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AN ASSESSMENT OF ADVANCE DIRECTIVES IN CHINA: THE "COMING OF AGE" FOR LEGAL REGULATION?

Yue An and Mimi Zou*

Advance directives (AD) are playing an increasingly important role in end-of-life medical care and treatment in ageing societies. A growing number of jurisdictions have introduced AD-related laws as a component of their medical and health care regulatory frameworks. This article presents an analytical account of why specific regulation on ADs has yet to develop in China, the most populous ageing society in the world. We argue that the regulatory vacuum to date can be partly explained by limited public demand, which can be further accounted by relatively low public awareness as well as the influence of traditional views on life-and-death and family relationships. Finally, we suggest that there may be a "coming of age" for ADs in China in the near future, given the growing importance of patient autonomy in medical decision-making, promotion of the concept by advocacy groups, expansion of hospice and palliative care, and emergent discussions among policymakers.

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I. INTRODUCTION

An advance directive (AD) generally refers to an instrument in which a person expresses his or her wishes regarding future medical care and treatment decisions in the event that the patient is no longer competent to participate in such decisions.[1] There are two common types of ADs: living wills and health care proxies.[2] The United Kingdom's Mental Capacity Act 2005 provides a fairly comprehensive definition of a "living will" (known as an "advance decision" in the UK): "a decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if — (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued".[3] Under the same legislation, a "health care proxy" involves a competent person giving authority (such as enduring powers of attorney) to another person to make decisions regarding his or her health care and medical welfare, including consenting to or refusing medical treatment on his or her behalf when the person loses capacity.[4]

The growing popularity of ADs around the world is situated in the context of substantial advancements in medical technology and therapeutics capable of extending human life expectancy. Recognising that "[t]he greatest demand for advance directives will probably come from elderly people who are still competent",[5] various jurisdictions with ageing populations have introduced AD-related laws as a component of their regulatory frameworks for medical and health care.[6] California was among the first jurisdictions in the world to introduce the regulation of ADs under the Natural Death Act of 1976.[7] Subsequent court decisions also gave further impetus to the promotion of ADs by recognising an incompetent patient's right to direct refusal of

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[1] Linda L. Emmanuel et al., *Advance Directives for Medical Care – A Case for Greater Use*, 324 NEW ENG. J. MED. 889, 889 (1991).

[2] *Id.*

[3] Mental Capacity Act 2005, c. 9, § 24(1) (UK).

[4] *Id.* at § 9.

[5] George S. Robertson, *Making an Advance Directive*, 310 BRIT. MED. J. 236, 237 (1995).

[6] *See, e.g.*, *id* at 236.

[7] *Id.*

life-sustaining treatment.[8] The Patients Self Determination Act of 1992 was an important step in "institutionalising" ADs in the United States by requiring health care providers receiving Medicare and Medicaid funds to ask patients about the status of ADs and provide information on their rights under relevant (state) laws on ADs.[9]

Besides the UK and US, a number of countries such as Germany,[10] the Netherlands,[11] Belgium,[12] Austria,[13] and Canada[14] have also implemented similar laws to recognise different forms of ADs. A handful of countries in Asia have also enacted laws to authorise the use of ADs in certain circumstances. For example, Singapore introduced the Advance Medical Directive Act in 1996, which gives a competent person the right to make an AD regarding the refusal of life-sustaining treatment in the event of terminal illness.[15] Taiwan enacted its Patient Autonomy Act in 2015 (to go into full effect in 2019), allowing patients to create ADs regarding their medical care preferences in the event of incapacity.[16] Similarly, Korean lawmakers introduced the Act on Decisions on Life-Sustaining Treatment for Patients in Hospice and Palliative Care or at the End of Life in 2016.[17] The Mental Healthcare Act of India,

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[8] *See, e.g.*, Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 268-69 (1990); *In re* Conroy, 486 A.2d 1209, 1229 (N.J. 1985).

[9] 42 C.F.R § 489.102(a)(1)(i) (1992).

[10] Drittes Gesetz zur A¨nderung des Betreuungsrechts [3. BtÄndG] [Third Law on a Change in the Right of Care], July 29, 2009, BUNDESGESETZBLATT TEIL I [BGBL I] at 2286 § 1901a (Ger.).

[11] Wet op de Geneeskundige Behandelingsovereenkomst [Medical Treatment Contract Act] 1 April 1995, Vws. 1995, Article 450 (Neth.).

[12] *See* BELG. FED. PUB. SERV. HEALTH, FOOD CHAIN SAFETY AND ENV'T, *Patients' Rights – An Invitation to Dialogue* 1, 16 (Apr. 16, 2007), *accessible at* https://www.health.belgium.be/en/booklet-patients-rights.

[13] BUNDESGESETZ ÜBER PATIENTENVERFÜGUNGEN [PatVG] [Federal Act on Living Wills] BUNDESGESETZBLATT I [BGBL I] NO. 55/2006, https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20004723 (Austria).

[14] In Canada, all 10 provinces and 1 out of 3 territories have enacted legislation on ADs in their provincial jurisdictions. *See* END-OF-LIFE LAW AND POLICY IN CANADA, *Advance Directives*, http://eol.law.dal.ca/?page_id=231 (last visited Aug. 29, 2018).

[15] The Advance Medical Directive Act, Cap 4A, s. 3(1) (1997).

[16] Bingren Zizhu Quanli fa (病人自主權利法)[Patient Autonomy Act] (promulgated by the Legislative Yuan, Dec. 18, 2015, effective 2019) (Taiwan).

[17] Hoseupiseu Mit Wanhwa Chiryo Ttoneun Salmui Kkeuteseo Hwanjareurwihan Pyeongsaeng Chiryo Gyeoljeonge Gwanhan Beomnyul (호스피스 및 완화 치료 또는 삶의 끝에서 환자를위한 평생 치료 결정에 관한 법률) [Act on Decisions on Life-Sustaining Treatment for Patients in Hospice and Palliative Care or at the End of Life], Feb. 2, 2016 (effective May 8, 2017) (S. Korea).

enacted in 2017, also provides for the use of living wills and healthcare proxies.[18] In Hong Kong, a statutory framework for ADs does not exist at the time of writing, but the Hospital Authority has 'template' AD forms that can be requested by patients in certain situations.[19]

Like other countries, Chinese policymakers are paying greater attention to the development of a regulatory framework for medical and health care that can respond to the complex needs and challenges of a rapidly ageing population. The population segment aged 65 or above in China has grown from 100.55 million people in 2005 to 143.86 million people in 2015.[20] It is estimated that this figure will increase to 437 million in 2050, representing more than 20% of the total population.[21] In this context, end-of-life care and treatment and the attendant legal and ethical issues are becoming more visible in the public discourse. Yet, there have been relatively few studies on the development of ADs in a country with the world's largest ageing population — a country that, in recent decades, has experienced unprecedented transformations in its demographic patterns as well as social relations and structures.[22] Notably, there is hardly any existing scholarship that examines ADs in China from a socio-legal perspective.[23] Our paper aims to fill in this important knowledge gap. Drawing on primary legal sources and policy documents, relevant studies involving patients' attitudes to end

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[18] Mental Healthcare Act, No. 10 of 2017, India Code (2017).

