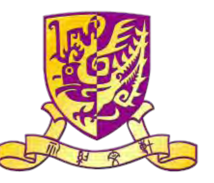

Overview of End-of-Life Care in Hong Kong Now and to the Future

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JCECC Conference: Collaboration in Creating Compassionate Holistic End-of-Life Care for the Future

World's Quality of Death By Ranking

An Economist Intelligence Unit study, commissioned by the Lien Foundation

THE 2015 QUALITY OF DEATH INDEX

RANKING PALLIATIVE CARE ACROSS THE WORLD

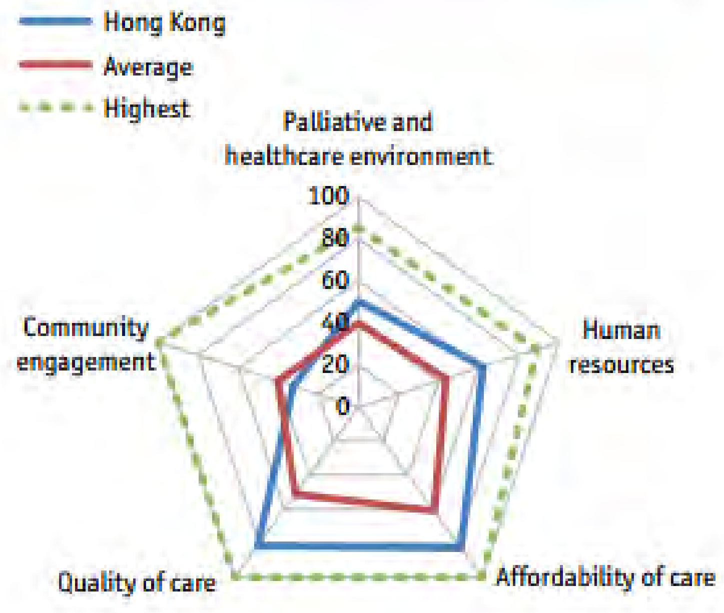
KEY FINDINGS INFOGRAPHIC

Figure 1.2

2015 Quality of Death Index—Overall scores

Rank	Country	Score
1	UK	93.9
2	Australia	91.6
3	New Zealand	87.6
4	Ireland	85.8
5	Belgium	84.5
6	Taiwan	83.1
7	Germany	82.0
8	Netherlands	80.9
9	US	80.8
10	France	79.4
11	Canada	77.8
12	Singapore	77.6
13	Norway	77.4
14	Japan	76.3
15	Switzerland	76.1
16	Sweden	75.4
17	Austria	74.8
18	South Korea	73.7
19	Denmark	73.5
20	Finland	73.3
21	Italy	71.1
22	Hong Kong	66.6
23	Spain	63.4
24	Portugal	60.8
25	Israel	59.8
26	Poland	58.7
27	Chile	58.6
28	Mongolia	57.7
29	Costa Rica	57.3
30	Lithuania	54.0
31	Panama	53.6
32	Argentina	52.5
33	Czech Republic	51.8
34	South Africa	48.5
35	Uganda	47.8
36	Cuba	46.8
37	Jordan	46.7
38	Malaysia	46.5
39	Uruguay	46.1
40	Ecuador	44.0
41	Hungary	42.7
42	Brazil	42.5
43	Mexico	42.3
44	Thailand	40.2
45	Venezuela	40.1
46	Puerto Rico	40.0
47	Turkey	38.2
48	Russia	37.2
49	Peru	36.0
50	Kazakhstan	34.8
51	Ghana	34.3
52	Morocco	33.8
53	Indonesia	33.6
54	Tanzania	33.4
55	Slovakia	33.2
=56	Egypt	32.9
=56	Greece	32.9
58	Vietnam	31.9
59	Zimbabwe	31.3
60	Saudi Arabia	30.8
61	Zambia	30.3
62	Bulgaria	30.1
63	Kenya	30.0
64	Romania	28.3
65	Sri Lanka	27.1
66	Malawi	27.0
67	India	26.8
68	Colombia	26.7
69	Ukraine	25.5
70	Ethiopia	25.1
71	China	23.3
72	Botswana	22.8
73	Iran	21.2
74	Guatemala	20.9
75	Dominican Republic	17.2
76	Myanmar	17.1
77	Nigeria	16.9
78	Philippines	15.3
79	Bangladesh	14.1
80	Iraq	12.5

Hong Kong Ranked 22 in the world!



	Rank/80	Score/100
Quality of Death overall score (supply)	**22**	**66.6**
Palliative and healthcare environment	28	50.4
Human resources	20	62.1
Affordability of care	=18	82.5
Quality of care	=20	81.3
Community engagement	=38	32.5

Highlights from the Report:

- Palliative care moderately developed
- Medical curriculum exposes students to the subject, but courses are not compulsory
- Accreditation is given for physicians but not for nurses
- DNR has no legal standing
- Most people have limited understanding about palliative care

South China Morning Post

Nobel winner wants to die in peace at home, wife says, as she urges Hong Kong to change culture on end-of-life care

Physicist Charles Kao Kuen, who has end-stage dementia, does not wan[...] comes

PUBLISHED : Sunday, 1[...]
UPDATED : Monday, 11[...]

'Free Hong Kong doctors to help dying patients end their days at home'

Former health minister calls for legal and operational barriers to be lifted so that fewer people have to spend their last days in hospital

PUBLISHED : Monday, 11 July, 2016, 8:02am
UPDATED : Monday, 11 July, 2016, 8:02am

COMMENTS:

End-of-life care in Hong Kong severely lacking, doctors warn

With only 19 palliative care specialists in the city, priorities and training must change, they say

PUBLISHED : Wednesday, 22 June, 2016, 8:02am
UPDATED : Friday, 24 June, 2016, 4:15pm

COMMENTS: 4

Majority of Hongkongers willing to sign document setting out end-of-life treatment, survey finds

Academic says government needs to enact legislation to back up such documents

PUBLISHED : Saturday, 01 October, 2016, 5:02pm
UPDATED : Sunday, 02 October, 2016, 1:24am

COMMENT: 1

明報

通識導賞

重新審視臨終護理

死在家可以嗎？

文｜黃熙蕾

我們常忘了，自己會死。那麼接下來的問題是，怎麼死？電視劇中，癌病主角在戀人懷中安詳去世，淒美的音樂同時安撫着觀眾，但現實是，戀人之後應該會好麻煩，首先要報警，程序上要解剖，以調查有否他殺或其他過失可能；又譬如，若然想以在自己的牀上一直睡下去的方式離開人世？現今法例下，想要在家離世，必須有醫生在兩周前探視，去世時為你簽發死亡證明，否則就得報警進行刑事調查，並解剖屍體。事實上，香港九成人都是在醫院過世，臨終前可能還聽到儀器響個不停，鄰牀病友的呻吟，醫生緊張急救，往往寫下戛然而暴烈的句號，且讓香港落得「死亡質量指數」排名落後的景況。

《經濟學人》去年公布的「死亡質量指數」，分析全球八十個地方的善終質素：英國排第一，台灣排第六，新加坡排十二，**香港排第二十二**。不過，政府與醫療界正在積極思變，計劃推動在家去世作為臨終病人的一個選擇，香港中文大學賽馬會公共衛生及基層醫療學院正進行研究，審視香港的醫護體系，臨終照顧是重點之一。前衛生福利及食物局局長、該院院長楊永強接受專訪時說，即將呈交的第二期報告將研究國際及香港的臨終護理，並提供在院舍及在家離世的法律、運作模式建議。

世界各地的人死在什麼地方？

在討論香港的情況前，先看看外國情況。

地方	死亡數字	在醫院去世	在家去世	其他(包括院舍)
英國	501,404（2014）	約48%	約23%	約29%
台灣	163,858（2015）	約40%	約40%	約20%
新加坡	19,393人（2014）	61%	27%	約12%
香港	45,710（2014）	約90%		約10%（其他(包括院舍、家)）

英國

著重臨終享受 聽音樂嘆香薰

英國的院舍機構指出，不少現時在醫院的病人，其實希望在家或院舍離世。因此，政府為這些末期病人提供大量支援，派紓緩治療護士上門護理，助病者減輕症狀、病楚，亦提供心理輔導。在英國修讀腦退化症碩士的崔志文說，醫生會向家人解釋病者未來的身體轉變，作為「mental rehearsal」。「他們有清晰指引，如儀器上顯示什麼數字，要怎麼辦，香港沒有指引，家人第一件事就是報警。」此外，英國的 National Health Service（衛生局）有指引，定立預設醫療指示（Advance Directives，AD）時必須醫生在場，醫生亦需要遵守AD，由法定機構監管執行，而且英國中小學將生死教育納入課程，着重人的選擇權及臨終享受「pleasure moment」的權利。「就算臨終，也不是什麼都不做，他們還讓病人聽音樂、嘆香薰。」

台灣

醫護上門紓緩不適

台灣推行全民健康保險制，紓緩治療的費用也包括在保險內。醫護團隊會上門助病者減少病楚、不適，護士會為病者更換人工管道、傷口、灌食、洗澡、採集化驗樣本等，並指導家人日常照顧，提供輔導、善終準備。台灣提倡市民定立「預立醫療自主計劃」，更有《安寧緩和醫療條例》，鼓勵末期病人立意願書選擇紓緩治療或作維生醫療抉擇，並將之註記在健保資料系統，方便醫生得悉及執行。此外，台灣於二○○○年將生死教育列入中小學課程，有教授設計教材，推動市民及早籌劃死亡。

香港呢？

拒去醫院

報警、調查、申請剖屍豁免

其實，香港起步比台灣早，是首個將紓緩治療列為專科的地區，但要做到容許更多病人選擇在家中過世，不論法例、醫院資源都要改變。如上所述，現行規定要有醫生在兩周前看過病人，上門簽死亡證明，但現時家庭醫生或公營醫院醫生都沒有上門應診的習慣。所以，現時如病人拒絕去醫院寧願在家過世便要報警，在社署旗下的安老院過世亦然，警方按程序需進行刑事調查，家人需申請豁免剖屍。

今年七十歲的楊永強笑言自己也是長者，他說醫院不是理想的離世地方，稍後提交給政府的報告，將包括在家及院舍去世的可行模式，例如是否需要修訂法例，如何提供社區支援，如何增強人才培訓等。他舉例，末期癌病人一個重要的治療是紓緩痛楚，新加坡的醫院會給病人一個藥盒，內有貼在皮膚的嗎啡貼止痛，於是在最後的日子不用返醫院。

暫時香港並無大規模研究了解市民對在家去世的意願，稍後會進行電話調查。楊永強表示知悉香港的文化忌諱死亡。他在馬來西亞出生，他的父母去世後，會將遺體帶回家，在家做喪禮儀式。「當然在馬來西亞地方較大，在花園擺，人們來坐夜，所以是很不同的文化。日本以前也很多人在家去世，本來有八成，最近雖然跌到約百分二十五，但仍比香港高，香港直情不會考慮。」他相信有關文化可以漸漸改變，強調是要給病人一個選擇。

危急關頭 做不做治療？

訂立預設醫療指示

要計劃好，就要及早開始。就算身體健康的市民，在變成「病人」前，也可透過預設醫療指示（AD）及「預立醫療自主計劃」（Advance Care Planning）及早安排危急關頭的治療意向。「當你去到末期，好危急時，你根本不會有時間思考。在危機前，我會否想將來如何？想不想有好多不必要的治療？例如插喉、吊鹽水、心臟停了要去「㩒」心肺復蘇是很傷害性（traumatic）的，我們做醫生時，好多時「㩒」到斷晒骨。當我知道時候差不多了（When I really know that my time has come），這些治療你還要不要做呢？」

不過，他也坦言，醫護人員對AD有不少疑慮，例如醫生會擔心按指示不施救會負上法律責任。那麼，要不要像外國般立法，進一步保障醫生？他則說，立法只是其中一步，「以前很多香港人都在家過世，但要讓市民可選擇在家過世，還需法例及社區資源配合」。有研究指出，香港人去世前六個月平均要入院三次，約住院二十八日，因安老院舍缺乏醫療支援，長者若有發燒、氣促等病痛，便會送院。「在醫院過身的，有近四成是由院舍來，因長者在院舍有什麼病痛，他們處理不到。」

