THE LAW REFORM COMMISSION OF HONG KONG

DECISION-MAKING AND ADVANCE DIRECTIVES SUB-COMMITTEEE

CONSULTATION PAPER

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

Executive Summary

(This Executive Summary is an outline of the Consultation Paper. Copies of the Consultation Paper 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.info.gov.hk/hkreform>.)

Introduction

1. This consultation paper 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).

Terms of reference

2. On 23 March 2002, the Secretary for Justice and the Chief Justice made the following reference to the Law Reform Commission:

> *"To review the law relating to:*
>
> *(a) decision-making for persons who are comatose or in a vegetative state, with particular reference to the management of their property and affairs and the giving or refusing of consent to medical treatment; and*
>
> *(b) the giving of advance directives by persons when mentally competent as to the management of their affairs or the form of health care or medical treatment which they would like to receive at a future time when they are no longer competent,*
>
> *and to consider and make recommendations for such reform as may be necessary."*

The Sub-committee

3. The Sub-committee on Decision-making and Advance Directives was appointed in May 2002 to examine and to advise on the present state of the law and to make proposals for reform. The members of the Sub-committee are:

Hon Mrs Sophie Leung, SBS, JP (Chairman)	Law Reform Commission member
Dr Lawrence Lai, JP (Deputy Chairman)	Hospital Chief Executive Queen Elizabeth Hospital
Mr Sunny Chan	Senior Government Counsel Law Drafting Division Department of Justice
Dr Ho Kin-sang	Consultant (Family Medicine) Elderly Health Services Department of Health
Dr Patrick Li	Chief of Service Department of Medicine Queen Elizabeth Hospital
Mr Herbert Tsoi	Partner Herbert Tsoi & Partners, Solicitors
Mrs Annie Williams	Assistant Official Solicitor Official Solicitor's Office Legal Aid Department
Dr Agnes Yeung	Sociologist
Ms Judy Cheung (Secretary)	Senior Government Counsel Law Reform Commission

Chapter 1
The concept of capacity and decision-making

Concept of capacity

4. 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.

5. 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.

6. 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

7. 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

8. 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.

9. 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

10. 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.

11. 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)

12. 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.

13. 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.

14. 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.

15. 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)

16. 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

17. 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

18. 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*. 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)

19. 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"

20. "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."*

21. "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.

22. 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

23. At common law, the court had no jurisdiction to approve or disapprove the giving of medical treatment to mentally disordered persons. 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".

24. 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.

25. Although it has been held at common law that the court has no jurisdiction to approve or disapprove the giving of medical treatment to a mentally disordered patient and that the lawfulness of the action depends upon whether the treatment is in the best interests of the patient, the court retains its power of inherent jurisdiction to make a declaration.

26. 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 facilities the decision-making process and which articulates the rights and duties of those affected.

Lack of autonomy of patient

27. 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

28. 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

29. The five possible reform options are:

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.

30. The advantages and disadvantages of Options A and B are similar. The advantages are:

- Both options amount to a general "tidying up" exercise which encourages a greater use of existing provisions without the need to embark on a wholesale revision of the law.
- Both mechanisms are flexible. It is not necessary to anticipate all future medical needs before the onset of illness.
- Both options ensure there is someone who can persuade, argue and discuss on the mentally incapacitated person's behalf.
- The attorney for health care resolves the problem of determining what should be done when relatives are in disagreement or when the family disagrees with the physicians.
- The attorney would be able to resolve ambiguities or inconsistencies in the patient's prior written and oral statements when deciding what the patient would want under the circumstances.
- The attorney provides doctors with the assurance that they have the authority to take particular actions, making doctors less vulnerable to legal reprisals or professional censure than if they rely on the informal consent of a relative.

31. The disadvantages are:

- The decision-making process may be largely unregulated and may be open to

exploitation and abuse.

- An enduring/continuing power of attorney may only be of value if the granter is properly advised and the need is perceived in time.