[19] A Law Commission Report in 2006 recommended a model form of AD without introducing legislation. see *See* Hong Kong Law Reform Commission, Substitute Decision-Making and Advance Directives in Relation to Medical Treatment 110 (Aug. 2006), https://www.hkreform.gov.hk/en/docs/rdecision-e.pdf. A subsequent Government Consultation report in 2009-2010 indicated insufficient public consensus or support for introducing such legislation. *See* Hong Kong Government Food and Health Bureau, *Introduction of the Concept of Advance Directives in Hong Kong Consultation Paper* (Dec. 20, 2017), http://www.gov.hk/en/residents/government/publication/consultation/docs/2010/AdvanceDirectives.pdf.

[20] *Statistical Communiqué of the People's Republic of China on the 2005 National Economic and Social Development,* Nat'l Bureau of Statistics of China (Feb. 28, 2006), http://www.stats.gov.cn/english/NewsEvents/200603/t20060302_25737.html.

[21] *World Population Ageing: 1950-2050*, U.N. Dep't. of Econ. and Social Aff., Population Div. 1, 11.

[22] *See generally,* Lindy Wilmott et. al, *Guardianship and Health Decisions in China and Australia: A Comparative Analysis*, 12(2) Asian J. of Comp. L. 371, 372 (2017).

[23] There have been a small handful of recent articles on guardianship laws in China in the context of healthcare decisions for older adults. *See e.g.*, Wilmott et al., *supra* note 22 at 382; Rebecca Lee, *Guardianship of the Elderly with Diminished Capacity: The Chinese Challenge*, 29 Int'l J. of L., Pol'y, and the Fam. 1, 2 (2015).

of life treatment, and various discussions with researchers and health professionals in the area of palliative and hospice care in China, we provide a critical assessment of the approach to end-of-life care and treatment decision-making in China and an analytical account of why specific legal regulation of ADs has been slow to develop.

In Section II, we first introduce the main positions in the debate on the ethics of ADs, which underpin some of the difficulties in its legal regulation. Section III proceeds to examine whether existing laws in China concerning patient consent and information disclosure in medical care may operate to facilitate or obstruct the use of ADs. The reasons why there has been a paucity of laws specifically governing ADs in China to date are subsequently explored in Section IV. We argue that this legal vacuum can be explained, in part, by the limited demand from the general public to use such instruments for arranging their end-of-life care and treatment. In Section V, we conclude with some observations about the potential for a paradigm shift in the near future as China faces ever-greater healthcare challenges arising from its ageing demographic.

II. THE ETHICS OF ADVANCE DIRECTIVES

The moral authority of ADs may not be as straightforward and absolute as it might be at the first glance. In cases where wishes of a person previously documented in an AD is incoherent with his current beliefs or is against opposing views of family members, which decision should prevail? Advocates of ADs emphasize the importance of autonomy.[24] In Dworkin's view, it "encourages and protects people's general capacity to lead their lives out of a distinctive sense of their own character, a sense of what is important to and for them."[25]

Some may argue that the state in which a competent person prescribes an AD is different than when they are incapacitated.[26]

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[24] *See, e.g.*, RONALD DWORKIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA AND INDIVIDUAL FREEDOM 226 (1993); *See also* Alexander Morgan Capron, *Advance Directives*, *in* A COMPANION TO BIOETHICS 261, 261 (Helga Kuhse & Peter Singer, 2nd ed. 1998).

[25] DWORKIN, *supra* note 24 at 224.

[26] *See, e.g.*, John A. Robertson, *Second Thoughts on Living Wills*, 21(6) HASTINGS CTR. REP. 6, 7 (1991); Rebecca S. Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46(2) RUTGERS L. REV. 609, 609 (1994); Rebecca S. Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, 25(6) HASTINGS CTR. REP. 32, 32 (1995).

In other words, what is important to and for a competent person at the time an AD was made should have immaterial or no relevance to that person in the present in usual circumstances. Furthermore, as Maclean argues, if ADs draw their authority from personal autonomy, then their authority should only apply to an individual who has the same moral entity that created the directive.[27] When an individual becomes a different person, the previous autonomous decision could cease to apply to the person without capacity.[28] This argument draws on the experience of Alzheimer's patients, who often have symptoms of memory loss and are unable to recognize family members and friends.[29] As the disease progresses, patients experience a total loss of self-management.[30] Such changes are so dramatic that arguably the person becomes a new person. This view is supported by Parfit's theory of personal identity, which sees the essence of personhood as the psychological awareness and continuity.[31] When a dramatic change takes place, such as the loss of capacity, the psychological continuity of the person is disrupted.[32] After such change, the "former" person ceases to exist. Their advance decisions, accordingly, should have no authority on the "current" new person.[33]

In response, Dworkin brings in the concept of critical interests, namely, interests that "reflect the person's autonomously determined goals and life-plan".[34] This is distinguished from the concept of experiential interests that "reflect the more immediate gratification of pleasurable activities".[35] It is our critical interests that are more relevant to our autonomy than experiential interest.[36] Hence, where there is a conflict between the two types of interests, critical interests should prevail because the incompetent person "lacks the necessary capacity for a fresh exercise of autonomy; his former

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[27] Alasdair R. Maclean, *Advance Directives, Future Selves and Decision-Making*, 14 MED. L. REV. 291, 298 (2006).

[28] *Id.* at 303.

[29] Rebecca S. Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46(2) RUTGERS U. L. Rev. 609, 683 (1994).

[30] *Id.* at 688.

[31] Derek Parfit, *Personal Identity*, 80(1) PHIL. REV. 3, 12-13 (1971).

[32] MacLean, *supra* note 27 at 298-99.