> **楊永強：如我將來過身，我都想在家過身，it's a much better place。在醫院，好 foreign environment，在醫院，你知道擠迫到什麼地步嘛，所以好難在醫院有 quality of death**

楊永強自從離開政府，同時亦遠離公眾視線，濶別多時，今天見他依然一派風度翩翩，談笑風生，充滿幹勁。這天的話題是死亡，他說，退休後，突然有天發現甲狀腺分泌過多，讓他開始想到人的脆弱，自己生命也有完結的一天。「但你怎麼知道自己幾時死？死亡是生命的歷程之一，是你要活出最好的生命（living your life to the fullest）。就算死亡，也要講生活質素（quality of life）。在你死之前，其實你還活着。」

現存問題

浪費醫療資源

《經濟學人》報告中提及，香港的不足之處在於公共醫療的開支、透過研究進行的政策評估及提供紓緩治療。楊永強說，紓緩治療不只是減少痛楚及不適，更是心理、社交、靈性支援。「其實好多人入院，醫生的維生治療根本作用不大，因我們都知道，只是時間的問題。」他說，現時不單是浪費了資源，更是對病人不必要的干預（interventions），「病人都好痛苦，如何計劃得更好？（how to plan better?）」另外，楊永強相信，公共醫療資源雖然緊絀，透過精簡架構與服務重組可改善服務。

資訊不知何處尋

支援在家療養的資源其實不差，市民可向社福機構申請，有護士、物理或職業治療師家訪，減少痛楚及不適，並減用有副作用的藥物。此外，社工亦為病者與家屬輔導，為離去作準備。陳曉蕾說，外國有的，香港全都有，質素不差，還比外國便宜，基層也負擔得來，只是大家沒留意。「但去到實際操作時，你住邊區，不同的（醫管局）聯網，也有不同的服務。」她形容現在的紓緩治療資源有如「大笪蓆」，「有好多個洞，不知道去哪裏找，例如醫院有房可讓人臨終去世，但可能護士都唔知。」市民通常由醫院取得資訊，但現在是連醫護人員都不重視。

如果有得揀……

崔志文：

> **我當然想在家終老，我想，我會在臨終前已佈置好地方，講給家人知我想有什麼形式，例如播一些我喜歡的音樂，選一些我喜歡的衣服離去，因身邊的一切都是有情感記憶的，這樣可以陪着我行最後一段路，無憾。**

曾於大專任教老年學課程，註冊社工崔志文說，「很多老人家說，聽到醫院的儀器響聲好驚，好困擾，在家照顧有個好處，無得預先同人比較。假如你有大腸癌，其實情況未必咁差，但見到對面牀都有大腸癌，又插喉又『搓』，心情都會好差。」

大眾負面看死亡 仍需教育

他說，不少國際研究都指出，病者希望在熟悉的環境中離開，但不一定在家，可以是院舍。要鼓勵大家在家終老，有數個問題要處理。第一是老人家覺得「唔老嚟」。「老人家連骨灰都不想放在家裏，覺得對家人不好。有人講，若死在家中，會變凶宅。在香港社會，暫時仍覺得死亡不是太正面的事，要教育大家，死亡不是正面，但也不是負面，是中性的，是人要經歷的階段。」

此外，紓緩治療涉及預設醫療指示，他認為要清晰定義「末期」、「維持生命」等關鍵詞，例如家人會認為末期是身體完全不能運作，但醫生說的末期是病理診斷，病人或許仍活動自如，故宜由專業人士定義，再教育公眾。現時預設醫療指示沒法律效力，有不少個案，是家人推翻病者的指示，因此他建議增加心理支援，訂立指示時，有社工或護士與病人商討如何邀請家人參與。

陳曉蕾：

> **我要看是什麼病，就算是癌症，也要看是什麼情況？我是否有自理能力處理？如果病症的症狀自己無得處理，就要專業處理。但如果照顧可以應付，當然是在熟悉地方（去世），同我喜歡的人一起，可以好warm（溫暖），而非好醫療化、冷冰冰的醫院。**

陳曉蕾在寫的新書，正是講病重臨終安排。「未來十年要推（在家善終）的話，我都幾樂觀。」她說，無論政策、學術、社福資源、未來長者的教育程度及經濟能力，都在改變。「香港其實法律上可行，現實中也有人做。」聯合醫院有先導計劃，由醫護人員上門，讓病者在家去世，當中不乏公屋住戶。

倡引入新工種 照顧臨終者

「最大的問題是誰來照顧。不是很多人留意到，最後的時間很短，癌症都是一兩星期。」對政府而言，推動紓緩治療的財政負擔也較輕，「在醫院過身其實非常貴，若將資源轉為支持醫生、護士上門，請護理員照顧最後一個月，若是癌症，以星期計，其實花得不多。現時只得普通家務助理或註冊護士，當然貴。」她建議引入半專業的新工種，概念有如陪月員，但需接受相關訓練。

區結成：

> **如果我唔想我最後那幾星期、幾日在醫院一個嘈吵、擠迫的病房，每日只准探四小時，這樣的情況下，有幾嘈吵或幾孤獨地走，我可能會 prefer（選擇）有其他方式，還應該係有好多選擇。**

醫管局質素及安全總監區結成醫生認為，引進在家離世是「應該做的方向」，「當然香港有好多限制，屋企這麼狹窄，好難在屋企照顧病重的人，有些屋企更不想（病人）死在屋企，然後層樓唔值錢，法律上也有好多嘢限住。香港不能照搬外國，但我相信我們應該有選擇。」

他說，在家或院舍離世，也能讓醫院沒那麼擠迫，西班牙有教授請醫生評估數個病房內的病人什麼時候離世，證明醫生的估計頗準確。「一個病房，你以為是急症、救傷扶危的病房，裏面原來有三四成的病人，半年一年內會去世，若是這樣，為什麼醫療模式不是幫他們面對最後半年的生活、最需要的care（照顧）？為什麼不是問他想要什麼？」後來這位教授說服一些醫生，在急症環境中做紓緩治療。

「這在全世界也是一個趨勢。我們這時代，意識上好過以前。美國在最近十年，法例上准許做善終照顧的中心，醫療保險可以cover（承保）。短時間內，善終中心就去到一個新階段，好多人選擇到這些地方度過最後的日子。如果健康保險包的話，就可以處理到這問題。」他認為社會在轉變，「所以楊教授的報告出來能得到迴響，政府和出面服務團體積極回應，香港是有可能去到另一個階段。這令香港醫療平衡一點。」

如何死得好好哋

讓實逼導

考試可揀綠試，表演可綵排，唯獨死亡無法排練，而人人終須一死。我們自小就上興趣班學琴棋書畫，卻從沒學過如何面對死亡，不論是自己的，還是身邊人的。

那麼，如何死得好？

早前我們報道過中大公共衛生及基層醫療學院受政府委託，審視香港的臨終照顧，院方剛完成電話調查，訪問了一千零六十七名三十歲以上香港市民，橫跨不同年齡、學歷，了解大家想「怎麼死」。[illegible]

可是，生死之間，除非是猝然而逝，那道「順其自然」的界線大部分時候並不乾脆，病人和家人要怎樣準備？醫生又要如何支援配合？

文｜黃熙龍

最新調查

中大公共衛生及基層醫療學院剛完成電話調查，訪問1,067名30歲以上香港市民，以下為部分結果：

1 若你被診斷出患絕症，最重要的是……

%	項目
33.9%	與所愛的人在一起
33.9%	免除痛苦不適、控制病情
11.0%	有私隱及尊嚴地離去
8.9%	有人照顧及尊重我的願望
4.3%	有愛護我的照顧者幫助我及家人
3.6%	其他
3.4%	滿足宗教、靈性或文化需要
3.1%	有專業的醫療支援應付緊急情況

你希望……

87.3% 接受紓緩治療 [illegible]

12.4% 盡可能以醫療方法延長生命，就算會感痛苦、不適

中大賽馬會公共衛生及基層醫療學院院長、前衛生福利及食物局局長楊永強：

[illegible]

生死 那條界

一個資深醫生，也是家人的取捨

「我感受很深，是有位爹爹『過淡仔』後因醫療事故過身，原來爹爹已九十九歲。老人家去到什麼情況下還要過淡仔？當然要看身體情況。」中大賽馬會公共衛生及基層醫療學院，醫療體系、政策及管理學部臨床專業顧問雷兆輝說。

「醫生，是實人『生』，好多時是盡力讓病人有希望，有時沒希望，都鬼佢病人試。不過，到了某一步，我們都要回頭思考，為什麼要這樣做。」雷兆輝是資深醫生，曾任醫管局新界東聯網服務管理及質素保證總監。但他也是別人的至親，最近送別了幾個親人，其中一個患腦退化，「神志清楚，只是吃不到東西，沒理由不幫他，於是插了胃喉」。親人在家休養，後來病情惡化，呼吸困難。「他沒投訴，但看着他不舒服，我的心也不安。若他有大解脫，我會接受。我們不會突然明天不餵食，只是若到了一個地步，不插人工呼吸就不能生存，我好清楚：that's the end。人工呼吸維持多三數天是否值得？像高校長（高錕），現在情況還可，只是有時發燒。我們不會不理會，也會說用抗生素，但若病情要插喉，他們都好清楚不會這樣做，而是家人點畫這條線。」患腦退化症的諾貝爾物理學獎得主高錕已簽署AD（預設醫療指示，Advance Directive），若日後昏迷，不勉強維生，而是自然去世。

不過，雖是兄弟生死知雷醫生，要與家人溝通，也不容易。「兄弟姐妹未必個個看法一樣，要決定何時停止營養？有時約好了情況怎樣要怎樣做，最後關頭又突然改變主意。」

不是人人都有親人是醫生，而且不少病人由得悉患絕症到離世，僅得半年至數星期，當中如何決定要不要搶救，用呼吸機，何時開始紓緩治療？「所以醫護人員要做多一點。」雷醫生希望加強醫生培訓，醫生日後可提供中立的建議及分析，助病人及家人做決定。

雷兆輝醫生

醫生 要懂得講「死」

雷兆輝試過在醫院聽到病人家屬的對話，說醫生問她要不要切除父親的腸，讓他感受很深。「其實醫生應解釋是血液循環不好，切了可阻止惡化，不切，幾星期就要離開……我們好多時候將責任給了家人，不懂幫病人分析好處壞處，幫他們決定。」

「見過有老人家吃不到東西，是否要插胃喉或在肚中開洞？若由病人自己提出，叫子女簽（AD）接受紓緩治療，其實好辛苦。有兒子簽完，到父親去世才感到後悔。現在我們是不懂得講給家人知，其實這情況下，很多做少都不會影響結局。」雷兆輝說，就是要訓練醫生懂得與病人對話。

「我常說，末端前也要談情說愛。講這些（臨終照顧）也是。一個人有病時，醫生已可漸漸去講，初期可做什麼，後期可試什麼。最難是何時將希望適當地調低，若知道只是假希望，就如實讓家人知道。最後一段路，有人是六個月，一年，有時不容易估，癌症大致準確，但心臟衰竭等不易估計。」

除了專業醫護意見，他說，要讓紓緩治療及在家去世成為可行選擇，還需不少支援。「在自己家中床上安詳離開是好事。但好多人未深思在家過世的情況，病人可能呼吸困難，有些人會抽氣好久，在醫院的好處，是有藥物紓緩。我可以請私家護士，但是否人人有能力、資源？第一家中要有地方，第二要有醫護照顧，像台灣就會送氧氣上門，此外，也要考慮有否親人陪伴，有否醫生肯上門看病人。」

一個人死 一個家庭的事

要好死，除了照顧身體，照顧情緒同樣重要。香港大學社會工作及社會行政學系臨床教授姚…（一般癌症病人三分之一有臨床抑鬱及憂慮要看精神科醫生，末期病者達六成，而末期病者的家人逾七成，甚至有病人去世後，家人自殺身亡。因此，她負責的賽馬會安寧頌計劃，致力為家人提供情緒支援，鼓勵他們同與病人討論病情，訂下ACP（預立照顧自主計劃，Advance Care Planning）。

