

THE LAW REFORM COMMISSION OF HONG KONG

REPORT

SUBSTITUTE DECISION-MAKING AND ADVANCE DIRECTIVES IN RELATION TO MEDICAL TREATMENT

EXECUTIVE SUMMARY

(This Executive Summary is an outline of the Report. Copies of the Report can be obtained either from the Secretariat, Law Reform Commission, 20/F, Harcourt House, 39 Gloucester Road, Hong Kong, or on the internet at <<http://www.hkreform.gov.hk>>.)

Introduction

1. This report is concerned with two specific circumstances, both relating to decision-making for persons who are unable to make those decisions at the time of execution of the associated action. The first relates to decisions made by a third party in respect of the medical treatment and the management of property and affairs of persons who are comatose or in a vegetative state. The second relates to advance decision-making by the individual himself as to the health care or medical treatment he wishes to receive at a later stage when he is no longer capable of making such decisions. The two aspects of the subject can perhaps best be distinguished or contrasted as being concerned with pre-incapacity decision-making (for persons in the second situation) and post-incapacity decision-making (for persons in the first situation).

2. Under the existing common law, an individual may, while capable, give directions as to his future health care once he no longer has the capacity to make such decisions. The Commission recommends that this concept of "advance directives" should be promoted initially by non-legislative means and the Government should review the position in due course once the community has become more familiar with the concept and should consider the appropriateness of legislation at that stage. The Commission also recommends that the definition of "mentally incapacitated person" should be amended for the purposes of the application of Parts II and IVC, and Part IVB of the Mental Health Ordinance (Cap 123), respectively, so as to cover comatose or vegetative persons.

Chapter 1

The concept of capacity and decision-making

Concept of capacity

3. It is presumed at common law that an adult has full capacity unless it is shown that he or she does not. The present law offers a number of tests of capacity

depending on the type of decision in issue. Case-law provides answers in some circumstances, and individual statutes contain provisions on capacity in others. However, it is important to distinguish between the *legal* concept of capacity or incapacity and the *medical* concept of capacity or incapacity.

4. A legal incapacity arises whenever the law provides that a particular person is incapable of taking a particular decision, undertaking a particular juristic act, or engaging in a particular activity. Incapacity can arise from a variety of conditions. These may include being under the age of majority or of unsound mind. There is also a basic common law test of capacity, to the effect that the person concerned must at the relevant time understand in broad terms what he is doing and the likely effects of his action. Thus, in principle, legal capacity depends upon understanding rather than wisdom; the quality of the decision is irrelevant as long as the person understands what he is deciding. However, the basic test has been adapted *ad hoc* to meet specific situations and the precise test now employed by the common law or statute may differ according to the situation.

5. Decision-making capacity is not a medical or psychological diagnostic category; it rests on a judgement of the type that an informed person might take. If the issue of capacity comes before a court because there is a dispute or because a legal determination of capacity is required for some purpose, the judge makes his determination not as a medical expert but as a lay person on the basis of evidence from the patient's doctors, others who know him, and possibly from personal observation.

Causes of mental incapacity

6. Mental incapacity may arise from a number of different causes. It may be caused by:

- a congenital intellectual disability
- brain damage brought about by injury or illness
- dementia
- a psychiatric condition
- substance abuse

Problems of decision-making disability

7. A person with a decision-making disability who is unable to make a decision alone may be able to make that decision with an appropriate level of assistance. However, some people have a decision-making disability which impairs their decision-making capacity to such a degree that they lack legal capacity to make some or all of their own decisions, either alone or with assistance. It may mean that the person is unable to make legally effective decisions about matters such as personal welfare and health care, and financial and property management. Yet certain decisions may have to be made: the person concerned may need medical treatment, for example, or it may be necessary to sell the person's home to arrange alternative accommodation. The problem that arises is that no one has an automatic right to make decisions on behalf of another adult, no matter how closely the two are related. A decision-maker for an adult

with impaired decision-making capacity must be legally authorised to act on behalf of the other person before the decision-maker's decisions have any legal force.