[33] John A. Robertson, *Second Thoughts on Living Wills*, 21(6) HASTINGS CTR. REP. 6, 7; MacLean, *supra* note 27 at 292.

[34] MacLean, *supra* note 27 at 295 n. 21.

[35] MacLean, *supra* note 27 at 295 n. 21

[36] MacLean, *supra* note 27 at 295 n.21.

decision remains in force because no new decision by a person capable of autonomy has annulled it".[37] In this way, the authority of ADs over the wishes of an incompetent person is justified for the protection of one's critical interests.

Dresser opposes Dworkin's view by asking: if the patient can no longer understand his critical interests, why should it be given any weight?[38] She observes that: "the goal of establishing a coherent narrative may be a less common life theme than the simple effort to accept and adjust to the changing natural and social circumstances that characterize a person's life".[39] On the contrary, she argues that experiential interests are more real and immediate and deserve greater protection.[40] Jaworska and Robertson hold the view that the focus should be on best interests of the current person.[41] As Jaworska puts it: "[T]he caregiver. . . is faced with a person — or if not a fully constituted person, at least a conscious being capable of pleasure and pain — who, here and now, makes a claim on the caregiver to fulfil her needs and desires; why ignore these needs and desires in the name of values that are now extinct?"[42] However, based on this argument, it remains unresolved as to what is then the "best interest" of the current person, and upon what standards and by whom to decide the "best interest".

In an effort to seek a balance between Dworkin's emphasis on the values of the previously competent person and Dresser's concern about the wishes of the currently incapacitated person, some scholars such as Herring and Maclean have put forward arguments that supposedly represent a "compromise".[43] Both scholars have proposed that ADs should be taken into account in deciding how to treat the incompetent person. Maclean draws an

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[37] MacLean, *supra* note 27 at 294.

[38] *See generally*, Rebecca S Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, 25(6) HASTINGS CTR. RET. 32 (1995); Rebecca S. Dresser, *Missing Persons: Legal Perceptions of Incompetent patients*, 46(2) RUTGERS U. L. REV. 609 (1994); Rebecca S. Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81(7) TEX. L. REV. 1823 (2003).

[39] Rebecca S. Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, *in* BIOETHICS: AN ANTHOLOGY 341, 346 (Helga Kuhse et al. eds., 3d ed. 2016).

[40] Rebecca S. Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81(7) TEX. L. REV. 1823, 1840 (2003).

[41] Agnieszka Jaworska, *Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value*, 28(2) PHIL. & PUB. AFF. 105, 109 (1999); *See generally*, John A. Robertson, *Second Thoughts on Living Wills*, 21(6) HASTINGS CTR. REP. 6, 7-9 (1991).

[42] JAWORSKA, *supra* note 41, at 108.

[43] Jonathan Herring, *Losing It? Losing What? The Law and Dementia*, 21(1) CHILD AND FAM. L. Q. 3, 22-24 (2009); MacLean, *supra* note 27 at 312-13.

analogy between 1) the relationship of the former competent self and later incapacitated self and 2) the parent-child relationship.[44] Maclean argues that the parent/ former-self should have the decisional authority, but should be "subject to the same limits as parental authority, with other interested parties being allowed to challenge the former-self's advance decision".[45] In other words, ADs should be followed unless it will cause severe harm to the patient. This approach, according to Maclean, can "capture what is morally important about precedent autonomy-guidance for how one's life winds down; as well as what is morally important about experiential interest: avoiding pain and continuing experiences of relative quality to the extent that clear prior autonomy is not compromised".[46]

Meanwhile, Herring advocates a greater emphasis on the interest of the current individual and he suggests that the wishes of the incompetent person be respected unless those would cause the patient serious harm.[47] He proposes that ADs should step in when a health care practitioner is making a decision on how to treat the patient and the current individual does not have strong views on the treatment.[48] In addition, Herring invites attention to the caregivers and the patient's relational context in which the decisions are being made.[49] He criticizes the individualistic nature of the legal approach and argues that the "best interests" of the patient should not be assessed in isolation.[50] This approach does not deny the authority of ADs but gives less weight to them.

The above arguments raise further questions over where to draw the line, for example, in situations where ADs should or should not be followed. For some other commentators, the weight of ADs depends on how well informed the creators were when they made them.[51] According to Menzel and Steinbock, "carefully considered AEDs that are based on realistic assessment of the facts and reflect the person's enduring values

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[44] MacLean, *supra* note 27 at 316.

[45] MacLean, *supra* note 27 at 320.

[46] Jonathan Herring, *Losing It? Losing What? The Law and Dementia*, 21(1) CHILD AND FAM. L. Q. 3, 23-24 (2009) (internal quotations omitted).

[47] *Id.* at 24.

[48] *Id.*

[49] *See id.* at 6.

[50] *Id.* at 27.

[51] *See, e.g.,* Paul T. Menzel & Bonnie Steinbock, *Advance Directives, Dementia, and Physician-Assisted Death*, 41(2) J. L., MED. & ETHICS 484, 497 (2013).

have greater moral force than AEDs that do not".[52] However, along this line, some critics may argue that it is impossible to foresee what a person would experience when they actually lose their capacity and that no one could predict all the possible medical situations that the person might end up with.[53] The divergent positions in this debate arise from variations in one's worldviews and identity theories. There is no "one size fits all" approach. Notwithstanding differences in moral positions, a growing number of jurisdictions have recognised the role of the law in facilitating an individual's choice over their end-of-life health care arrangements.[54]

III. CURRENT LAWS IN CHINA

Despite increasing awareness of this concept in China, a definition or reference to ADs is yet to be found in any statutory provisions, administrative regulations, or guidelines issued by governments at any levels. The Law of the People's Republic of China on Protection of the Rights and Interests of Elderly Persons ("PRIEP") recognizes an array of rights of older persons in China.[55] However, the legislation does not mention any rights to medical and health care decision-making by the older person.[56] PRIEP has a limited number of provisions concerning the state guaranteeing basic medical needs and access to medical care by older persons and obligations on family members to ensure that an older person suffering from illness receives timely treatment and care.[57] There is no mention of respecting an individual's wishes and preferences with regards to end of life care.[58] If we take the principle of legality that posits "no crime nor punishment without law",[59] it may be argued that

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[52] *Id.* at 494.

[53] Dresser, *supra* note 38, at 35-36.

[54] *See supra* Part I.