其中一個個案，是確診患鼻咽癌、六十六歲的綠先生。他確診時已是晚期，但化療無效，而且腫瘤已生到眼眸旁，若繼續嘗試下一步的電療，或會失去視力及活動能力，經社工輔導，一家人決定不做電療，改做紓緩治療。「他擔憂影相及聽音樂，詳細考慮後決定不做電療，反而影好多靚相，同家人去旅行玩，出席女兒的婚禮。」最後一家人把握時間相處，綠先生在最後數天才入院，安詳離世。

姚綺為，要做到「好死」，家人要一起計劃，而醫院並不適合末期病人。「醫院是急救的，末期病人應去療養院。若香港有上門護理，加強社區服務，家人就有時間在一起。現在最大的問題是，病人一入醫院，情況就走下坡，不能動，肌肉就會萎縮，不能活動自如，就要用尿片。香港每年四萬多人死，如何令這班長者死亡時，不是活在恐懼中？一個人離世，是一個家庭的事。」

Advance Directive

預設醫療指示

在有人見證下訂立的醫療指示，如病危時要否施行心肺復蘇，無法進食，要否插喉，不能呼吸，要否用呼吸機等。讓病人保留自主權，日後就算不省人事，家人和醫生都了解其意願。在美國、台灣等地具法律效力，香港則未有立法。

4

調查顯示，85.7%市民未曾聽過預設醫療指示（AD），在解釋何謂AD後，你認同應在診斷出患絕症後設立AD嗎？

- 21.9% 不肯定/中立
- 4.2% 不認同
- 73.9% 認同

若AD具法律效力，你會設立AD嗎？

- 16.5% 不肯定
- 22.6% 不會
- 60.9% 會

Palliative care

紓緩治療

以藥物、物理治療等減輕末期病人的痛楚及不適，着重病人的舒適及心理需要，而非以延長壽命為首要目標。

Advance Care Planning

預立照顧自主計劃

比預設醫療指示範圍更廣，包括照顧計劃，如住院或在家進行紓緩治療，由誰照顧，甚至臨終要穿什麼衣服等安排。

2 你希望在哪裏去世？

擇日死？在家死？無痛死？

安老院/療養院/紓緩中心	家	醫院
16.2%	30.8%	51.8%

其他（例如外國）0.2%

若你不希望在家去世，你的考慮是……（可選多於一項）

%	項目
80.0%	不想麻煩家人
45.6%	欠缺專業醫護支援
22.3%	欠缺科技支援
10.7%	樓價
10.0%	法律及其他程序繁複
7.0%	害怕感受
3.4%	其他/不肯定

若一個人在家自然去世，而非意外或受傷或外來因素……

會否在房子中感到不自在？ 25.7% 會；74.3% 不會

會否覺得房子變成凶宅？ 12% 會；88% 不會

3 觀念改變 談死不再忌諱

大家會想「怎麼死？」據調查發現，原來，近九成市民若確診患絕症，會選擇紓緩治療，而非以痛苦的急性治療（如插喉）延長生命，而且愈年長，愈傾向選擇紓緩治療。此外，出乎意料，有三成市民希望在家去世，而不想死在家的，主要不是怕影響樓價，而是怕麻煩家人（見圖表第三部分）。

值得留意的是，政府曾於二〇〇九年就AD立法諮詢，惟二〇一二年食衞局表示諮詢結果顯示死亡仍是部分人的忌諱，市民普遍對AD不太熟悉，未再推動立法。不過，今次調查或反映社會觀念已變，雖然逾八成市民從未聽過AD，對「善終」認識不多，惟當市民了解何謂AD後，七成人認同應在確診絕症後設立AD，若AD具法律效力，更有逾六成人會訂立AD。其實，近九成市民同意醫護人員應直言自己的病情及臨終照顧計劃，顯示大家對死亡已非想像般忌諱。

「最後半年」港人進出三次醫院

《經濟學人》早前發表的死亡質量指數分析八十個地方的善終質素，香港排第二十二，落後於英國、新加坡及台灣，原因之一正是紓緩治療不足。

常聽人說，「五福臨門」的第五「福」，是善終正寢。香港人，值得死得好一點。

排行第二十二的實況到底是如何的？現行任何居於家中或社會環境下安老院的重病者，遇有「冬瓜豆腐」，身邊人會打999召救護車。一旦送院前身亡，便將被送到公眾殮房剖屍進行刑事調查。不然的話，進到急症室便會接受心肺復甦，也許會按裂胸骨、喉管餵飼、靜脈注射等痛苦的急性治療。折騰半天，待情況穩定送上醫院病房。有研究指出，因安老院缺乏醫療支援，長者常因肺炎、發燒、進食不足等併發症進出醫院，香港人去世前半年平均要入院三次，約住院二十八日。換言之，這循環要發生三次，你才走完最後一程。而且臨終一刻，家人也許受限於探病時間未能相伴，剩你獨自在嘈吵擠迫的病房嚥下最後一口氣。

試行計劃 直入療養醫院

有見及此，醫管局新界東聯網於二〇一二年試行「安老院舍晚期醫護服務先導計劃」，由醫生與病人及家人制訂ACP。當長者情況轉差，院舍會聯絡專責護士評估病情，直接入住沙田醫院，不用經急症室。一般晚期病人的住院日數與其他內科病人差不多，平均約十四天。沙田醫院是療養醫院，探病時間彈性，並提供個人化照顧，病人可帶喜愛的物品及播放心愛的音樂。晚期病人繞過急症室直接入院的比率，於去年已達七成。

死在香港

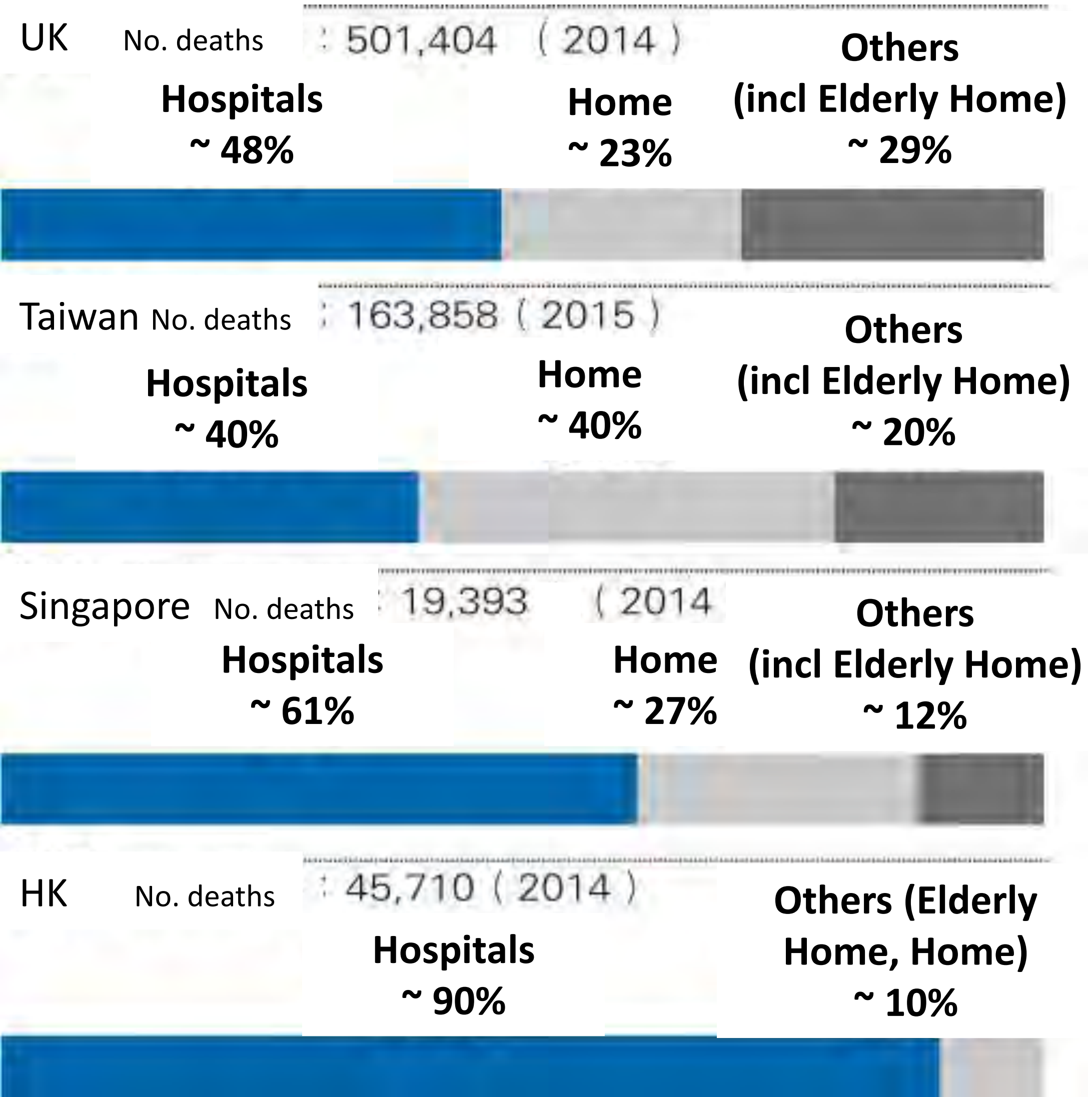
循環（港人去世前半年平均入院3次，約住院28日）

家中/院舍 → 打999 → 救護車 → 救回 → 急症室 → 留醫 → 醫院病房

去世 → 公眾殮房（剖屍）；去世 → 醫院殮房

沙田醫院試行中：療養醫院 個人化病房

Comparisons across countries – Place of Death



Ref: Mingpao News July 10, 2016

The FHB Commissioned Research Project
"Quality of healthcare for the ageing –
Health system and service models to better cater for an ageing population"

Objectives:

- To identify barriers and recommend service models for end-of-life (EOL) care in Hong Kong
- To recommend service models and changes (including legislation) if required

Methods

Key informant interviews

- 10 management-level informant from the health and social care sectors
- 4 legal experts
- 3 pathologists and mortuary staff
- 2 private sector medical doctors
- 2 private funeral agents

Focus groups

- 11 groups of staff from the healthcare sector
- 11 groups of staff from the social care sector

Current Barriers and Gaps

Issues, Gaps and Barriers

	Anticipation & Preparation	EOL Care Delivery	Death and Post-death
Legal	• Advance Directives (AD) and Advance Care Planning (ACP) • Mental Health Ordinance (Cap 136) • Powers of Attorney (Cap 31) & Enduring Powers of Attorney	• Fire Services Ordinance (Cap 95)	• Coroners Ordinance (Cap 504)
Operational & Organizational	• Low uptake and lack of formal status for AD • Lack of standardized policy, protocol, and formal status of for ACP • Uncertainties of EOL prognostication • Lack of continuous EOL care conversation	• Inadequate capacity, support and resources for supporting EOL care in the community • Inadequacy for supporting EOL care in the hospital settings • Inadequate medical-social interface and coordination	• Dying at hospitals • Death on/before arrival to A&E • Dying at RCHE • Dying at nursing home • Dying at home
Socio-cultural & Practical	• Death as a cultural taboo • Inadequate discussion and education • Challenge for healthcare providers to initiate conversations	• Lack of appropriate culture, mindset and skills of staffs to deliver EOL care • Inadequate training and education on EOL issues for medical, nursing and residential care home staffs • Misconception of EOL care in the general public	• Dying at home • Dying at RCHE • Dying at nursing home • Concerns of the general public over reportable deaths • General concerns over funeral and cremation services • Lack of emphasis on post-death and bereavement services

Issues, Gaps and Barriers

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LEGAL
Anticipation and Preparation

Advance Directives (AD)

- Disputes over types of decision to be included in AD, e.g.
  - Duration of validity
  - Option to revoke a previous decision
  - Refusal of life-sustaining treatments only or also basic care, which is broadly defined in the UK Mental Capacity Act 2007 as *"actions that are needed to keep a person comfortable, e.g. warmth, shelter, actions to keep a person clean and the offer of food and water by mouth."*)
- Operates under common law framework, but not legislated yet
- Still a debate: Should AD be legislated?