- Determining the exact time of the onset of incapacity still presents a problem.

- There may be a lack of procedural safeguards to impose any positive duties on an attorney to act.

32. Option C (Expand the functions of the Guardianship Board) has the benefit of balancing a "paternalistic" approach with some support for patients in their decision-making. It also ensures positive action in respect of the patient, in contrast to Options A and B which impose no duty to act on an attorney.

33. The disadvantages of Option C are similar to those which apply to Options A and B. Advance directives are only of value if a patient is properly advised before the onset of his mental incapacity and he perceives the need in time. The other arguments against this option may include the following:

- The Guardianship Board may not have full regard to the autonomy of the patient, and the patient's views and wishes could be overridden if the Board considers that it is in the interests of the patient to do so.

- The Guardianship Board can only give effect to the advance directives if they are able to ascertain their existence. However, there may be difficulties in ascertaining the existence of advance directives in some situations.

- There is a limited choice of decision-maker under the framework of the Guardianship Board. In some cases, the decision-maker may be totally unrelated to the patient, or could be someone whom the decision-maker regards as unreliable, or whom he does not favour.

- Guardianship proceedings are sometimes perceived as embarrassing to the patients who are adjudicated as "mentally incapacitated." This could be viewed as a stigma by the patients and their families.

34. Option D (Create a legislative basis for advance directives) covers a range of possibilities, from a comprehensive statutory regime covering all aspects of substitute decision-making on behalf of mentally incapacitated adults, to a more modest provision which merely provides a statutory form of advance directive. A statutory form of advance directive would give legal force to the concept of advance directives and would provide the legislative basis for the necessary substantive and procedural safeguards. Under this approach, both the format and the manner of execution of advance directives would be prescribed by law. This is the approach followed in Singapore. Its advantage is that it provides greater certainty for doctors, and reduces the likelihood of disputes between doctors and patients' families.

35. The advantage of a comprehensive scheme of reform is coherence, and that it could more easily accommodate new ideas and models which may not fit easily into

existing law or procedures. Option D would also enhance the principle of patients' autonomy.

36. However, the concept of advance directives is still new to the community and it would be premature to legislate when most people have little knowledge of the concept. In addition, legislation may deter, rather than encourage, the use of advance directives. A statutory advance directive form would also be less flexible, with the risk that the validity of an advance directive might be challenged on the basis of a minor technical error in its execution. The Sub-committee is also concerned that the process of revocation of a statutory advance directive may be seen as more daunting than useful.

37. Option E (Retain the existing law and promote the concept of advance directives by non-legislative means) is proposed on the basis that the defects in the existing law can be taken care of by common law development. 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.

38. One advantage of Option E is that it retains the flexibility inherent in judicial decisions. When disputes arise between medical practitioners and patients' relatives over the patient's prior instructions or wishes as to their medical treatment, application may be made to the court for a decision. Each case would then be decided on its own facts and merits, and the court could take into consideration the individual's circumstances as well as changing social needs before arriving at its decision.

39. The Sub-committee acknowledges that resort to the court to resolve such issues is not ideal. Court proceedings are costly and beyond the financial means of many in the community. The Sub-committee also appreciates that the traditional courtroom atmosphere and the legal culture of adversarial proceedings may alienate and intimidate applicants. However, not every case needs to be taken to the court for a decision, and providing an agreed form of advance directive, not necessarily statutory in nature, would reduce the likelihood of dispute and uncertainty. One of the drawbacks of retaining the existing law is the uncertainty of outcome of court proceedings. However, the provision of a pro-forma advance directive would provide an effective way in which evidence may be presented to the court to assist in determining the patient's wishes.