[55] Zhonghua Renmin Gongheguo Laonianren Quanyi Baozhang Fa (中华人民共和国老年人权益保障法) [Law of the People's Republic of China on Protection of the Rights and Interests of Elderly Persons] (promulgated by the Standing Comm. Nat'l People's Cong., Apr. 24, 2015, effective Apr. 24, 2015).

[56] *See generally, id.*

[57] *Id.* at art. 14.

[58] *See generally, id.*

[59] Zhonghua Renmin Gongheguo Xing Fa (中华人民共和国刑法) [Criminal Law of the People's Republic of China] (promulgated by Nat'l People's Cong., Mar. 14, 1997, effective Oct. 1, 1997) art. 3 (stating that the law must expressly stipulate that an act is a crime in order for a person to be convicted and punished for that act).

the creation of an AD would not be unlawful. Yet at the same time, its validity or binding effect would not be protected by law, which leaves its legal position as rather uncertain. In the absence of specific laws and regulations directly governing ADs in China, we discuss below whether other existing legal provisions may facilitate or obstruct the creation and implementation of ADs.

As early as 1998, the Law on Practicing Doctors of the People's Republic of China imposed a statutory duty of information disclosure for doctors.[60] For example, Article 26 of this Law requires doctors to tell the patients or their family members the conditions of the patient truthfully.[61] Furthermore, doctors conducting experimental clinic treatment on a patient without the consent of the patient or the family will be held responsible and liable for sanctions that range from a warning to suspension of medical license and criminal sanctions.[62] Under this provision, disclosure can be made to family members instead of the patient himself.[63]

The Tort Liability Law, which took effect in 2010,[64] has reflected a slight shift in legislative direction with respect to whom disclosure should be made and from whom consent should be obtained. Article 55 of the Tort Liability Law imposes a duty of information disclosure by medical staff in two situations: (1) in general diagnosis and treatment, a duty to explain the illness condition and relevant medical measures to their patients; and (2) in the case of surgery, special examination or treatment, a duty to inform the patient of the medical risks, alternative medical treatment plans and other information in a timely manner and to obtain written consent of the patient.[65] This provision clarifies that it is the patient herself who is the main subject of medical practitioners' duty of disclosure regarding the patient's health conditions. Failure to disclose such information and causing harm to a patient can give rise to tort liability.[66] In

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[60] Zhonghua Renmin Gongheguo Zhiye Yishi Fa (中华人民共和国执业医师法) [Law of the People's Republic of China on Practicing Doctors] (promulgated by the Standing Comm. Nat'l People's Cong., Jun. 26, 1998, effective May. 1, 1999) art. 26.

[61] *Id.*

[62] *Id.* at art. 37(8).

[63] *Id.* at art. 26.

[64] Zhonghua Renmin Gongheguo Qinquan Zeren Fa (中华人民共和国侵权责任法) [Tort Liability Law of the People's Republic of China] (promulgated by Standing Comm. Nat'l People's Cong., Dec. 26, 2009, effective Jul. 1, 2010).

[65] *Id.* at art. 55.

[66] *Id.*

other words, family members cannot, in normal circumstances, be a substitute for the patient in receiving the patient's health information and in approving medical treatments for the patient.

There are various administrative regulations that recognise patients' right to informed consent with respect to medical treatment. Under the State Council's Detailed Rules for the Implementation of the Regulation on the Administration of Medical Institutions, medical institutions are required to obtain consent from the patient as well as written consent from family members and relevant parties when an operation, special examination, or special treatment is to be conducted.[67] At the same time, these rules also stipulate that medical institutions shall respect patients' right to be informed of his condition, diagnosis and therapy.[68]

Whilst generally recognising patients' right to informed consent, the above-mentioned laws and regulations stipulate various exceptions. For example, Article 62 of Managerial Regulations of Medical Institutions allows family members to give consent when the patients' view cannot be determined.[69] Article 56 of the Tort Liability Law permits medical measures to be taken without the patient's consent where the opinion of a patient cannot be obtained in the case of an emergency.[70] Importantly, Article 55 of the Tort Liability Law provides medical practitioners with considerable discretion to withhold information from the patient when it is "not proper" to disclose such information.[71] Instead of disclosing the information to the patient, the medical practitioner is to explain the information to and obtain written consent from a close relative of the patient.[72] Such an exception alludes to the recognition of "therapeutic privilege" that is found in other jurisdictions such as Australia

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[67] Yiliao Jigou Guanli Tiaoli Shishi Xize (医疗机构管理条例实施细则) [*Detailed Rules for the Implementation of the Regulation on the Administration of Medical Institutions*] (promulgated by Ministry of Health, Aug. 29, 1994, effective Sept. 1, 1994) art. 61-62 (China).

[68] *Id.* at art. 62.

[69] *Id.*

[70] Zhonghua Renmin Gongheguo Qinquan Zeren Fa (中华人民共和国侵权责任法) [Tort Liability Law of the People's Republic of China] (promulgated by Standing Comm. Nat'l People's Cong., Dec. 26, 2009, effective Jul. 1, 2010) at art. 56 (China).

[71] *Id.* at art. 55.

[72] *Id;* Bingli Shuxie Jiben Guifan (病历书写基本规范) [Basic Standards for Medical Record Keeping] (promulgated by Ministry of Health, Jan. 22, 2010, effective Mar. 1, 2010) art.10 (China).

and the US.[73] There is no further legislative, administrative, or judicial interpretation and guidance on when it is "not proper" to disclose information or who is entitled to determine whether the disclosure is "not proper." The breadth and vagueness of Article 55 can therefore create a backdoor for overriding the general recognition of patient self-determination in medical decision-making.

In practice, it can be quite common for medical practitioners and the patient's family to withhold information from the patient. Studies have shown that medical professionals and family members in China are either unaware of patients' right to be informed or are reluctant to tell patients their real conditions.[74] One survey conducted in Wuhan involving 634 doctors and nurses also revealed the reluctance of medical and health care professionals to directly inform patients of severe illnesses and a preference for letting family members make important medical decisions for patients.[75] Studies examining the families of terminally ill patients also showed similar findings. In one study involving 382 patients and 482 relatives in Chengdu, 90.8% of cancer patients at the early stage and 60.5% of those at the terminal stage believed that they should be informed of their true medical conditions.[76] However, only 60.5% and 34.4% of the family members surveyed held the same belief at the respective stages.[77] Another survey in Beijing revealed

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[73] "Therapeutic privilege" is recognized as a defense applied in Australia and was endorsed as part of Australian law by the High Court in *Rogers v. Whitaker* (1992) 175 CLR 479 (Austl.). In the US, The AMA Code of Medical Ethics Opinion on Informing Patients about Treatment Options Opinion 8.08 and Opinion 8.122, "Withholding Information from Patients"- Informed Consent explicitly allows therapeutic privilege as an exemption from informed consent guidelines. AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *AMA Code of Medical Ethics' Opinion on Informing Patients § 8.082*, 14(7) AMA J. Ethics 555, 555 (July 2012) (citing AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMA Code of Medical Ethics' Opinions on Informing Patient, § 8.122, AMA J. Ethics). Courts usually adopt professional standard to determine the extent of the necessary disclosure. *See* Elizabeth G. Patterson, *The Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You, or Can It?*, 64 NEB. L. REV. 721, 724 (1985).