Advance Care Planning (ACP)

- No formal legal standing → ACP wishes not binding

LEGAL
Anticipation and Preparation

Mental Health Ordinance (Cap 136)

- Uncertainties with definition of "mental incapacity" → refer to Law Reform Commission's report *Substitute Decision-making and Advance Directives in Relation to Medical Treatment (2006)*

Powers of Attorney Ordinance (Cap 31)

- Currently only allows the attorney to handle financial matters before and after he/she becomes mentally incapacitated

LEGAL
EOL Care Delivery

- **Fire Services Ordinance (Cap 95)**
  - Duty clause: to *"assist any person who appears to need prompt or immediate medical attention by (i) securing his safety; (ii)* ***resuscitating or sustaining his life****; (iii)* ***reducing his suffering or distress****".*
  - Therefore, FSD is still obligated to perform resuscitation, if required, despite having completed DNACPR, ACP or AD documentations → FSD's non-participation in the HA's DNACPR guidelines
  - Points (ii) and (iii) may contradict in some cases

LEGAL
Death & Post-death

Coroners Ordinance (Cap 504):

- Dying at Residential Care Homes for the Elderly (RCHE):
  - **Type 16:** *"Any death of a person where the death occurred in any premises in which the care of persons is carried on for reward or other financial consideration (other than in any premises which comprise a hospital, nursing home or maternity home registered under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap 165))."* → death at RCHE automatically reportable
- Dying at home:
  - **Type 2**: *"Any death of a person (excluding a person who, before his death, was diagnosed as having a terminal illness) where no registered medical practitioner has attended the person during his last illness within 14 days prior to his death."* → reportable but can be exempted

Issues, Gaps and Barriers

	Anticipation & Preparation	EOL Care Delivery	Death and Post-death
Legal	• Advance Directives (AD) and Advance Care Planning (ACP) • Mental Health Ordinance (Cap 136) • Powers of Attorney (Cap 31) & Enduring Powers of Attorney	• Fire Services Ordinance (Cap 95)	• Coroners Ordinance (Cap 504)
Operational & Organizational	• Low uptake and lack of formal status for AD • Lack of standardized policy, protocol, and formal status of for ACP • Uncertainties of EOL prognostication • Lack of continuous EOL care conversation	• Inadequate capacity, support and resources for supporting EOL care in the community • Inadequacy for supporting EOL care in the hospital settings • Inadequate medical-social interface and coordination	• Dying at hospitals • Death on/before arrival to A&E • Dying at RCHE • Dying at nursing home • Dying at home
Socio-cultural & Practical	• Death as a cultural taboo • Inadequate discussion and education • Challenge for healthcare providers to initiate conversations	• Lack of appropriate culture, mindset and skills of staffs to deliver EOL care • Inadequate training and education on EOL issues for medical, nursing and residential care home staffs • Misconception of EOL care in the general public	• Dying at home • Dying at RCHE • Dying at nursing home • Concerns of the general public over reportable deaths • General concerns over funeral and cremation services • Lack of emphasis on post-death and bereavement services

OPERATIONAL & ORGANIZATIONAL Anticipation and Preparation

Low uptake and lack of formal status for AD

- Only 1,919 people signed AD in public hospitals between August 2012 and March 2016
  - due to various reasons: reluctance to start EOL conversations, concerns over lack of protection for the healthcare providers, inadequate awareness and knowledge of AD and uncertainties of AD
- Lack of mechanism to alert the healthcare providers within HA of the possession of a valid and applicable AD for the patients

OPERATIONAL & ORGANIZATIONAL Anticipation and Preparation

Lack of standardized policy, protocol, and formal status of for ACP

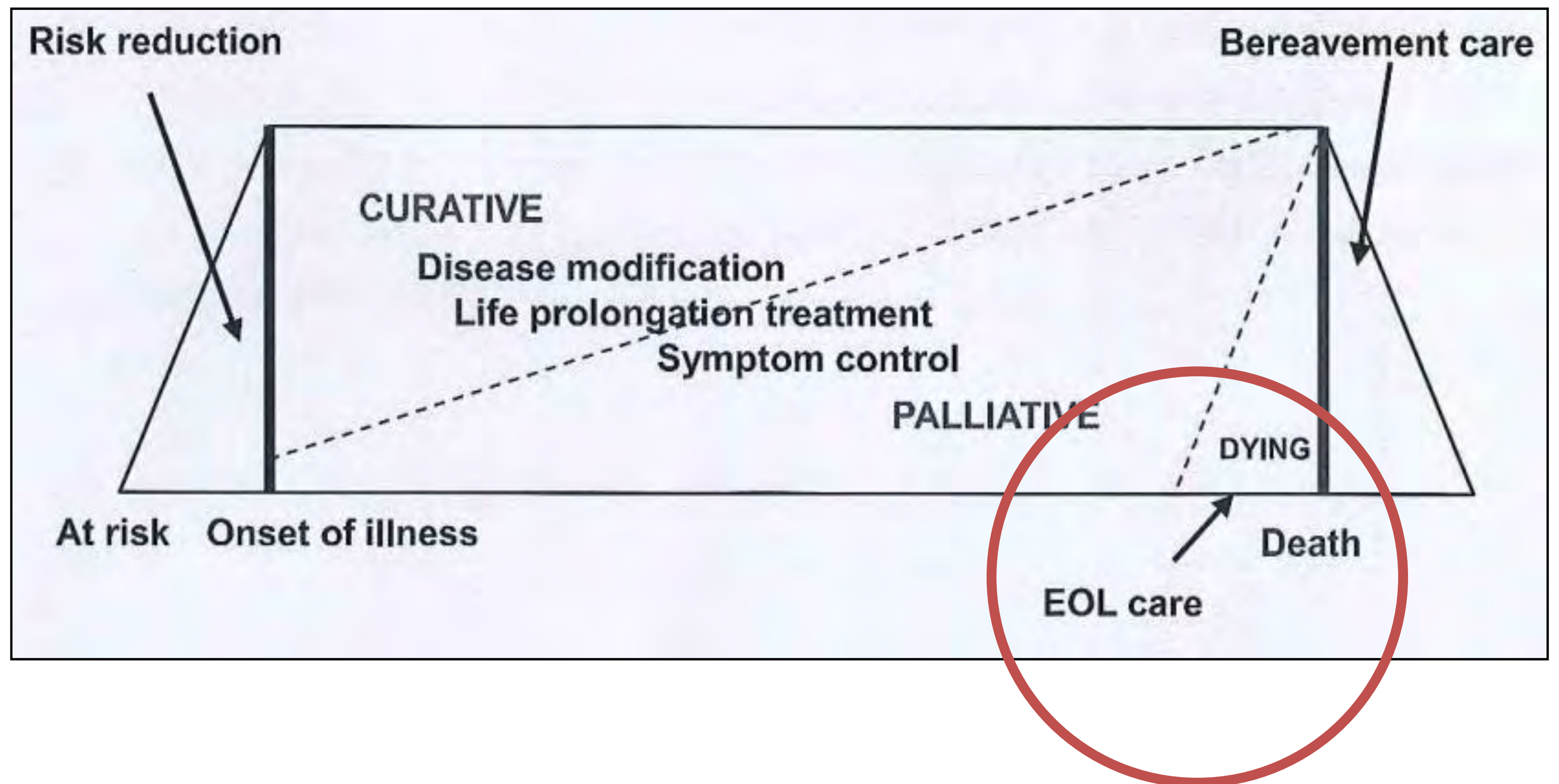
- No formal recognition by related sectors, including HA, other healthcare institutes, RCHEs, nursing homes, Fire Services Department, police
- FSD's non-participation in the HA's DNACPR guidelines

Uncertainties of EOL identification and prognostication

- Lack of standard protocol: when should the EOL conversation start?

Lack of continuity in EOL care conversation

Changing course of health care needs along the illness trajectory (Adapted from WHO)



Source: WHO, *Cancer control: Palliative care- WHO guide for effective programmes*, 2007.

OPERATIONAL & ORGANIZATIONAL EOL Care Delivery

Inadequate capacity, support and resources for supporting EOL care in the community

- **Manpower:** VMOs at RCHEs, no requirement for on-site medical doctors at nursing homes, untrained informal carers at homes and low awareness of EOL care services in the community
- **Equipment, facility and space:** e.g. wheelchairs, oxygen supply, oral suction, IV drip/syringe pump, etc.
- **Transportation:** Inadequate non-emergency transportation to the hospitals for EOL patients who require sub-acute attention

OPERATIONAL & ORGANIZATIONAL EOL Care Delivery

Inadequacy for supporting EOL care in the hospital settings

- Medical doctors traditionally trained in delivering curative care but not EOL care with palliative care at its core
- 19 palliative care specialists in HK
- Insufficient coordination and communication between the different departments (e.g. A&E with the parent team)

OPERATIONAL & ORGANIZATIONAL
EOL Care Delivery

- **Inadequate medical-social interface and coordination**
  - Referral, transfer, information sharing and access, etc. to ensure timely, appropriate and continuous care
  - Mechanism and system that enables multi-disciplinary coordination (E.g. HA's pilot program of Enhanced CGAT for EOL Care in RCHEs)
    - No clarity as to whether RCHE/ nursing home staffs need to follow/execute AD/ACP made in hospitals
  - No common understanding between the 2 sectors → distrust
  - Overlaps of services provided to the patients in the community (e.g. CGAT, CNS, Integrated Care and Discharge Support, home palliative care services, other organ-specific programs as well as other community and home care visits by allied health professionals) → lack of system to coordinate and manage these services

OPERATIONAL & ORGANIZATIONAL
Death and Post-death

- **Dying at hospitals**
  - Limited space and flexibility of visiting hours at public hospitals
  - General practice to transfer/rush back patients from community to hospitals to die → ambulance → A&E
  - Inadequate understanding and coordination between A&E and other extended care facilities regarding terminally ill patients at EOL

OPERATIONAL & ORGANIZATIONAL
Death and Post-death

- **Death on/before arrival**
  - Common misconception: Deaths occurred within 24 hours of A&E arrival must be reported to the coroner
    - No such legal requirement → if doctor is familiar with the case, they can sign the Medical Certificate of the Cause of Death (Form 18)
    - Patients being sent to hospital as soon as they show any early/suspected sign of dying → crowding out A&E resources, false alarm, revolving door syndrome

OPERATIONAL& ORGANIZATIONAL
Death and Post-death

- **Dying at RCHE**
  - RCHE not designed to facilitate dying in place!
  - Limited in space, may lack extra air-conditioned room
  - No required storage of non-designated drugs in RCHEs
  - RCHE staff not trained and equipped to handle death and post-death
  - Counseling of bereaved family members and to assist them with handling police investigation, death reporting and registration, etc.

OPERATIONAL & ORGANIZATIONAL
Death and Post-death

- **Dying at nursing home**
  - Legal (non-reportable), but…
  - Not all nursing home have regular medical practitioner available 24 hours a day → Difficulty to find doctor to view the body and issue Form 18
  - Limited in space, may lack extra air-conditioned room
  - Non-coroner's case
    - A resting place is required for storage before burial/ cremation
    - Alternative: funeral parlor services which incur more costs than deaths at hospitals and reportable deaths
  - Counseling of bereaved family members and to assist them with handling police investigation, death reporting and registration, etc.

OPERATIONAL & ORGANIZATIONAL
Death and Post-death

- **Dying at home**
  - Legal (non-reportable), but…
  - Difficulty to find doctor to view the body and issue Form 18
  - Home deaths may generate fear and discomfort to neighbors living nearby
  - Removal of body:
    - May cause inconvenience to neighbors
    - Handled by funeral parlor services for non-reportable deaths → incur more costs
  - Home deaths may trigger police investigations → distress to family members

Issues, Gaps and Barriers

	Anticipation & Preparation	EOL Care Delivery	Death and Post-death
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SOCIO-CULTURAL AND PRATICAL EOL Care Delivery

- **Lack of appropriate culture, mindset and skills of staffs to deliver EOL care**
  - Good EOL care will not fall into places with only operational protocols and policies
  - Inadequate medical ethics training
  - Fear and feeling of uncertainty of legal liabilities for administering EOL care (e.g. AD/ACP, DNACPR, withdrawal of life-sustaining treatments)
- **Inadequate training and education on EOL issues for medical, nursing and residential care home staffs**
  - Inadequate emphasis on psychological and spiritual needs of patients and family members
- **Misconception of EOL care in the general public**
  - Feeling of guilt if they do not care enough for the patients (Andershed & Harstade 2007)
  - Filial piety to do the utmost ← inadequate EOL education and discussion
  - Inadequate discussion and understanding between patients and their family

Ref: Andershed B, Harstade CW. Next of kin's feelings of guilt and shame in end-of-life care. Contemp Nurse. Australia; 2007 Dec;27(1):61–72.