8. The present law is unclear as to who has authority to authorise medical treatment in the case of comatose or vegetative persons, or to manage the property and affairs of the individual in the absence of an enduring power of attorney. In relation to advance directives given by persons when mentally competent as to the form of health care or medical treatment which they would like to receive at a future time when they are no longer competent, there is at present no legal framework to give force to such advance decision making.

Chapter 2

The concept of advance directives

Advance directives

9. An advance directive for health care is a statement, usually in writing, in which a person indicates when mentally competent the form of health care he would like to have at a future time when he is no longer competent. The development of advance directives is largely derived from the principle of informed consent and the belief in a person's autonomy in health care decisions.

10. An advance directive about health care can also be explained as an "anticipatory decision" about health care which is intended to have effect even if a patient loses the capacity to make such a decision at some future time. Some commentators use the term "living will".

Chapter 3

Mentally incapacitated persons: existing statutory provisions

Mental Health Ordinance (Cap 136)

11. In Hong Kong, the statute law relating to mental incapacity is principally consolidated in the Mental Health Ordinance (Cap 136). The key parts of the Mental Health Ordinance which aim to provide protection for mentally incapacitated persons in respect of their health care, their consent to medical treatment, and the management of their property, include:

- Part II, which deals with the management of property and affairs of mentally incapacitated persons;
- Part IVB, which provides for guardianship; and
- Part IVC, which regulates consent to medical and dental treatment.

12. Part II of the Mental Health Ordinance generally empowers the court, on application, to make an order directing enquiry as to whether any person who is alleged

to be mentally incapacitated is incapable, by reason of mental incapacity, of managing and administering his property and affairs.

13. Part IVB of the Mental Health Ordinance deals with the guardianship of mentally incapacitated persons, and the establishment and role of the Guardianship Board. The Board is a body corporate, which considers and determines applications for the appointment of guardians of these persons who have attained the age of 18 years.

14. Sections 59ZB to 59ZK of Part IVC make provision for the giving of consent to the medical, dental or "special" treatment of a mentally incapacitated person who has attained the age of 18 years and is incapable of giving consent to that treatment. "Special treatment" is defined as medical or dental treatment "of an irreversible or controversial nature" as specified by the Secretary for Health, Welfare and Food. Before specifying that a particular treatment is "special treatment", the Secretary for Health, Welfare and Food is required to consult the Hospital Authority and "other appropriate bodies", which include the Department of Health, the Hong Kong Medical Association and the Hong Kong Dental Association.

Enduring Powers of Attorney Ordinance (Cap 501)

15. The Enduring Powers of Attorney Ordinance provides a procedure whereby a power of attorney, if made in the prescribed form, executed in the prescribed manner and containing the prescribed explanatory information, can continue after the donor becomes mentally incapacitated. An enduring power of attorney can only confer on the attorney authority to act in relation to the property and financial affairs of the donor and must specify the particular matters, property or affairs in relation to which the attorney has authority to act. An enduring power of attorney is of no avail in relation to consent to medical treatment. If the attorney has reason to believe that the donor is or is becoming mentally incapable he must apply to the Registrar of the High Court for registration of the instrument creating the power. If the donor subsequently becomes mentally incapable, the attorney may not do anything until the power is registered.

Chapter 4

Mentally incapacitated persons: the common law and consent to medical treatment

16. It is a long established principle that every person's body is inviolate. A doctor cannot treat a patient who is competent without the patient's consent. To do so would be unlawful. A number of factors will affect the determination as to whether or not consent has been given. These include the nature of any outside influence, and whether the consent or refusal was informed. In certain circumstances, consent may be dispensed with under the principle of necessity.

Chapter 5

Practice in the medical profession relating to medical treatment and the assessment of mental capacity

17. This chapter takes a brief look at the medical profession's existing practice in relation to the medical treatment of comatose, vegetative or other mentally incapable patients, including the Hospital Authority's *Guidelines on Life-sustaining Treatment in the Terminally Ill* and the UK General Medical Council's *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making*. This chapter also considers the guidelines provided by the British Medical Association. Further assistance is provided by the *Frequently Asked Questions and Answers in the Application of the Mental Health Ordinance* prepared by Dr H K Cheung of Castle Peak Hospital.