[74] Ruiping Fan & Benfu Li, *Truth Telling in Medicine: The Confucian View*, 29(2) J. MED & PHIL. 179, 182 (2004); M.S. Pang, *Protective Truthfulness: The Chinese Way of Safeguarding Patients in Informed Treatment Decisions,* 25(3) J. Med. Ethics 247, 250-52 (1999).

[75] Jing-Bao Nie, *The "Cultural Differences" Argument and Its Misconceptions: The Return of Medical Truth-Telling in China, in* BIOETHICS IN THE 21ST CENTURY 103,108 (Abraham Rudnick eds., 2011).

[76] JING-BAO NIE, MEDICAL ETHICS IN CHINA: A TRANSCULTURAL INTERPRETATION 1877 (2011).

[77] Yu Jiang et al., *Different Attitudes of Chinese Patients and Their Families*

that 73.7% of the patients preferred to be informed after a confirmative diagnosis of cancer either alone or with family members.[78] However, only 2.1% of family members wanted the patient to be directly informed of the diagnosis alone and only 16.4% preferred both patients and families to be informed together.[79] The findings from these studies suggest that it can be quite common for patients (especially those with severe illnesses) not being informed of their medical conditions and patient consent being replaced by decisions made by their family members.

The system of adult guardianship law in China remains limited in addressing substitute decision-making regarding older persons' end-of-life medical and health treatment. As Willmott and others argue, "[m]any uncertainties still exist about who has authority to make health decisions, for whom such decisions can be made, and the principles which should inform the decision-making process."[80] The 1986 General Principles of the Civil Law provides that a guardian shall act on behalf of a person who is mentally unsound, incapable of discretion in his own actions, and has no capacity for civil acts.[81] As Lee has observed, such a provision gave "no consideration of the elderly whose intellectual, physical, and mental capacity deteriorates over time, but who may not be mental patients."[82] Recent regulatory developments have expanded the scope for an older person to determine a guardian. Article 26 of the amended PRIEP allows older persons with full capacity to "determine, through negotiation, their guardians among their close relatives or other individuals or organisations that have close relationships with them and are willing to bear the guardianship" to act on behalf of the older person when they lose all or part of their civil capacity.[83] A significant development has been the 2017 General

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Toward Truth Telling of Different Stages of Cancer, 16(10) PSYCHO-ONCOLOGY 928, 931 (2007).

[78] Rui-xian He, et. al, *The Preferences of Chinese Patients and their Relatives Regarding the Disclosure of Cancer Diagnoses*, 16(3) CHINESE J. CLINICAL ONCOLOGY & REHAB. 283 (2009), http://en.cnki.com.cn/Article_en/CJFDTotal-ZGZK200903036.htm.

[79] *Id.*

[80] Willmott et al., *supra* note 22, at 382.

[81] Zhonghua Renmin Gongheguo Minfa Tongze (中华人民共和国民法通则) [General Principles of the Civil Law of the People's Republic of China] (promulgated by Nat'l People's Cong., Aug. 27, 2009, effective Aug. 27, 2009) art. 13.

[82] Rebecca Lee, *Guardianship of the Elderly with Diminished Capacity: The Chinese Challenge*, INT'L J. OF L., POL'Y AND THE FAM. 1, 3 (2015).

[83] *Id.* at 8.

Provisions of the Civil Law, which allows all adults with full capacity for civil conduct to determine their guardians in writing when they lose or partially lose their capacity.[84]

Indeed, there are numerous important issues that remain unresolved by the fragmented system of guardianship law as described above. For example, the existing laws are unable to articulate the relationship between a person's capacity for civil conduct and their capacity for medical decision-making. In other words, is it possible for a person to have limited capacity for civil conduct but have the capacity for making a decision regarding their healthcare? Another deficiency concerns a lack of rules or principles governing medical and healthcare decision-making by a guardian. The General Principles of the Civil Law sets out a broad duty of a guardian to protect the person, property and other lawful rights and interests of his wards.[85] The relevant judicial interpretation provides that a guardian must protect the health of the ward, take care of the ward's life, manage and protect the property of the ward, carry out civil activities on behalf of the ward and manage and educate the ward.[86] Willmott and others have also pointed out that there is no guidance on the extent to which an AD made by a person is relevant in decision-making.[87]

In the absence of a specific legislation, the legality of an AD remains uncertain. Even if a patient is sufficiently informed, properly advised about their health conditions, and creates an AD based on informed consent, current laws in China do not guarantee its execution. It is uncertain whether ADs can be notarized. Article 11 of the Law of Succession stipulates matters for which the notarial office shall perform notarial acts, including ten specific types of matters and a "fall-back" provision enabling notarization of other matters that a natural person,

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[84] Zhonghua Renmin Gongheguo Minfa Zongze (中华人民共和国民法总则) [General Provisions of the Civil Law of the People's Republic of China] (promulgated by Nat'l People's Cong., Mar. 15, 2017, effective Oct. 1, 2017) at art. 33 (China).

[85] *Id.* at art. 34.

[86] Guanyu Guanche Zhixing Zhonghua Renmin Gongheguo Minfa Tongze Ruogan Wwenti De Yijian (Shixing) (关于贯彻执行<中华人民共和国民法通则>若干问题的意见(试行)) [Several Issues Concerning the Implementation of the General Principles of the Civil Law of the People's Republic of China (For Trial Implementation)] (Sup. People's Ct. Apr. 2, 1988), *reprinted at* http://www.npc.gov.cn/huiyi/lfzt/swmsgxflsyf/2010-08/18/content_1588353.htm.