SOCIO-CULTURAL AND PRATICAL
Anticipation and Preparation

- **A vicious cycle:**
  - Death as a cultural taboo <-> Inadequate discussion and education in general public
  - Reluctance to engage in discussions on life-and-death and EOL among younger generations, more so than the elderly

Challenge for healthcare providers to initiate conversations

- 90% medical students felt that they did not have sufficient knowledge on EOL and were unprepared to handle such issues (Siu MW et al. 2010)
- Administering palliative care = giving up hope

Ref: Siu MW, Cheung TY, Chiu MM, Kwok TY, Choi WL, Lo TK, et al. The preparedness of Hong Kong medical students towards advance directives and end-of-life issues. East Asian Arch Psychiatry. 2010;20(4):155–62.

SOCIO-CULTURAL AND PRATICAL
Death and Post-death

- **Dying at home**
  - Fear and discomfort of neighbors ← socio-cultural/religious beliefs, taboo and concept that body would quickly decompose and smell
  - Inadequate knowledge of administrative procedure for dealing with death at home
  - Patient might not have expressed their wishes to die at home to family members, who may not prefer the patient to die at home (e.g. going back home = giving up hope, hospital is the best place for dying, **perceived fear of depreciation of property value!**)

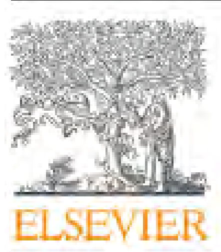
SOCIO-CULTURAL AND PRATICAL
Death and Post-death

- **Dying at RCHE**
  - Fear and discomfort of staff and housemates
  - General concern over decomposition and smell of the body
  - General concern over possible requirements for autopsy if coroner's process is triggered
- **Dying at nursing home**
  - Similar to RCHE
  - No expectation for family members of the patient to die at nursing home

SOCIO-CULTURAL AND PRATICAL
Death and Post-death

- **Concerns of the general public over reportable deaths**
  - Perceived notion: time-consuming and onerous for family members
  - Socio-cultural/religious belief: “completeness” of the body
- **General concerns over funeral and cremation services**
  - 15 days of waiting list for cremation service on average
  - Some family members choosing convenient time and “auspicious” date
  - Hospital mortuaries are free-of-charge for storage
- **Lack of emphasis on post-death and bereavement services**
  - Lack of awareness of such services even when available

JAMDA xxx (2017) 1.e1–1.e9



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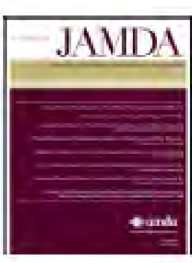


Original Study

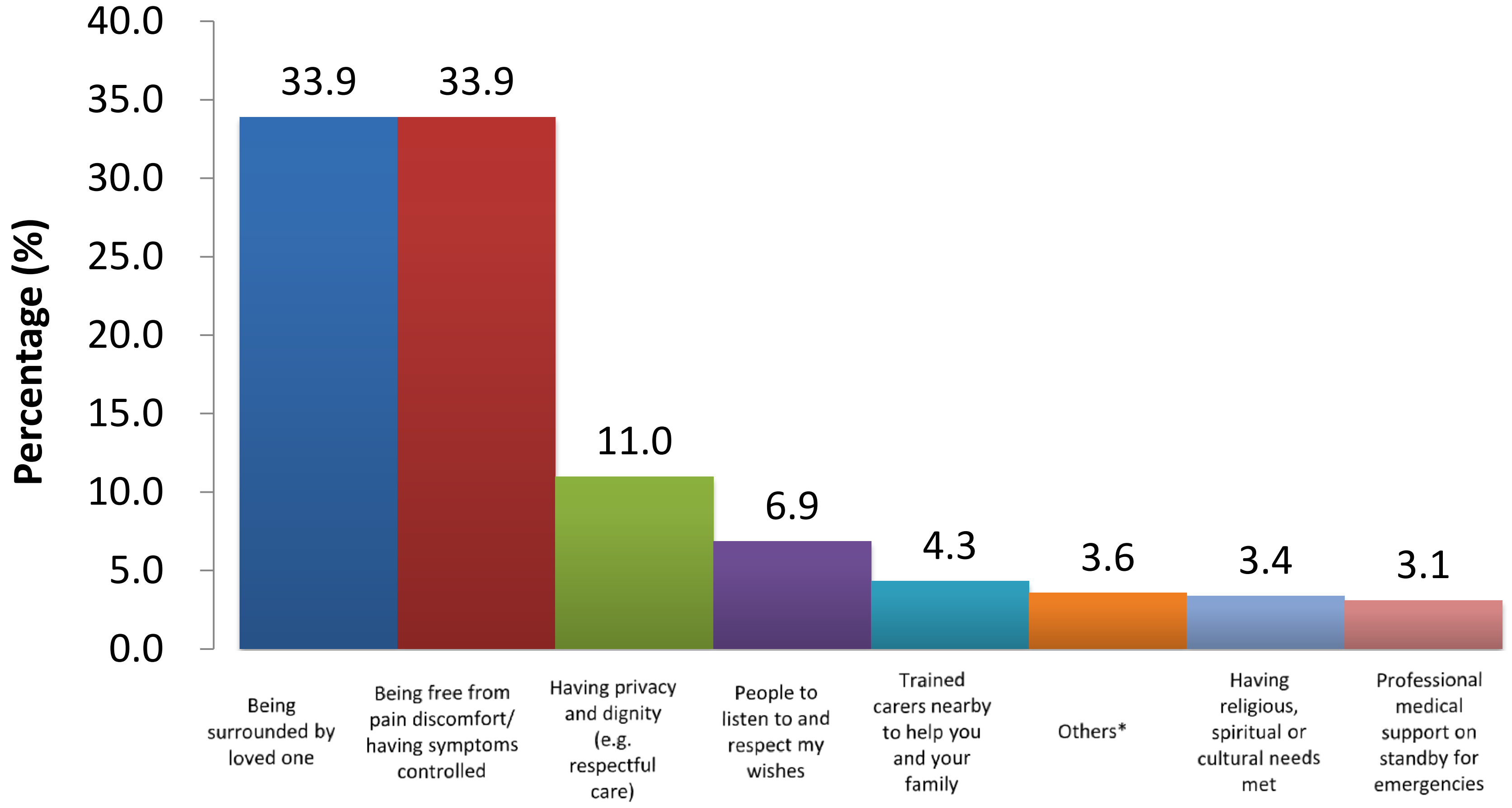
Knowledge, Attitudes, and Preferences of Advance Decisions, End-of-Life Care, and Place of Care and Death in Hong Kong. A Population-Based Telephone Survey of 1067 Adults

A Telephone Survey of 1,067 adults of the General Hong Kong Population above 30 years old

Roger Yat-Nork Chung, Eliza Lai-Yi Wong, Nicole Kiang, Patsy Yuen-Kwan Chau, Janice Lau, Samuel Yeung-Shan Wong, Eng-Kiong Yeoh, Jean Woo

Main Findings – EOL Care

Most important element of EOL care if you were being diagnosed to be terminally ill:



* To be sure that I am not a burden to other people ; Being in a familiar surrounding; Access to professionals for last minute concerns regarding family or legal affairs ; Nothing important; Didn't answer

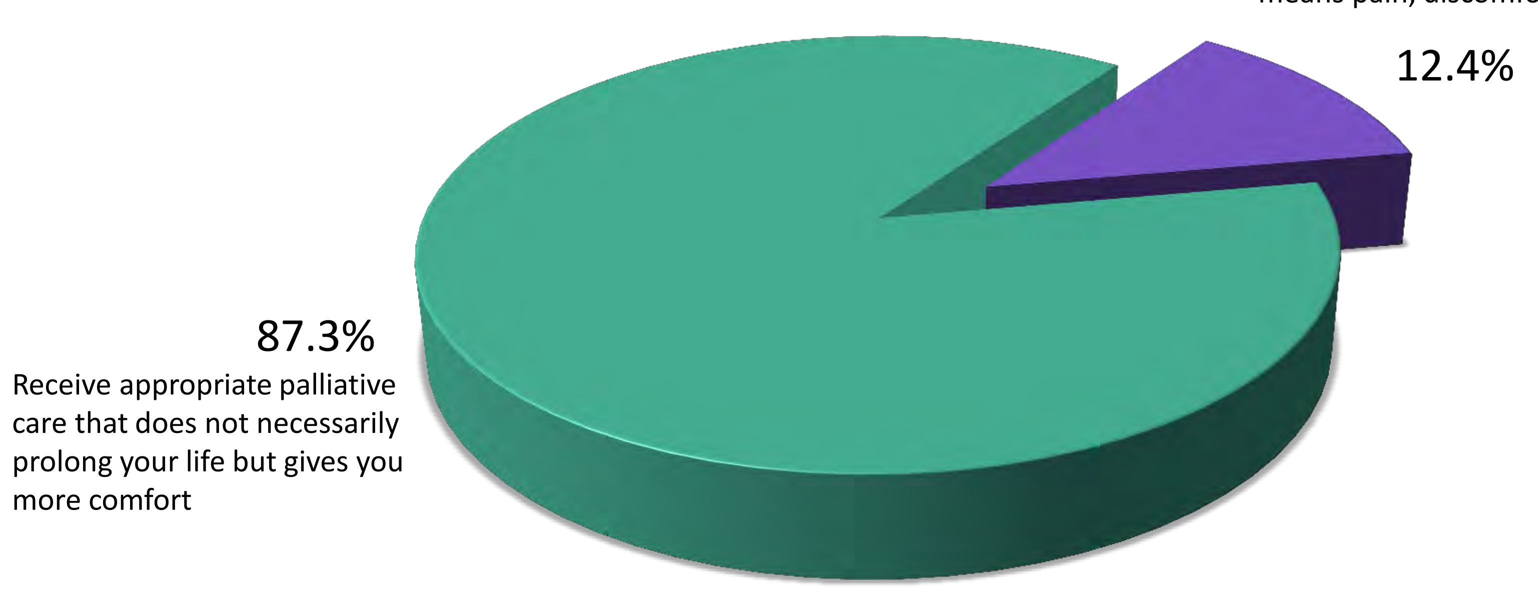
Main Findings – EOL Care

If you were being diagnosed to be terminally ill, you would prefer to:

- Prolong your life as much as possible with medical interventions even when it means pain, discomfort and suffering
- Receive appropriate palliative care that does not necessarily prolong your life but gives you more comfort