Chapter 6

Problems with the existing law

Deficiencies in the Mental Health Ordinance (Cap 136)

18. It is unclear whether persons who are "vegetative" or in a state of coma, or who suffer from other forms of incompetence such as dementia, may be regarded as "mentally incapacitated" for the purposes of the Mental Health Ordinance (Cap 136). Another difficulty is that the common law provides uncertain guidance as to the lawfulness of treatment given to a mentally disordered patient.

The definition of "mental incapacity"

19. "Mental incapacity" is defined in section 2 to mean "mental disorder" or "mental handicap". "Mental disorder" is defined as:

- (a) *mental illness;*
- (b) *a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;*
- (c) *psychopathic disorder; or*
- (d) *any other disorder or disability of mind which does not amount to mental handicap."*

20. "Psychopathic disorder" is defined in section 2 as:

"a persistent disorder or disability of personality (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned."

Cap 136 therefore provides an explanation of categories (b) and (c) of its definition of

"mental disorder", but does not clarify what falls within categories (a) and (d) of that definition.

21. The term "mental illness," which is used in category (a) of Cap 136's definition of "mental disorder", is not defined in the Ordinance and the determination of the mental competence or incompetence of a patient therefore depends on the particular doctor's diagnosis. The absence of a precise legal definition in Cap 136 of "mental illness" places a significant burden on the individual medical practitioner in deciding his patient's mental competence.

Uncertainty of the common law regime

Decision-making as to health care or medical treatment

22. At common law, the court had no jurisdiction to approve or disapprove the giving of medical treatment to mentally disordered persons (though the court retains its power of inherent jurisdiction to make a declaration). The lawfulness of the action depended upon whether the treatment was in the "best interests" of the patient. It may not be desirable that the "best interests" of the patient should be a matter of "clinical judgement".

23. Recent developments in medicine and technology and the changing nature of contemporary society have highlighted the need for an adequate substitute decision-making mechanism for the mentally incapacitated. The problem of proxy decisions arises almost daily and with an aging population its incidence can be expected to increase. It may therefore be necessary to put in place a mechanism which facilitates the decision-making process and which articulates the rights and duties of those affected.

Lack of autonomy of patient

24. It is important that any legislation recognises that persons with a decision-making disability, whether through mental incapacity or some other cause, enjoy the same fundamental human rights as any other members of the community. Persons with a decision-making disability should be afforded as much autonomy as possible and given appropriate decision-making assistance whenever it is required. Their rights should not be taken away from them by virtue of the fact that they have become mentally incapacitated.

Chapter 7

The law and proposals for reform in other jurisdictions

25. This chapter discusses the position in Australia, Canada, England and Wales, Scotland, Singapore, and the United States. All the major common law jurisdictions have introduced the concept of advance directives in respect of elderly people or the mentally incapacitated, and each of these jurisdictions has looked at the inadequacies of their legislation in this area by proposing reforms of varying degrees and scope. Although there may be cultural differences between Hong Kong and these other

jurisdictions, the social and economic conditions are not dissimilar.

Chapter 8 Proposed options for reform

Part 1: Advance directives

Options

26. The five possible reform options identified for consultation were:

- Option A: Extend the existing scope of enduring powers of attorney;
- Option B: Create welfare or continuing powers of attorney;
- Option C: Expand the functions of the Guardianship Board;
- Option D: Provide a legislative basis for advance directives; or
- Option E: Retain the existing law and promote the concept of advance directives by non-legislative means.

27. There were 60 written responses to the consultation paper from both individuals and religious, professional, social welfare and educational organisations.

28. The majority of respondents to the consultation paper agreed that the existing law should be retained and that the concept of advance directives should be promoted by non-legislative means. A significant number of those in favour of this approach thought that this should be an interim measure and that legislation should be considered once the community had become familiar with the concept of advance directives.

Recommendation 1

29. ***The Commission recommends that the concept of advance directives should be promoted initially by non-legislative means. The Commission recommends that the Government should review the position in due course once the community has become more widely familiar with the concept and should consider the appropriateness of legislation at that stage. That review should take into consideration three factors, namely, how widely the use of advance directives had been taken up; how many disputes had arisen; and the extent to which people had accepted the model form of advance directive.***

30. In reaching this conclusion, the Commission has been persuaded by a number of considerations.

- Firstly, the concept of advance directives is not one with which the community is generally familiar. The Commission believes that it would be

premature to attempt to formulate a statutory framework, and to embark on the legislative process, without greater public awareness of the issues involved.