[87] Willmott, *supra* note 22, at 395.

legal person or any other organization voluntarily requests for.[88] Although an AD is not expressly stipulated as a specific type of matter, it would seem that the "fall-back" provision could be used as long as voluntariness is proven. However, it has been reported that when a notary representative was asked about whether an AD can be notarized, the response was that only requests for notarization of matters which involve the disposition of property would be accepted, but not requests for the notarization of "the disposition of human life."[89]

We have argued so far that the creation and implementation of ADs would not violate any existing laws in China. Yet, in the absence of specific laws regulating these instruments (and recognizing their validity), the withholding of patient's true medical condition by health care practitioners and patients' family members is likely to obstruct the use of ADs. Despite recent developments in China's adult guardianship regime, there are considerable limitations in its current regulatory form for dealing with end-of-life healthcare decision-making. In the next section, we examine the reasons why Chinese lawmakers have yet to follow the footsteps of other jurisdictions that have introduced specific laws in this area.

IV. DEMAND FOR ADs AND LEGAL REGULATION

One of the primary functions of law, is "providing facilities for private arrangements" between individuals.[90] We argue that ADs, as instruments facilitating the disposition of an individual's end-of-life treatment, can be treated as one such arrangement. If the actual or perceived demand by citizens to make such an arrangement is not particularly strong or urgent, lawmakers are less likely to prioritise regulation in this area. We examine below how limited public awareness and the influence of traditional views on life and death and parent-child relationship have stalled the demand for ADs and their legal

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[88] Zhōnghuá rénmín gònghéguó zhǔxí lìng (中华人民共和国主席令)[The Notarization Law of the People's Republic of China](promulgated Aug. 28, 2005, effective Mar. 1, 2006) at art. 11(11).

[89] *See* Hao Zhang, Falv Wu Zhichi Wei Jinzhi "Shengqian Yuzhu" Neng Zou Duoyuan (法律无支持未禁止"生前预嘱"能走多远) [With No Support or Prohibition From the Law, How Far Can Advance Directives Go?], LEGAL DAILY, Sept. 2, 2013, http://www.legaldaily.com/cn/bm/content/2013-09/02/content_4808833.htm?node=20732. (last visited Dec. 20, 2017).

[90] JOSEPH RAZ, THE AUTHORITY OF LAW: ESSAYS ON LAW AND MORALITY 178 (2nd ed. 2009).

regulation in China to date. We should stress that like every other culture, Chinese culture is pluralistic, diverse, and complex. We attempt to present some commonly held beliefs rooted in Chinese tradition that have influenced practices of end-of-life care which may not be conducive to the making of ADs.

In terms of public awareness, the concept of ADs is still alien to many people in China. There is no unified translated term of ADs in the Chinese language; at least six different versions of such a concept can be found in media and research reports.[91] An investigation conducted in 2012-2013 among 429 elderly residents in 31 nursing homes in Wuhan showed that only 21 respondents have ever heard of ADs.[92] A more recent survey conducted in 2014-2015 of 1,000 residents in Pingpu (a district of Shanghai) showed a considerably higher rate (39.4%) of awareness.[93] In two studies, patients' awareness of ADs was statistically significantly associated with having attained a higher education level.[94] These studies also found that a lack of understanding or misunderstanding of end-of-life care is an important factor preventing people from making ADs in China.[95] Furthermore, there is a general lack of formal training on ADs and end-of-life treatment within the medical profession.[96]

The creation of an AD inevitably invites expectation or consideration of death. ADs have been advocated in the US under the banner of "Dying with Dignity" (DWD).[97] Such an approach is premised on the belief that a key function of ADs is to preserve an individual's personal dignity when faced with death. However, perceptions of death are culturally sensitive. Death is traditionally considered in Chinese society as a taboo,

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[91] The Chinese term of ADs are translated as the following: *yuli yiliao zhishi, shengqian yuzhu (生前预嘱), yuxian yiliao zhishi (预先医疗指示), yiliao yuzhu (医疗预嘱), yuxian zhishi (预先指示),* and *yuqian zhishi (预前指示).*

[92] Ping Ni et. al, *Investigation of Current Status and Predictors of Advance Directives among Nursing Home Residents in Wuhan China*, 29(3) J. NURSING SCI., 15 (2014).

[93] Ping He & Jianping Xu, *Analysis and Countermeasure Research in Community Residents' Different Attitudes Toward Living Will*, 14(6) J. CMTY. MED. 4 (2016).

[94] *See, e.g.* Lin Kang et. al, *Attitudes Toward Advance Directives Among Patients and Their Family Members in China*, 18(9) J. AM. MED. DIR. ASS'N. 808.e7, 808.e9(2017), https://www.jamda.com/article/S1525-8610(17)30293-1/fulltext.

[95] Ning Zhang et. al, *Attitudes Towards Advance Care Planning and Healthcare Autonomy Among Community-Dwelling Older Adults in Beijing, China*, 2015 BIOMED RES. INT'L. 7 (2015).

[96] *Id.* at 5.

[97] For example, in the state of Oregon in the US, the law on AD is called the Death with Dignity Act. *See generally* Or. Rev. Stat. §127.800 et. seq (1994).

while longevity and immortality have been regarded as "[t]he ultimate goal".[98] The above and other cultural factors have been found to shape the reluctance of patients and family members to consider discussions on end-of-life care, including the making of ADs.[99]

Furthermore, some scholars have argued that based on a traditional understanding of the Confucian notion of filial piety ("*xiao*"), a child agreeing to a parent's refusal of treatment would violate this principle.[100] One study revealed that family members of advanced cancer patients were often under internal and external pressures to pursue aggressive treatment for the patient.[101] Some participants of the study regarded choosing active medical intervention as part of their filial duty and that they would have a "guilty conscience" if they withdrew life-sustaining treatment on behalf of their parent.[102] Some were also worried about being seen by friends and neighbours as not "doing their best" to save their parents by giving up active medical intervention.[103]

Related to filial piety is the belief that in a parent-child relationship, parents are providers of care for their children and later the recipients of their children's care.[104] There is even a traditional Chinese proverb that refers to "rearing [children] for old age."[105] Such an idea is reflected in Article 21 of the Chinese Marriage Law, as well as the entire Chapter II of PRIEP that sets out the obligations of family members to care and provide for older persons.[106] Reliance of older persons on their family

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[98] TAOISM 286 (Zhongjian Mou ed., Junliang Pan & Simone Normand, trans., Brill 2012).