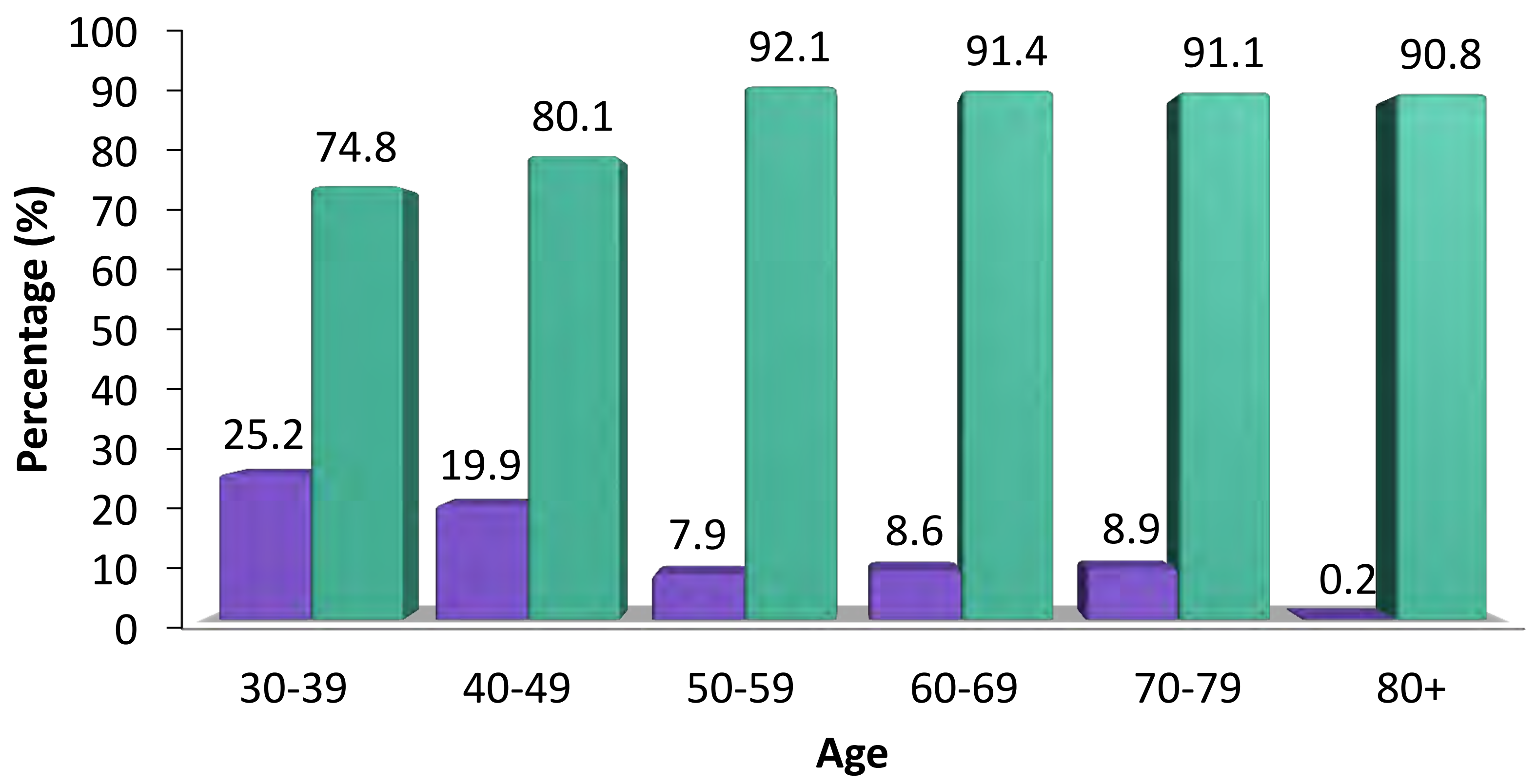
Main Findings – EOL Care

If you were being diagnosed to be terminally ill, you would prefer to:



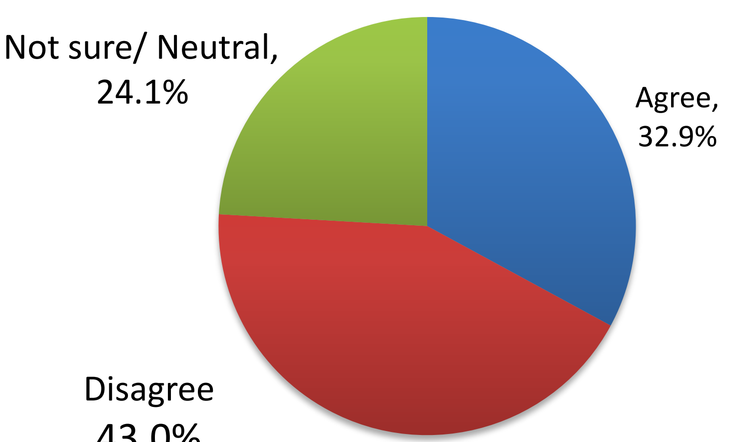
Main Findings – EOL Care

If you were being diagnosed to be terminally ill, you would prefer to:

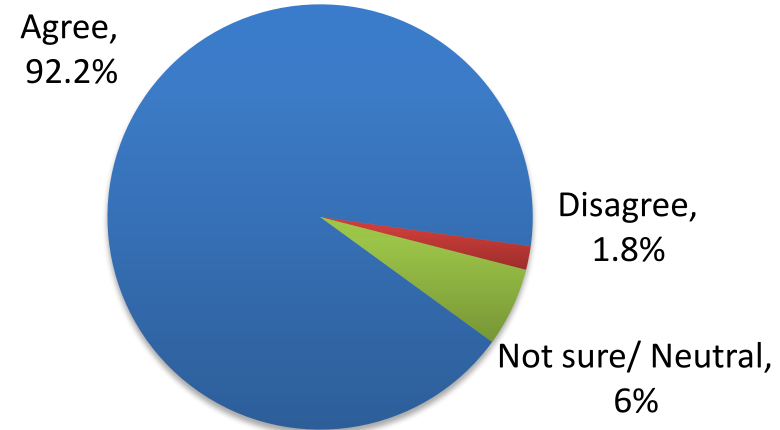


Main Findings – EOL Care

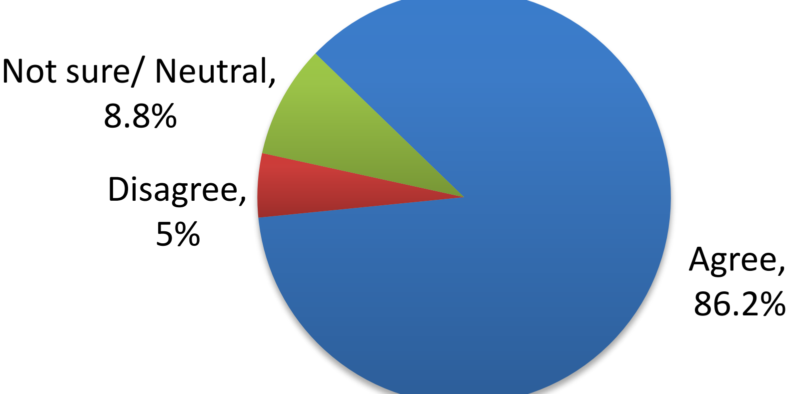
Doctors should generally try to keep their patients alive by any means (e.g. machines, intubation) for as long as possible, even if it means pain, discomfort, and suffering



It is a good practice for medical staff directly inform patient about their situation and end of life care plans



The patient's own wishes should determine what treatment he/she should receive



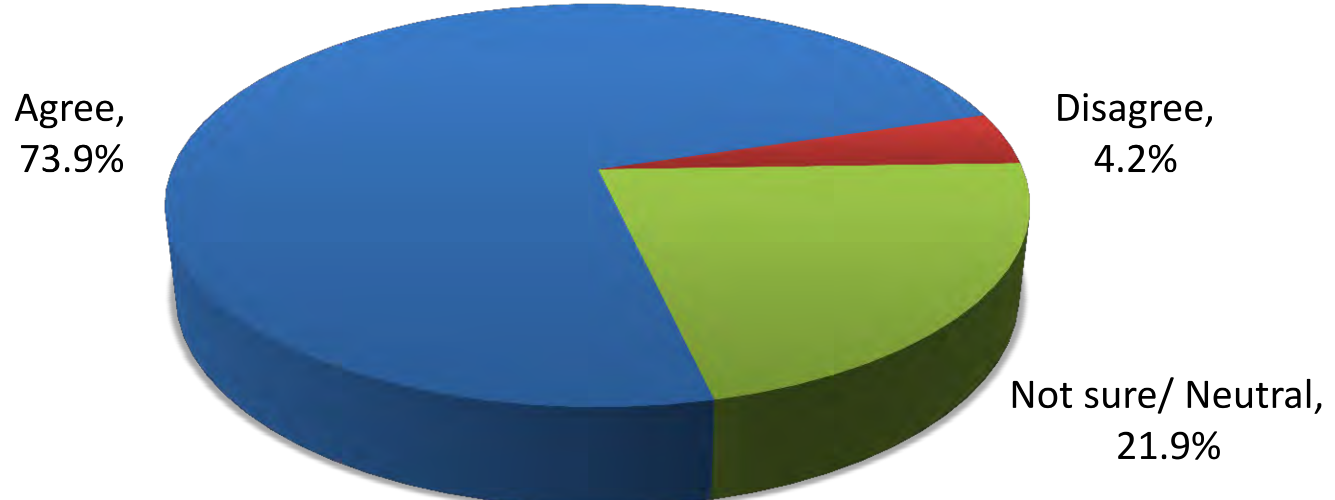
Main Findings
Advance Directive

Main Findings – Advance Directive

85.7% have not heard of Advance Directive (AD)

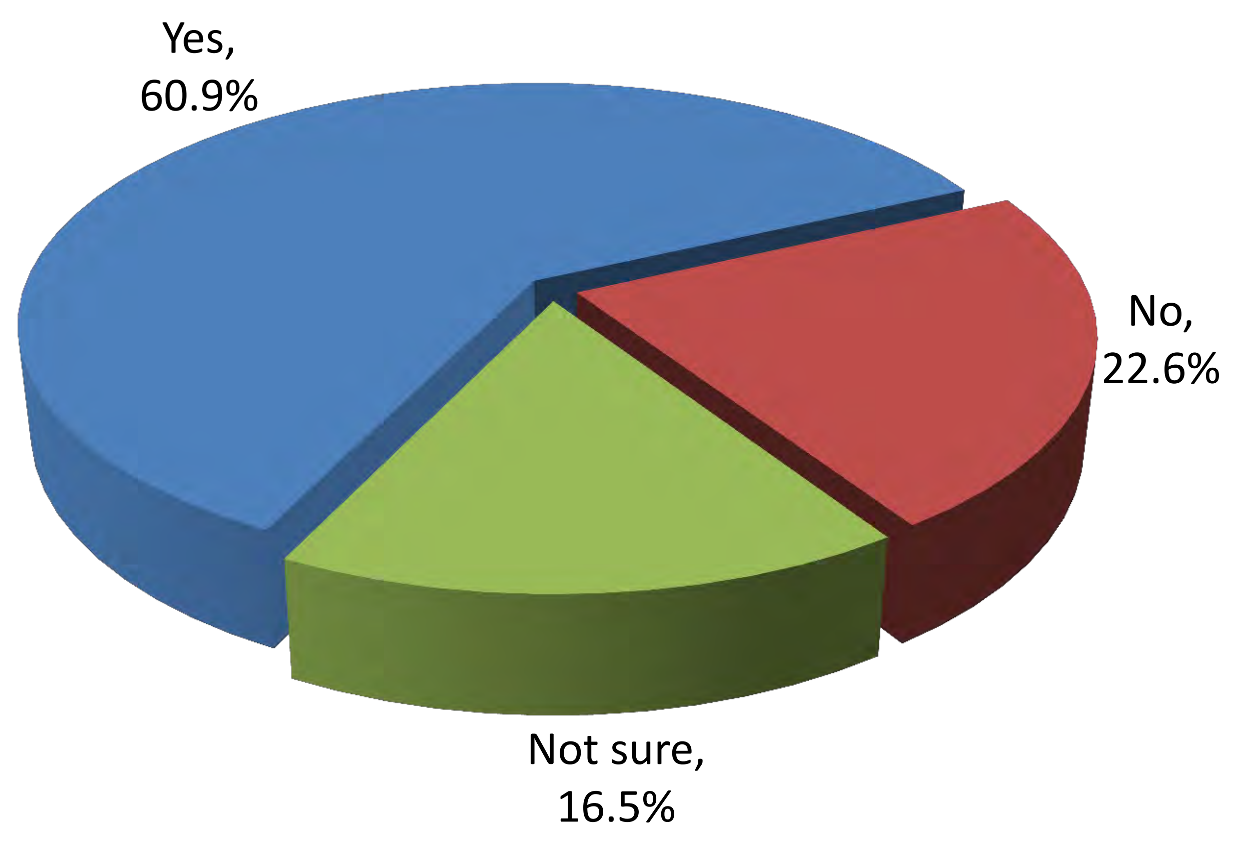
After explanations of what AD means…

It is a good approach to make an advance directive when a patient is diagnosed to be have an incurable disease.