- Secondly, in such a socially sensitive matter as this, there is much to be said for proceeding by cautious increments. The law currently recognises the validity of advance directives but there is no guidance given as to what form such a directive should take to ensure it is sufficiently clear to provide medical staff with assurance that they may safely act upon it. The provision of a statutory form would fill that gap, but a half-way house (and a step on the road to legislation at a later stage) would be to offer guidance to the public in the shape of a model advance directive, without the backing of legislation.
- Thirdly, the publication and dissemination of a model form of advance directive can be achieved quickly and cost-effectively. It would offer immediate assistance to patients, their families and medical practitioners, without the delays inherent in the legislative process, by making widely available the means for individuals to make a clear and unambiguous statement of their wishes.

31. Some respondents were concerned that a non-legislative approach might not provide sufficient protection to doctors or other health-carers in implementing a patient's advance directives, particularly when the directives are at odds with the wishes of the patient's family. The existing common law, however, already offers adequate protection to doctors as long as they have acted in the best interests of the patient, or the provision or otherwise of medical treatment is in accordance with the patient's instructions previously made.

32. The provision of a model form of advance directive would do much to answer the problems currently encountered by patients, their families and the medical profession. The Commission proposes that wide publicity should be given to a non-statutory form, which individuals could use if they chose. The advantage of the model form would be that, if correctly completed, the individual could be reasonably assured that his wishes would be executed. There is no element of compulsion in this proposal and it would remain a matter for the individual to decide whether or not he wished to execute an advance directive in the form proposed, or to choose some other form. An advance directive executed in a different form would, as now, be enforceable so long as its instructions are clear, and it is freely made by a competent person.

Recommendation 2

33. ***We recommend the publication and wide dissemination of the model form of advance directive we propose, and that the use of the model form should be encouraged.***

Recommendation 3

34. ***We recommend that appropriate publicity should be given to encourage individuals to consider and complete advance directives in advance of any life-threatening illness.***

Recommendation 4

35. ***We recommend that the Government should launch publicity programmes to promote public awareness and understanding of the concept of advance directives. The Department of Health and all District Offices should have available for public reference material which provides general guidance to the public on the making and consequences of an advance directive and should provide copies of the model form of advance directive for public use.***

Recommendation 5

36. ***The Government should endeavour to enlist the support of the Medical Council, medical associations, the Bar Association, the Law Society, the Hospital Authority, all hospitals and medical clinics, non-governmental organisations involved in care for the elderly, and religious and community groups in this information campaign about the use and effect of advance directives.***

37. The three medical conditions that would activate an advance directive (namely, that the patient is terminally ill, in an irreversible coma, or in a persistent vegetative state) should be confirmed and certified by at least two doctors before any advance directive was activated. Palliative and basic care which is necessary to maintain the patient's comfort, dignity, or for the relief of pain, should always be provided.

Recommendation 6

38. **We recommend that, for the purpose of making an advance directive, the terms "terminally ill" and "life-sustaining treatment" should be defined as follows:**

- (a) **the "terminally ill" are patients who suffer from advanced, progressive, and irreversible disease, and who fail to respond to curative therapy, having a short life expectancy in terms of days, weeks or a few months.**
- (b) **"life sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialized treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration. Artificial nutrition and hydration means the feeding of food and water to a person through a tube.**

Witness

39. The majority of respondents favoured the suggestion that the model form should be completed in the presence of two witnesses, one of whom should be a medical practitioner. The advantages of having a medical practitioner witnessing the signing of the form are, firstly, the doctor acting as a witness would be in a position to explain to the maker the nature and implications of an advance directive. The witnessing doctor would be able to advise the maker of the advance directive of the possibility that future medical or technological advances may affect decisions reflected in the advance directive. Secondly, a medical practitioner would be well able to assess whether the individual understands the nature and implications of an advance directive at the time of making the advance directive. Thirdly, the witnessing doctor would be able to explain to the second witness the nature of the document he is to witness.