40. The advantages of this option may be summarised as follows:

- It provides a simple and cost-effective way of ensuring that a person's views and wishes are respected.
- It retains the flexibility inherent in the common law, and allows the courts to take account of the particular circumstances of each case.
- It avoids the rigidity of a statutory form, where any deviation from the form may affect the validity of the instructions from the outset.
- Exploitation or abuse is less likely under this option than one where an individual is appointed to act as another person's health care attorney.
- This option offers a less intrusive way than legislation of promoting public

awareness and acceptance of the concept of advance directives.

- This option may be implemented readily without the need to go through the legislative process.

41. In keeping with the Sub-committee's preference for a cautious approach in this sensitive matter, the model directive is restricted to medical treatment alone and does not extend to organ donation.

Recommendation 1

The concept of advance directives should be promoted by non-legislative means and those wishing to issue advance directives should be encouraged to use the model form of advance directive which the Sub-committee proposes.

42. There is a need to promote greater public awareness and understanding of the concept of advance directives. The Government has a key role to play in any such campaign, together with legal, medical and health care professionals and religious and community groups.

Recommendation 2

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 general information on advance directives and should be able to supply sample advance directive forms for public use.

Recommendation 3

The Government should endeavour to enlist the support of the Medical Council, the Medical Association, the Bar Association, the Law Society, the Hospital Authority, all hospitals and medical clinics, and religious and community groups in this information campaign.

43. The Sub-committee proposes that the instructions contained in an advance directive should apply when a patient is in one of three major medical conditions: irreversible coma, persistent vegetative state, or terminally ill.

44. Palliative and basic care which is necessary to maintain the patient's comfort, dignity, hydration or nutrition, or for the relief of pain, should always be provided.

Recommendation 4

For the purpose of making an advance directive, the terms "terminally ill" and "life-sustaining treatment" should be defined as follows:

(a) a patient is "terminally ill" when he is in an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or

permanent recovery where –

(i) death would in reasonable medical judgment be imminent, regardless of the application of life-sustaining treatment; and

(ii) the application of life-sustaining treatment would only serve to postpone the moment of death.

(b) "life sustaining treatment" means any medical procedure or measure (including cardiopulmonary resuscitation and assisted ventilation) which will only prolong the process of dying when death is imminent, but excludes palliative care.

45. The Sub-committee has prepared a sample advance directive form (at Annex 1 of the Consultation Paper). In drawing up the form, the Sub-committee has considered and referred to the sample advance directive forms produced by the British Medical Journal (at Annex 2 of the Paper), the District of Columbia Hospital Association of the United States of America (at Annex 3 of the Paper), and an "Advance Medical Directive" form produced by the Singapore Ministry of Health (at Annex 4 of the Paper).

46. An important issue to be considered is the witness requirements which should be imposed in relation to the proposed new form of advance directive. The Sub-committee's proposes that the new form should be completed in the presence of two witnesses, one of whom should be a medical practitioner. There are, of course, a number of alternative approaches which could be adopted in respect of witness requirements, each with their own potential disadvantages and advantages and the Sub-committee would particularly welcome views on this aspect of their proposals.

47. A medical practitioner as one of the witnesses to the advance directive would be well able to assess whether the individual is of sound mind at the time he makes the advance directive. He would also be in a position to explain to the maker the nature and implications of the making of the advance directive. The Sub-committee considers that consistency of practice by witnessing doctors could best be achieved by the Medical Council or other relevant professional body issuing guidelines for doctors who witness the making of advance directives.

48. The Sub-committee remains open-minded as to whether the witnessing doctor should be a doctor other than one who is treating, or has treated, the individual making the advance directive.

<u>Recommendation 5</u>

The model form of advance directive should be witnessed by two witnesses, one of whom should be a medical practitioner. Neither witness should have an interest in the estate of the person making the advance directive.

The Government should encourage the Medical Council or other relevant professional body to consider issuing guidelines for doctors witnessing the making of advance directives to ensure consistency of medical practice in this area.