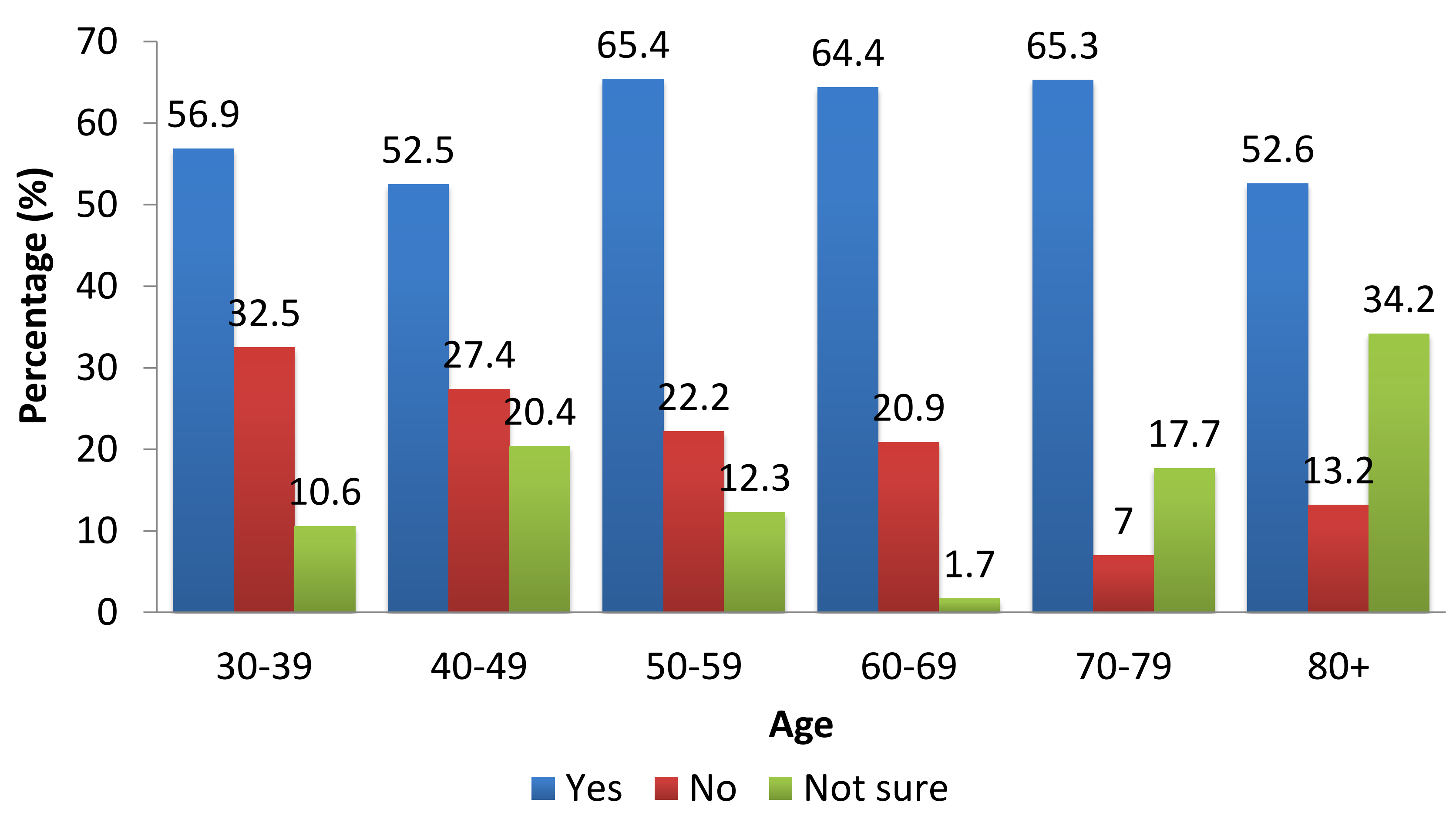
Main Findings – Advance Directive

Would make AD if formally legislated in HK



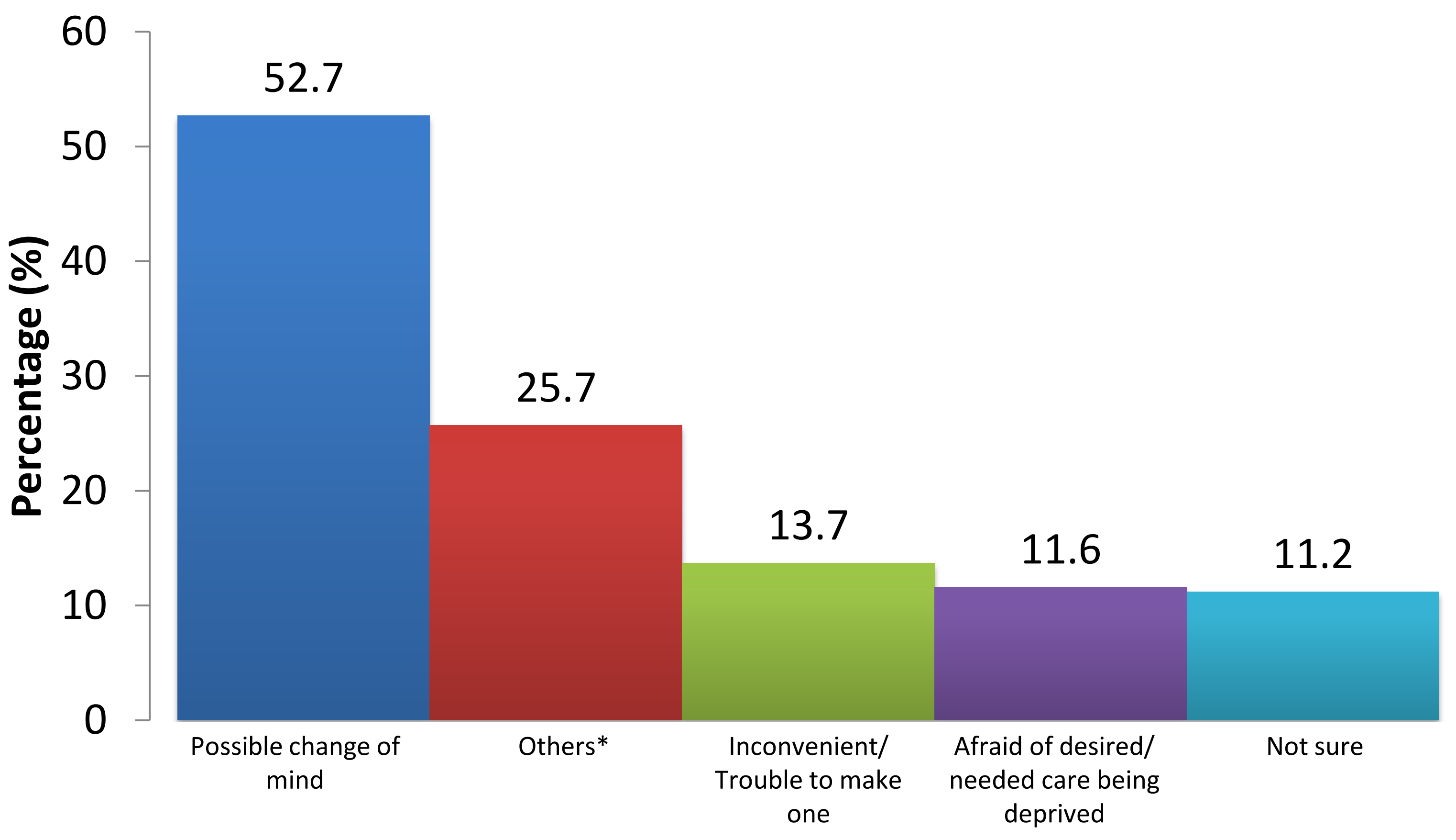
Main Findings – Advance Directive

Would make AD if formally legislated in HK



Main Findings – Advance Directive

Reasons for not making an AD (Can choose more than one)



Main Findings
Preferred Place of Care/Death

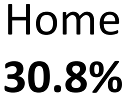
Main Findings – Preferred Place of Care

	Home	Hospital	RCHE/ Nursing Home/ Hospice	Others
Last Year	618 (57.9%)	180 (16.9%)	251 (23.5%)	9 (0.8%)
Last Weeks	430 (40.3%)	430 (40.3%)	186 (17.4%)	12 (1.1%)
Last Days	358 (33.6%)	524 (49.5%)	164 (15.4%)	12 (1.1%)