40. As to the issue of whether the witnessing doctor should be a doctor other than one who is treating, or has treated, the individual making the advance directive, the Commission is of the view that the choice should be best left to the maker of the advance directive.

Recommendation 7

41. **(a) The model form of advance directive requires that it be witnessed by two witnesses, one of whom must be a medical practitioner, neither witness having an interest in the estate of the person making the advance directive.**

(b) The Government should encourage bodies such as the Hospital Authority, the Medical Council, the Hong Kong Medical Association and other relevant professional bodies to consider issuing guidelines for doctors witnessing the making of advance directives to ensure consistency of medical practice in this area. The guidelines should also provide guidance for the medical profession (a) as to the effect of advance directives and (b) in assessing the validity of an advance directive.

(c) Where an individual is not able to make a written advance directive, an oral advance directive should be made before a doctor, lawyer or other independent person who should not have an interest in the estate of the person making the advance directive.

Revocation of advance directives

42. As it is with the model form of advance directive, so it is with the recommendations we make in respect of revocation: we believe that by following our proposed method of revocation, the individual's wishes will be made clear. An individual may validly revoke his advance directive in a different manner if he so chooses. Provided the revocation is clear and unambiguous, it will be effective.

43. The person who witnesses a written revocation should (as in the case of an oral revocation) be an independent person who has no interest in the estate of the person making the revocation.

44. If a member of the medical staff becomes aware of a patient's revocation, that information should be properly documented in the patient's medical records.

45. It should be made clear that an advance directive will only be implemented at the point where the patient lapses into an irreversible coma or persistent vegetative state. So long as the coma is acute, rather than irreversible, life-sustaining treatment will continue to be given. The Commission considers that doctors should err on the side of caution in cases where the diagnosis of irreversible coma or persistent vegetative state is not clear-cut.

Recommendation 8

46. **We recommend that :**

- (a) for the sake of certainty and the avoidance of doubt, those wishing to revoke an advance directive should be encouraged to do so in writing;**
- (b) if an advance directive is revoked in writing, it should be witnessed by an independent witness who should not have an interest in the estate of the person making the revocation;**
- (c) if an advance directive is revoked orally, the revocation should be made before a doctor, lawyer or other independent person who should not have an interest in the estate of the person making the revocation, and where practicable that witness should make a written record of the oral revocation; and**
- (d) if medical staff learn that an individual has revoked his advance directive, that information should be properly documented in the individual's medical records.**

Central Registry

47. The Commission has decided not to recommend the establishment of a central registry to record advance directives. Although a central registry would offer a convenient way in which medical staff could ascertain the existence and terms of a patient's advance directive, the essence of the Commission's proposals is that they are non-mandatory. Just as the model form of advance directive is put forward as one which the individual may or may not choose to adopt, as he sees fit, so the filing of an advance directive in the proposed registry would be entirely voluntary, with each individual deciding whether or not he wished to make use of that facility. The result of voluntary filing means that the records kept by the proposed registry would not be complete, and any search of those records by medical staff would therefore not be conclusive.

Conscientious objection

48. The Commission thinks that any healthcare worker who finds himself unable to carry out the patient's instructions should make arrangements for some one else to act in his place.

Consideration of legal advice and consultation with family

Recommendation 9

49. **We recommend that the Government should, as part of its public awareness campaign about advance directives, encourage those who wish to make an advance directive to seek legal advice and to discuss the matter first with their family members. Family members should also be encouraged to accompany the individual when he makes the advance directive.**

