) *Do you think that the public at large is ready to accept the concept of advance directives?*	43	13
(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?*	45	10
(3) *Do you agree with the above fundamental principles* (respecting a person's right to self-determination; a valid and applicable advance directive; a person should have the primary responsibility of keeping an advance directive; sufficient safeguards should be provided to preserve lives)?	57	1
(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?*	49	7
(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?*	45	13
(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?*	53	5
(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?*	22	36
(8) *Do you agree that a person may revoke or modify an advance directive at any time?*	54	4
(9) *Do you agree that an advance directive must be made or modified in writing?*	34	21
(10) *Do you agree that both verbal and written revocation of an advance directive should be accepted?*	42	11
(11) *Do you agree that a legally-valid advance directive must be witnessed as safeguard?*	55	3
(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?*	47	10
(13) *Do you agree that written revocation of advance directive need not be witnessed to avoid imposing unnecessary hurdles?*	17	41
(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?*	21	37
(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?*	29	28
(16) *Do you think that the proposed safeguards* (The original copy of the advance directive should be presented under normal circumstances; The advance directive should be sufficiently clear and is not being challenged; The advance directive must not have been withdrawn; The person has not done something that clearly goes against the advance directive which suggests that he/she has changed his/her mind) *to ensure validity of an advance directive are sufficient?*	25	32
(17) *Do you think 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?*	52	6
(18) *Do you think that the proposed safeguards* (not be applicable if the patient has the capacity to make the decision when the treatment concerned is proposed; not be applicable to treatments or conditions not specified in the advance directive; not be applicable if there are reasonable grounds for believing that the current circumstances were not anticipated by the patient and, if they had been anticipated by him/her, would have affected his/her decision) *to ensure the applicability of advance directives are sufficient?*	23	33
(19) *Do you agree to allow emergency rescue personnel to accept advance directives with signed DNACPR forms attached and not attempt CPR?*	34	21
(20) *Do you agree to the use of a model DNACPR form, rather than a statutory prescribed form?*	24	33
(21) *Do you agree to allow emergency rescue personnel 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?*	30	28
(22) *Do you agree that the advance directive document may be recorded in eHRSS?*	49	6
(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?*	46	12
(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?*	42	16
(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?*	45	13
(26) *Do you agree with the proposed arrangements on liability* (a treatment provider does 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 advance directive does not exist; a treatment provider does not incur any civil or criminal liability for the consequences of withholding or withdrawing a treatment from individuals if, at the time, he/she reasonably believes that a valid and applicable advance directive exists; a treatment provider does not incur any civil or criminal liability for carrying out or continuing CPR if, at the time, he/she reasonably believes that a valid and applicable DNACPR form does not exist)?	47	10
(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?*	49	8
(28) *Do you agree with the proposed consequential change to the Mental Health Ordinance to remove the potential conflict?*	52	6
(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 RCHEs from reportable deaths?*	29	28
(30) *Do you think that the proposed safeguard for RCHE residents is sufficient if deaths in RCHEs may be exempted from reportable deaths?*	12	44

CPR, cardiopulmonary resuscitation; DNACPR, do not attempt cardiopulmonary resuscitation; eHRSS, Electronic Health Record Sharing System; RCHE, residential care homes of elderly.