Decreasing

Increasing

Main Findings – Preferred Place of Death



Home
30.8%

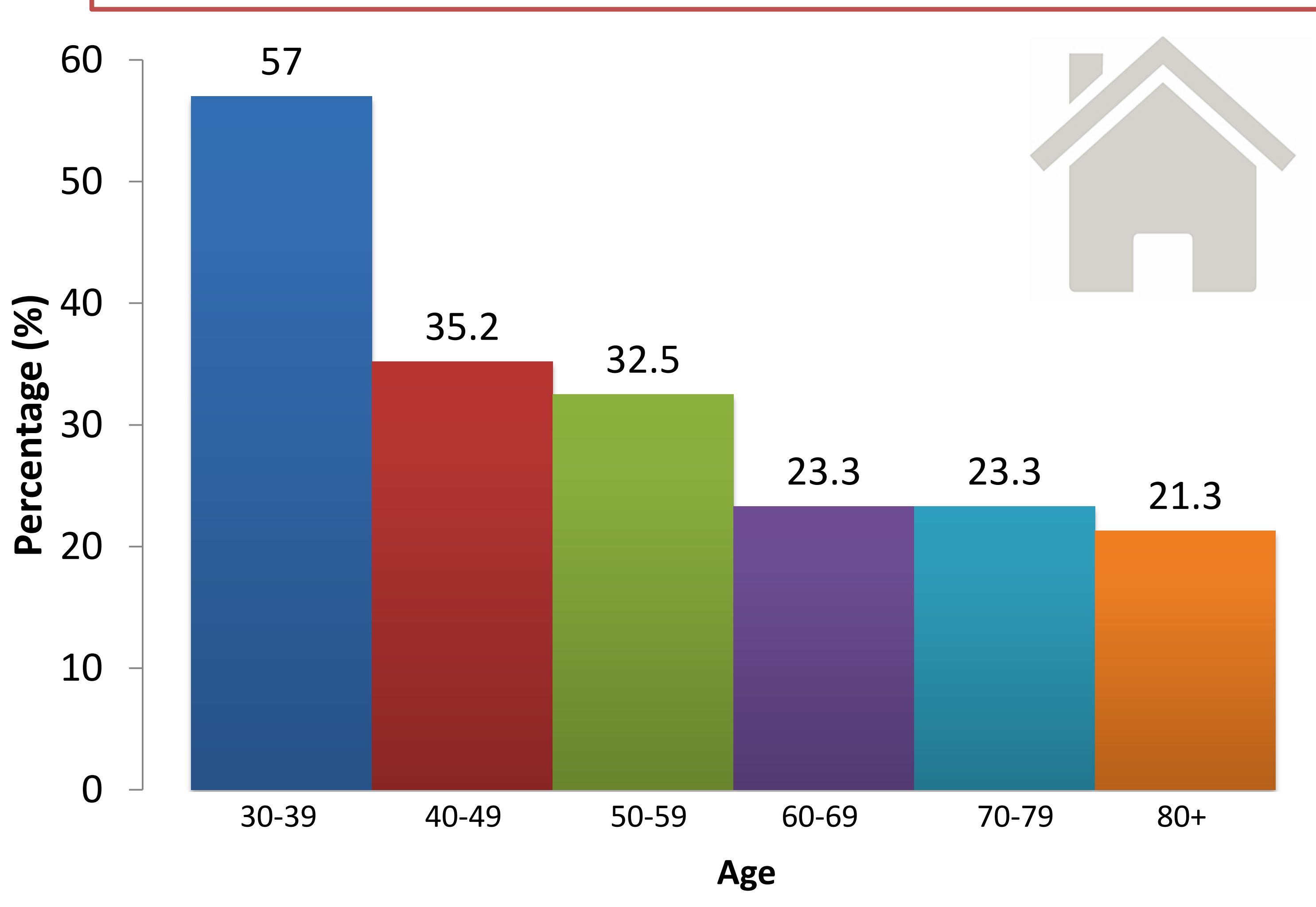
Hospital
51.8%

Aged/ Nursing home/ Hospice
16.2%

Others
0.2%

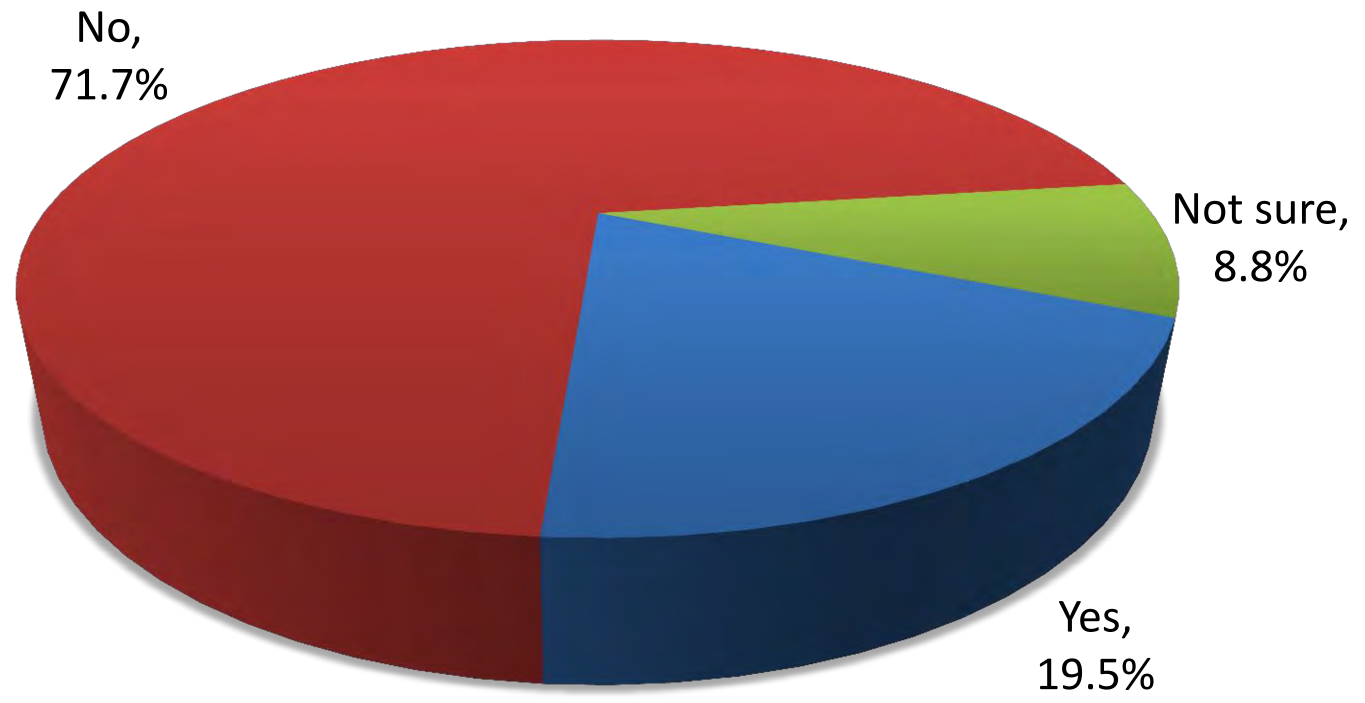
Main Findings – Preferred Place of Death

A clear trend of increasing age for lower preference to die at home



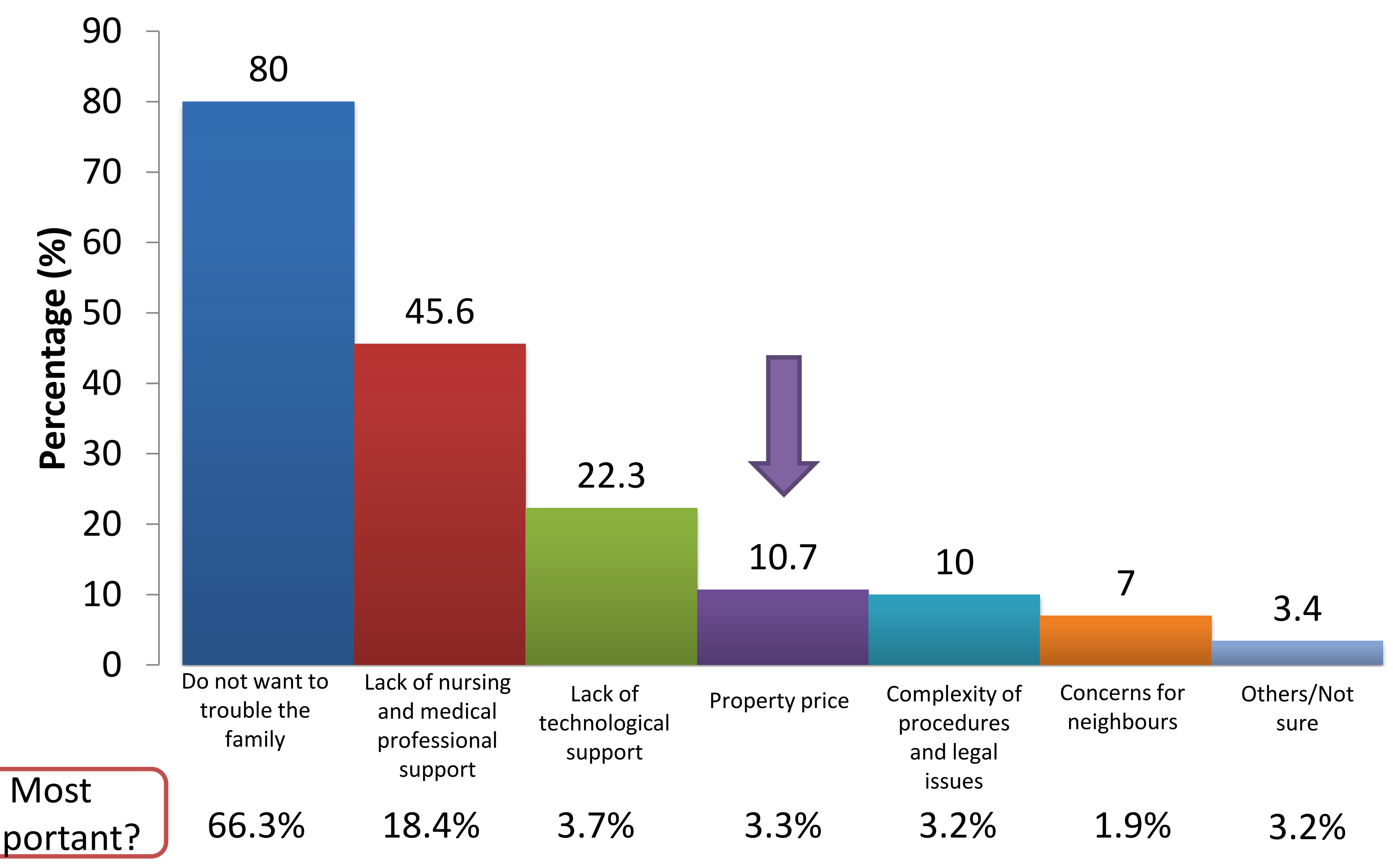
Main Findings – Preferred Place of Death

Would you still prefer to die at home even if you did not have sufficient support and care from family and friends or the social and medical professionals?



Main Findings – Preferred Place of Death

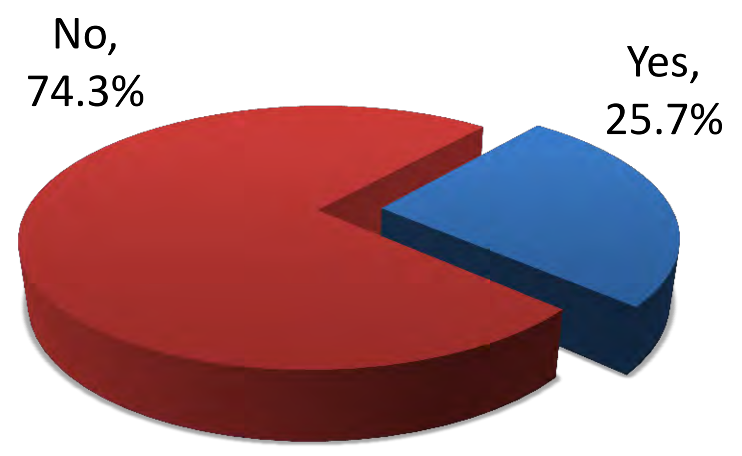
Reasons for not choosing home as place of death
(can choose more than one)



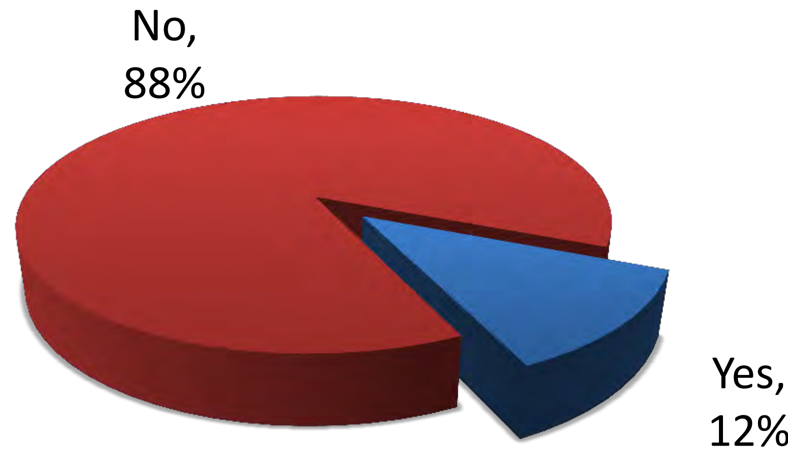
Main Findings – Preferred Place of Death

If a person passes away at home naturally, in other words, not by accidents, injuries, external causes…

Feeling uncomfortable about the house



Feeling the house is "haunted" (凶宅)



Take-Home Messages

1. First comprehensive population-based survey on the matters in HK
2. Most important aspects of EOL care are the close relationships and being free from pain and discomfort
3. EOL care with palliative care as its core needs to be more emphasized
4. Patient's autonomy should be considered as an important aspect of their best interest
5. Most people want to make advance wishes for themselves → AD legislation can be considered
6. The gap between people's wishes and reality in terms of preferred place of death is very wide → Hospitals may be crowded out in the future due to population aging → need to be more options!
7. Most important reason not to die at home is about their family members, NOT property price!
8. Still misunderstanding of what "haunted house" (凶宅) entails → public education across life course needed

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- The Research Team
- All participants
- Ethical approval of the research protocol was granted by the Survey and Behavioural Research Ethics Committee of the Chinese University of Hong Kong

References

1. Roger Yat-Nork Chung, Eliza Lai-Yi Wong, Nicole Kiang, Patsy Yuen-Kwan Chau, Janice Lau, Samuel Yeung-Shan Wong, Eng-Kiong Yeoh, Jean Woo. 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. JAMDA xxx (2017) 1.e1e1.e9
2. The Law Reform Commission of Hong Kong., *Substitute Decision-making and Advance Directives in Realation to Medical Treatment*. 2006.
3. Food and Health Bureau., *Introduction of the Concept of Advance Directives in Hong Kong: Consultation Paper*. 2009.
4. Hospital Authority Clinical Ethics Committee., *Guidance for HA Clinicians on Advance Directives in Adults*. 2014.
5. Kaan, T., *Law and the end of life in Singapore.* 2011.
6. Legislative Yuan of Taiwan., *The Patient Autonomy Act*. 2015.
7. The Law Reform Commission of Hong Kong., *Enduring Powers of Attorney: Personal Care*. 2011.
8. Department of Health., *Mental Capacity Act*. Vol. 6. 2005, London: HMSO. 2005--2006.
9. Hospital Authority., *HA Guidelines on Life-sustaining Treatment in the Terminally Ill.* 2015.
10. Hong Kong Legislative Council., *Powers of Attorney Ordinance (Cap 31)*. 1999.

Thank You!