Part 2: Decision-making for persons in a coma or vegetative state

50. As discussed in Chapter 6, there is some uncertainty as to whether a comatose or vegetative person can be said to be suffering from "any other disorder or disability of mind," which would bring him within the scope of the definition of "mentally incapacitated person" in the Mental Health Ordinance (Cap 136). In order to remove the uncertainty, the Commission considers that the term "mentally incapacitated person" should be given a new definition for the purposes of Parts II, IVB and IVC of the Mental Health Ordinance ("MHO"), so that these Parts will apply to a comatose or vegetative person when the need arises, with regard to the management of their property and affairs and the giving or refusing of consent to medical treatment. However, the existing definition of "mental incapacity" given in the MHO should continue to apply to Part III (Reception, Detention and Treatment of Patients), Part IIIA (Guardianship of Persons Concerned in Criminal Proceedings), Part IIIB (Supervision and Treatment Orders Relating to Persons Concerned in Criminal Proceedings), Part IV (Admission of Mentally Disordered Persons Concerned in Criminal Proceedings, Transfer of Mentally Disordered Persons under Sentencing and Remand of Mentally incapacitated Persons) and Part IVA (Mental Health Review Tribunal) of the MHO. These Parts deal specifically with the confinement and medical treatment of persons suffering from mental disorder and would not be expected to apply to a comatose or vegetative person. Accordingly, a reference to a "mentally incapacitated person" in these Parts will continue to mean a person suffering from mental disorder or mental handicap as currently defined.

51. The Commission notes the approach taken by the English Law Commission in its draft Mental Incapacity Bill, where two categories of person fall within the definition of "mentally incapacitated person". The first category comprises those who are unable to make decisions for themselves on the matters in question due to "mental disability". The second category comprises persons who are unable to communicate their decisions because they are unconscious or for any other reason.

This second category would clearly include persons in a comatose or vegetative condition and clarifies the scope of the term "mentally incapacitated person".

52. The Commission proposes that a similar but slightly modified approach should be reflected in the new definition of "mentally incapacitated person" for the purposes of Parts II, IVB and IVC of the Ordinance. The Commission recommends that two categories of person should be included within the definition of "mentally incapacitated person". The first category should comprise those who are unable to make decisions for themselves, and should include persons who are suffering from:

- (a) mental illness;
- (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct;
- (c) psychopathic disorder;
- (d) mental handicap; or
- (e) any other disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

53. This formulation incorporates within a single definition the separate elements of mental disorder and mental handicap which currently constitute the definition of "mentally incapacitated person" in the MHO. The conditions described in paragraphs (a), (b) and (c) above are the same as the first three categories of "mental disorder" as currently defined in the MHO, while paragraph (d) refers to mental handicap. Paragraph (e) is intended to provide greater clarity than the existing paragraph (d) of the definition of "mental disorder" in the MHO. Firstly, it states clearly that it would cover both permanent or temporary disability or disorder. Secondly, it is more comprehensive and will include patients whose mental disability is caused other than by psychiatric illnesses.

54. The second category of persons included in the proposed definition of "mentally incapacitated person" are those who are unable to communicate their decisions. This category would cover a comatose or vegetative person and certain stroke patients.

55. Most respondents agreed that for the purposes of Parts II, IVB and IVC of the MHO, the current definition of "mentally incapacitated person" should be revised to clarify any doubt that might exist. Some respondents suggested that a new definition of "mental incapacitated person" for those Parts should refer only to persons within certain diagnostic categories, such as "suffering from dementia, stroke or mental handicap". The Commission does not agree with this approach as it is impracticable to draw up an exhaustive list of medical conditions which would have the effect of rendering individuals incapable of making decisions. An alternative suggested by other respondents was to revise the existing definition so that it was solely based on an individual's functional capabilities, such as the ability to understand or retain information. The Commission does not consider this approach desirable either, as the tests of a person's functional capabilities relating to decision-making are not easy to define or to apply and to rely solely on such tests may result in uncertainty. The Commission's recommendation combines elements of both the "status approach" and the "functional approach": it refers,

for instance, to a person who has a psychopathic disorder **and** is unable to make a decision for himself.

56. Some respondents suggested that "advance dementia" should also be included as a category within "mental disability" but we do not agree with this suggestion. The range of disability covered by dementia is too wide, and it would be difficult to provide a sufficiently precise definition as to when a person is suffering from "advance dementia".

57. The Commission has examined the question of who may be received into guardianship under the existing law, and considers that Recommendation 9 of the Consultation Paper (now renumbered as Recommendation 10) should be amended by excluding Part IVB of the MHO from the application of the proposed definition of "mentally incapacitated person" (ie the proposed definition should apply only to Parts II and IVC of the MHO), so that the existing scope of Part IVB will not be restricted unnecessarily.