49. An individual should be able to revoke any advance directives previously made by him, as long as he is mentally competent at the time he makes the revocation. A revocation may be made orally or in writing, though where the advance directive was made in writing the Sub-committee's provisional view is that the revocation must also be in writing. The Sub-committee has also considered the situation where, for example, an individual involved in a serious accident is only able to orally express his wish to revoke a directive before lapsing into a coma. The Sub-committee thinks that the proposed requirement that any revocation of a written advance directive must be in writing should not apply in an acute emergency situation. In such circumstances, an oral revocation should suffice to revoke the advance directive.

50. Where the revocation is of a written advance directive, a single witness should suffice. Annexed to the Consultation Paper (at Annex 5) is a sample form for revocation of an advance directive. Where the revocation is of an oral advance directive, the revocation can be oral or written, without the need for a witness.

Recommendation 6

(a) any or all advance directives previously made by an individual may be revoked by him at any time if he is mentally competent when he makes the revocation;

(b) a written advance directive may be revoked in writing, and should preferably be witnessed by a single witness; and

(c) in acute emergency situations, a written advance directive may be revoked orally.

Recommendation 7

A central registry should be established for the safe-keeping of all advance directives. The registry should be accessible 24 hours a day for the confirmation of any advance directives which have been made by an individual.

51. This would allow confirmation of advance directives to be made whenever the need for urgent medical treatment arises.

Recommendation 8

The Government should, as part of its public awareness campaign on 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.

52. This should ensure that both the individual and his family understand the nature of the directive, and should help to reduce disputes about medical decisions which may arise later between physicians and the individual's family.

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

53. 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 Cap 136. In order to remove the uncertainty, the Sub-committee is of the view that the term "mentally incapacitated person" should be given a new definition for the purposes of Parts II, IVB and IVC of the Ordinance, 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 Sub-committee considers that the existing definition of "mental incapacity" given in the Ordinance 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 Ordinance. 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.

54. The Sub-committee has noted 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".

55. The Sub-Committee 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 Sub-committee proposes 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.

56. Paragraph (e) is intended to provide greater clarity than the existing paragraph (d) of the definition of "mental disorder" in the Ordinance. 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.

57. The second category of persons included in the proposed definition of "mentally incapacitated person", like the definition adopted in the English Law Commission's draft Bill, are those who are unable to communicate their decisions. This category would cover a comatose or vegetative person and certain stroke patients.

Recommendation 9

The definition of "mentally incapacitated person" for the purposes of the application of Parts II, IVB and IVC of the Mental Health Ordinance (Cap. 136) should be amended along the following lines:

(1) For the purposes of Parts II, IVB 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.

58. The Sub-committee considers that the effect of the new definition will be to bring comatose and vegetative persons within the protection of the existing legal framework. As 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", the Sub-committee takes the view that the existing powers conferred on the Guardianship Board are adequate for the protection of these persons. Sufficient safeguards are found in sections 7, 8 and 9 of the Mental Health Ordinance, which 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".

Recommendation 10

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; and

(c) the criteria for basic care.

59. The Sub-committee has considered the enduring powers granted under the Enduring Powers of Attorney Ordinance (Cap 501) and thinks that these powers should remain limited to the management of property and should not be extended to cover healthcare decisions because of the risks of exploitation and abuse.

60. The Sub-committee's proposed new definition of the term "mentally incapacitated person" is intended to apply only for the purposes of Parts II, IVB and IVC of the Mental Health Ordinance (Cap 136), so that it is possible for a comatose or vegetative person to resort to the protection provided for in those Parts. The existing definition will continue to apply for the purposes of all other Parts of Cap 136, and it is that definition

which will continue to apply to other Ordinances where “mentally incapacitated person” is defined by reference to Cap 136. Having regard to the fact that each enactment has its own objectives, the Sub-committee does not propose that its revised definition should apply to provisions in other Ordinances concerned with mental incapacity.

(NB: Some of the contents of this Summary are extracted from other source materials. The Consultation Paper may be referred to for details of the source materials)