[99] Richard Lee, *Palliative and Hospice Comfort Chinese Seniors at the End of Life* (Summer Chiang trans.) ACE AGING, https://aging.stanford.edu/2013/10/palliative-hospice-comfort-chinese-seniors-end-life/ (last visited Dec. 20, 2017).

[100] Kerry W. Bowman & Peter A. Singer, *Chinese Seniors' Perspectives on End-of-life Decisions*, 53(4) SOC. SCI. & MED. 455, 461 (2001).

[101] *See generally*, He et al., *supra* note 78.

[102] *See* He et al., *supra* note 78.

[103] *See* He et al., *supra* note 78.

[104] Maria C. Stuifergen & Johannes J. M. Van Delden, *Filial Obligations to Elderly Parents: A Duty to Care?*, 14(1) MED. HEALTH CARE, & PHIL. 63, 64 (2011).

[105] A COLLECTION OF CHINESE PROVERBS XXV (William Scarborough trans. 1875).

[106] Zhonghua Renmin Gongheguo Hunyin Fa (中华人民共和国婚姻法)[Marriage Law of People's Republic of China] (promulgated by Standing Comm. Nat'l People's Cong., Sep. 10, 1980, effective Jan. 1 1981) at art. 21(2); Zhonghua Renmin Gongheguo Baohu Laonianren Quanyifa (中华人民共和国保护老年人权益法)[The Law of People's Republic of China of the Rights and Interests of the Elderly] (promulgated by Standing Comm. Nat'l People's Cong., Dec. 28, 2012, effective July 1. 2013) at art. 13.

members for care in old age can lessen their desire to convey and insist their personal views about end-of-life decisions. Furthermore, the cultural emphasis on the family over the individual can affect the Chinese understanding of the autonomy of the older person in their end-of-life decision-making. This is reflected in the Confucian view of "the arrangement of Heaven (*tian*) that every individual is born to a family, possessing special relations to other family members and living one's life inseparably from the family."[107] ADs would therefore not be viewed as the manifestation of an individual's decision to exercise choice and autonomy, but entirely as a family matter.

Some have argued the Confucian ethics does not necessarily hinder but instead serve as a normative basis for the making of ADs other than arguments based on personal autonomy or dignity.[108] The principle of filial piety is contended by Yang to have "three parts . . . that are integral for making an argument for a Confucian family-oriented approach to ADs".[109] First, filial piety is the paramount virtue in Confucian ethics that relates to *ren* or benevolence, which requires children to treat their parents with compassion.[110] In this sense, Yang argues that it is not an exercise of *xiao* to ignore the pain and suffering that one's parent is experiencing from aggressive medical intervention.[111] Second, Confucius emphasized the importance of reverence and criticized the behaviour of those who merely support one's parents without showing such reverence.[112] Based on this understanding, Yang maintains that one should also care for their parents' dignity and spiritual welfare.[113] Hence, if the medical treatment will deprive the parent their dignity and cause them mental suffering, insistence on such treatment would not be in conformity with *xiao*.[114] If one's parent has properly made an AD, one should respect such a decision.[115]

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[107] Ruiping Fan, *Self-determination vs. Family-determination: Two Incommensurable Principles of Autonomy*, 11(3) BIOETHICS 309, 317 (1997).

[108] *See, e.g.*, Yaning Yang, *A Family-Oriented Confucian Approach to Advance Directive in End-of-Life Decision Making for Incompetent Elderly Patients in* FAMILY-ORIENTED INFORMED CONSENT 275 (Ruiping Fan eds., 2015).

[109] *Id.* at 264.

[110] *Id.*

[111] *Id.*

[112] CONFUCIUS: ANALECTS: WITH SELECTIONS FROM TRADITIONAL COMMENTARIES 11 (Edward Slingerland trans., Hackett Publishing Co. 2003).

[113] YANG, *supra* note 108, at 265.

[114] YANG, *supra* note 108, at 265.

[115] YANG, *supra* note 108, at 266-67.

Finally, Yang suggests that the making of an AD should invite discussions between the parent and children as well as respectful communication when there are disagreements.[116] In this way, Confucian ethics can encourage a "family-oriented approach" to AD making and implementation whereby children can provide end-of-life care with compassion while preserving parents' dignity and respecting their wishes.

V. A SHIFTING PARADIGM?

A joint survey performed by the Beijing Living Will Promotion Association and the news app Toutiao in September 2016 illustrated that 85% of the 1,000 respondents believe they are the best person to make important decisions about their treatment, and that more than 90% want a painless, dignified death in the event of contracting a terminal illness. Interestingly, about 83% alleged they would make the same decision on behalf of their family members.[117] People are increasingly aware that quality of life is more important than longevity. Otherwise, participants favoured honesty (91.8%) and self-determination (50.6%), respectively, once informed of ADs in a study in 2017.[118] More than half the participants also wished to document their wishes, a higher proportion than previous reports.[119] This shows a change in health care behaviour and lesser role of family centeredness in determining use of ADs.

In recent years, grassroots projects have emerged to promote the concept of ADs in China. In 2006, a website called "Choice and Dignity" was created to provide advice to the general public on making living wills.[120] It provided templates of ADs (in Chinese language) that contained information on: whether the person wanted medical treatment of any kind, whether they wanted life-sustaining support, how they wanted other people to treat them, what information should be made available to family and friends, and who should come to the

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[116] YANG, *supra* note 108, at 266-67.

[117] Liu Zhihua, *Living Wills Enliven Debate About Death*, CHINA DAILY (Nov. 3, 2016), http://usa.chinadaily.com.cn/china/2016-11/03/content_27260450.htm.

[118] Kang et. al, *supra* note 94.

[119] Kang et. al, *supra* note 94.

[120] Wu Nan, *Chinese NGO Seeks Dying with Dignity by Writing a Living Will*, SOUTH CHINA MORNING POST (Aug. 11, 2013) https://www.scmp.com/news/china/article/1295819/chinese-ngo-seeks-dying-dignity-writing-living-will.

person's aid.[121] In June 2013, the Beijing Civil Affairs Bureau approved the founding of the Living Will Promotion Association, which was responsible for creating the website.[122] In the same year, the Beijing Geriatric Hospital started a project aimed at promoting ADs to hospital patients and their family members.[123] The hospital created documents with end-of-life treatment options and distributed them to patients and visitors.[124] Specific procedures for the creation of an AD were set out, requiring two doctors to confirm the incurability of the disease and two close relatives to act as proxies witnessing the signing of ADs.[125]

Public awareness of ADs is also growing with the expansion of hospice and palliative care for critically ill patients in recent years. Although the development of critical care services in China started at a relatively later stage in comparison with other countries, it is a rapidly growing area.[126] In 2017, the State Council's National Health and Family Planning Commission's new decree added hospice care into the categories of medical institutions that are recognised under the Implementation of Administrative Regulations on Medical Institutions.[127] It has also published guidelines mapping out the standards and provisions for the administration of hospices.[128] Based on these

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[121] Xinyuan Zhang, *Dying with Dignity*, GLOBAL TIMES (Sept. 1, 2015), http://www.globaltimes.cn/content/940203.shtml.