Recommendation 10

58. **We recommend that the definition of "mentally incapacitated person" for the purposes of the application of Parts II and IVC of the Mental Health Ordinance (Cap. 136) should be amended along the following lines:**

- (1) For the purposes of Parts II and IVC, a mentally incapacitated person is a person who is at the material time -**
 - (a) unable by reason of mental disability to make a decision for himself on the matter in question; or**
 - (b) unable to communicate his decision on that matter because he is unconscious or for any other reason.**

- (2) For the purposes of subsection (1), a person is at the material time unable by reason of mental disability to make a decision if, at the time when the decision needs to be made, he is –**
 - (a) unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision; or**
 - (b) unable to make a decision based on that information.**

- (3) In subsection (1), "mental disability" means –**
 - (a) mental illness;**
 - (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;**
 - (c) psychopathic disorder;**
 - (d) mental handicap; or**

- (e) any other disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.**

(4) A person shall not be regarded as unable to understand the information referred to in subsection (2)(a) if he is able to understand an explanation of that information in broad terms and in simple language.

(5) A person shall not be regarded as unable by reason of mental disability to make a decision only because he makes a decision which would not have been made by a person of ordinary prudence.

(6) A person shall not be regarded as unable to communicate his decision unless all practicable steps to enable him to do so have been taken without success.

59. Applying the same concept behind the proposed definition in Recommendation 10 regarding vegetative and comatose persons, a new definition of "mentally incapacitated person" for the purposes of Part IVB of the MHO should be provided. The Commission has examined the grounds for application for a guardianship order under section 59M(2) of the MHO. Those grounds cover two categories of persons, namely, mentally incapacitated persons suffering from mental disorder and mentally incapacitated persons who are mentally handicapped. In the new definition proposed for the purposes of Part IVB of the MHO, those two categories of persons will be included without modification so as not to affect the scope of that Part. However, the Commission recommends adding a further category, namely, persons who are unable to communicate their views and wishes, which would therefore include persons who are comatose or vegetative.

Recommendation 11

60. **We recommend that the definition of "mentally incapacitated person" for the purposes of the application of Part IVB of the Mental Health Ordinance (Cap. 136) should be amended along the following lines:**

- (1) For the purposes of Part IVB, a mentally incapacitated person is –**
 - (a) a person suffering from mental disorder;**
 - (b) a person who is mentally handicapped; or**
 - (c) a person who is unable to communicate his views and wishes because he is unconscious or for any other reason.**

- (2) A person shall not be regarded as unable to communicate his views and wishes unless all practicable steps to enable him to do so have been taken without success.**

61. In Recommendation 11, the persons described in subsection (1)(a) and (b) are the same as the two categories of persons in respect of whom guardianship orders may be applied for under Part IVB of the MHO. Paragraph (c) includes persons who are unable to communicate their views and wishes, such as a comatose or vegetative

person. This definition would therefore not restrict the scope of Part IVB of the MHO and would clarify the scope of the term "mentally incapacitated person" for the purposes of that Part in that a vegetative or comatose person is clearly regarded as a "mentally incapacitated person" under that Part.

62. The effect of the new definitions proposed in Recommendations 10 and 11 will be to bring comatose and vegetative persons within the protection of the existing legal framework. The Commission notes that the Guardianship Board is enabled with various powers to issue orders dealing with the healthcare, medical treatment, property and affairs of a "mentally incapacitated person"; and considers that the existing powers conferred on the Guardianship Board are adequate for the protection of these persons, and that sufficient safeguards are found in sections 7, 8 and 9 of the MHO. These sections provide a power of inquiry and a power to examine a person alleged to be "mentally incapacitated" when an application is made by a third person to deal with the property of the "mentally incapacitated person".

63. It was proposed in the consultation paper that the medical profession should establish guidelines for doctors to follow in assessing a patient's ability to communicate. This proposal was well received and the Commission maintains this recommendation.

Recommendation 12

64. **The Government should encourage the Medical Council or other relevant professional body to issue guidelines or a code of conduct to enhance consistency of medical practice in relation to:**

- (a) the assessment of a person's ability to communicate;**
- (b) the treatment of persons in a vegetative or comatose state;**
- (c) the criteria for basic care;**
- (d) the assessment of the validity of an advance directive; and**
- (e) the implementation of advance directives.**