Diocesan Committee for Bioethics, Catholic Diocese of Hong Kong

Response to Consultation by the Food and Health Bureau on the Consultation Paper "End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place"

The Diocesan Committee on Bioethics of the Catholic Diocese of Hong Kong was formed in June 2005, comprising lay representatives of various Catholic medical and healthcare professional organizations as well as priests and religious personnel, to communicate with the curia to make timely and appropriate response on healthcare issues, especially in the field of medical ethics. In its terms of reference, the Committee has been charged with making known the position of the Catholic Church on bioethics issues. It is in the discharge of this duty that the Committee responds to this consultation exercise.

1. Fundamental principle

The first fundamental principle should be the principle of defense of physical life in the principle of Personalism[1]. This is the fundamental value of the person, the first embodiment and the unique foundation for self-expression and manifestation. Respect, defense and promotion of life constitute man's first ethical imperative toward himself and others. Everyone particularly medical workers have the moral obligation to defend and promote health of all humans in proportion to their need. The right to life should precede the right to choose, i.e. patients' autonomy. It is because of this fundamental principle that patients cannot instruct doctors to omit palliative or basic care in advance directive.

2. Definition

Per-specified conditions to apply advance directive should be clarified to avoid confusion to doctors and public. Current definition of "Terminally ill" in HA AD form is that, "suffering from advanced, progressive, and irreversible disease, and failing to respond to curative therapy, having **a short life expectancy in terms of days, weeks or a few months**; and the application of life-sustaining treatment would only serve to postpone the moment of death." This is not satisfactory since terminal illness e.g. metastatic cancer can still have active treatment to control disease and prolong survival from months to years successfully nowadays. The view of short life expectancy is too broad from days to months. For example, even a patient suffered from colonic cancer with multiple metastasis and anemia on best supportive care without active therapy can still offer symptomatic blood transfusion every few months and the patient can survive for one or two years more with good quality of life, apart from hospitalization for one or two days to receive blood transfusion. Thus we must define clearly what kind of terminal illness do we refer to.

In response to **Q6**, Advance directive aims for advance refusal of futile medical intervention in the dying process in the final stage of life and spares patients from further suffering and be allowed to die naturally, in peace and with dignity. That is the moment when death is imminent, no matter the patients have terminal illness or in persistent vegetative state or irreversible coma. In Singapore "terminal illness" is defined in the Advance Medical Directive Act 1996 as "an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery where - (a) **death would within reasonable medical judgment be imminent** regardless of the application of

[1] SEGRECCIA Elio, *Personalist Bioethics: Foundations and Applications*, National Catholic Bioethics Center 2012, Philadelphia p176.

extraordinary/disproportionate life-sustaining treatment; and (b) the application of extraordinary/disproportionate life-sustaining treatment would only serve to postpone the moment of death."[2]

We agree and support to put imminent death as the essential condition in the pre-specified condition (Q17). When death is imminent, argument on artificial nutrition and hydration as medical treatment or basic care can be settled as discussed below.

3. Artificial nutrition and hydration

When death is imminent in one or two days in terminal illness, giving nutrition or hydration by enteral or parental artificial means cannot avoid the natural dying process. Withdrawal of artificial nutrition and hydration in that sense will not create a new death different from the original natural death. In such situation there is no argument to consider artificial nutrition and hydration as disproportionate medical treatment and withdrawal is acceptable.

In persistent vegetative state or irreversible coma without the need of organs support, the consideration is totally different. With adequate nutrition and hydration they can survive for years. Artificial means is the only possible route they can receive nutrition and hydration, thus artificial nutrition and hydration is considered as **basic care** for them, a natural means to preserve life. In that case withdrawal of artificial nutrition and hydration will lead to starvation and dehydration and cause a new death, i.e. euthanasia. This is **gravely immoral** and totally against the doctors' mission to save life. This is consistent with our Catholic church teaching:

"The obligation to provide the 'normal care due to the sick in such cases' (Congregation for the Doctrine of the Faith, Declaration on Euthanasia, p. IV) includes, in fact, the use of nutrition and hydration (cf. Pontifical Council Cor Unum, Some Ethical Questions Relating to the Gravely Ill and the Dying, no. 2, 4, 4; Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers, no. 120). The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission" [3]

However, when death is imminent in persistent vegetative state or irreversible coma due to other terminal disease condition, consideration of artificial nutrition and hydration will follow the fore-mentioned discussion as in terminal illness.

In response to **Q5** "Do you agree that artificial nutrition and hydration should be covered under an advance

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[2] Advance Medical Directive Form, Ministry of Health, Singapore
https://www.moh.gov.sg/docs/librariesprovider5/forms/form1amd(270905).pdf

[3] Commentary on artificial nutrition and hydration by Congregation for the Doctrine of the Faith.
http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html

directive and can be withheld or withdrawn according to the patient's wish?" We propose to **follow Singapore NOT to separate terminal illness from vegetative state, and include the condition of imminent death**, then there will be no argument on artificial nutrition and hydration as life-sustaining treatments. In current Full AD form by HA, there is a third category, namely "Other end-stage irreversible life limiting condition", which is unnecessary and causes confusion when a healthy individual wants to sign AD. The simple and precise definition of terminal illness in the condition of imminent death is worthwhile to take reference to revise AD form.

It is worthwhile to consider Singapore's definition on "extraordinary life-sustaining treatment" to replace in the long list of life sustaining treatment in current Full AD form. In Advance Medical Directive Act 1996 "extraordinary life-sustaining treatment" is defined as "any medical procedure or measure which, when administered to a terminally ill patient, will only prolong the process of dying when death is imminent, but excludes palliative care." This can avoid long explanation on medical knowledge before layman can understand the meaning, particularly for elderly or uneducated public.

4. <u>Health care agent</u>

Besides, we think that the best option for the patients is to allow them to designate **a health care agent** in their AD. This health care agent can be a close family member or friend, who acts as a proxy decision-maker if the patient is not able to make his or her own decisions. Since no matter how well-crafted, **an AD can never predict all the possible problems that may occur at a later time, nor can it anticipate all future treatment options**. The health care agent understands the patient's values and can apply them to the patient's situations and respond to questions as they arise at that moment.

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