[122] Nan, *supra* note 120.

[123] Laonian Yiyuan Shouqi Shengqian Yuzhu Shengming Moqi Xu Liang Yisheng Rending (老年医院首启生前预嘱生命末期需两医生认定) [Elderly Hospital Launches Advance Directive Program Where Terminal Illness Shall be Affirmed by Two Doctors], BEJING TIMES (Aug. 1, 2013), http://news.sohu.com/20130801/n383084389.shtml.

[124] *Id.*

[125] *Id.*

[126] The first modern ICU bed was established in 1982 at the Beijing Union Medical College Hospital. It was not until the end of the 1990s that hospitals at or above county levels gradually set up ICUs. In 2005, Critical Care Medicine Association was established as a branch of the Chinese Medical Association, whilst corresponding institutions in the United States (Society of Critical Care Medicine) were set up thirty years earlier. *See* Bin Du et. al, *Clinical Review: Critical Care Medicine in Mainland China*, 14(1) CRIT CARE 206 (2010); *See also* Society of Critical Care Medicine, *Governance*, http://www.sccm.org/About-SCCM/Governance (last visited Dec. 31, 2018).

[127] Guojia Weisheng Jisheng Wei Guanyu Xiugai Yiliao Jigou Guanli Tiaoli Shishi Xize De Jueding (国家卫生计生委关于修改医疗机构管理条例实施细则的决定) [Decision of the National Health and Family Planning Commission on Revising the Implementation Measures of Managerial Regulations of Medical Institutions] (promulgated by Nat'l Health and Fam. Planning Commission, Feb. 21, 2017, effective Apr. 1, 2017) art. 3 (China).

[128] Aning Liaohu Zhongxin Jiben Biaozhun He Guanli Guifan

guidelines, community engagement will be an integral part of hospice care programs.[129]

Education and training of physicians, nurses, and other health personnel in palliative care will also expand along with palliative care services.[130] A recent study found an overall positive attitude towards advance care planning among a surveyed group of 102 physicians, nurses, and social workers with experience in palliative and end-of-life care.[131] Nevertheless, the study also highlighted a lack of confidence and sense of reluctance among the survey respondents to engage in discussions on advance care planning.[132]

Living wills and palliative care have increasingly become topics of discussion in government conferences and forums. A member of National People's Congress put forward a proposal in the 11th National People's Congress recommending the legalization of ADs.[133] In 2015, a member on the Standing Committee of the National Political Consultative Conference (who was a former Chairman of the Hong Kong Hospital Authority) also submitted a proposal on ADs and palliative care to the National People's Congress.[134] Although these proposals have not gone further in the National People's Congress at the time of writing, they have at least stirred up discussion within the governmental and attracted media attention on ADs in

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(安宁疗护中心基本标准和管理规范) [Basic Standards of Hospice Care Centers (Trial)] (promulgated by Nat'l Health and Fam Planning Comm'n Jan. 25, 2017 effective Jan. 25, 2017) (China); *See also* YAN HE, *A Milestone in the Development of Hospices in China*, CHINA GLOBAL TELEVISION NETWORK (Apr. 20, 2017), http://news.cgtn.com/news/3d59544e30557a4d/share_p.html.

[129] *See* Aning Liaohu Zhongxin Jiben Biaozhun He Guanli Guifan (安宁疗护中心基本标准和管理规范) [Basic Standards of Hospice Care Centers (Trial)] (promulgated by Nat'l Health and Fam Planning Comm'n Jan. 25, 2017 effective Jan. 25, 2017) (China).

[130] Mark Schubauer et. al, *Reflections on Palliative Care in Beijing*, 33 CANCER EDUC. 724, 725 (2018).

[131] Mei Ching Lee et. al, *Challenge to Advance Care Planning Among Multidisciplinary Health Professionals in China,* 23(11) INT'L J. PALLIATIVE NURSING 552, 554 (2017).

[132] *Id.* at 555.

[133] Gu Jin Dai Biao Jian Yan: Tui Guang 'Zun Yan Si' Hen You Bi Yao (顾晋代表建言：推广'尊严死'很有必要) [Representative Gu Jin Proposes: It Is Necessary to Promote "Death with Dignity"] Nat'l People's Cong. China (Mar. 9, 2012), http://www.npc.gov.cn/npc/dbdhy/12_1/2013-03/09/content_1773463.htm.

[134] Han Zhao, Hu Ding Xu: Zai Zhong Guo Shi Shi Huan He Yi Liao Ke Bu Rong Huan (胡定旭:在中国实施缓和医疗刻不容缓)[*Hu Dingxu: Palliative Care Shall be Implemented in China Without Delay*], CAI XIN (Mar. 13, 2015), http://topics.caixin.com/2015-03-13/100791001.html.

China.

VI. CONCLUSION

Notwithstanding ongoing debates about the moral justifications for ADs, an increasing number of jurisdictions have recognised the legal validity of these instruments. China has not yet implemented any law specifically regulating the creation and execution of ADs, rendering its legal status uncertain. Various obstacles include broad exceptions to a patient's right to informed consent and the customary practice of practitioners and family members withholding information from patients. A lack of public awareness and misunderstanding, along with certain influence of traditional beliefs regarding death and filial piety, have thwarted the development of ADs and its legal regulation in China.

On the other hand, changing socioeconomic and cultural factors, grassroots initiatives by NGOs to promote ADs in the community and for patients in hospices and their family members, as well as more dedicated resources and education in palliative and hospice care by the government could see a steady change in public attitudes in the near future. The development of a regulatory framework for ADs in China could be coming of age as the country seeks to deal with the increasingly complex healthcare needs of an ageing population. With growing public discussions on end-of-life care issues, further research on best practices for incorporating the principle of patient autonomy with inclusion of family members in healthcare decision making and dispute resolution mechanisms would help to guide the potential development of a regulatory framework for ADs in China.