
Advance Directives in Asia: Towards “Generative Accommodation”

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17.1 Introduction

This edited collection has surveyed the law and practice of advance directives (AD) in 16 Asian jurisdictions. In this final chapter, we offer some comparative analysis and tentative concluding comments. We begin with an examination of different aspects of the law and practice of ADs in these jurisdictions, identifying similarities and trends. With this summary of the various connections between these jurisdictions, we then offer some broader reflections on two key features common to Asian jurisdictions, the role of religion and the role of the family. We conclude with a critical examination of this emerging picture of ADs in Asia, arguing that these insights suggest that distinctive patterns of “generative accommodation” are observable as a way of aligning international consensus with localised traditions and expectations in a more nuanced account of the meeting ground between the East and the West.

17.2 Overall Observations

In order to provide an overarching thematic structure to the book, we categorised the 16 jurisdictions into “well-regulated”, “semi-regulated” and “non-regulated”, according to the extent to which ADs are formally legally regulated in that jurisdiction. The following table picks out the key relevant legislative frameworks and/or guidelines in each jurisdiction.

	Jurisdiction	Key relevant laws/guidelines
Well-regulated	Israel	Dying Patient Law (2005)
	Singapore	Advance Medical Directive Act (1996) Mental Capacity Act (2008)
	South Korea	Act on Hospice and Palliative Care and Decisions on Life-sustaining Treatment for Patients at the End of Life (2016)
	Taiwan	Hospice Palliative Care Act (2000) Patient Right to Autonomy Act (2019)
	Thailand	National Health Act (2007)
	India	Guidelines from <i>Common Cause</i> decision (2018) Mental Healthcare Act (2017) ¹
Semi-regulated	Hong Kong	Legislative Proposal (2019 consultation paper: End-of-Life Care: Legislative Proposals on Advance Directives and Dying in Place) Guidance for Hospital Authority Clinicians on Advance Directives in Adults (2020)
	Iran	Iran Charter of Patient Rights (2009) General Guidelines of Professional Ethics (2020)
	Malaysia	Guidelines on Consent for Treatment of Patients by Registered Medical Practitioners (2017) Code of Professional Conduct (2019) Guidelines for Resuscitation Training for Ministry of Health, National Committee on Resuscitation Training (2016)
	Philippines	Various hospital guidelines Ethics Guidelines on COVID-19 (2020) National Mental Health Act (2018) ²
	Turkey	Patient Rights Regulation (1998) Turkish Medical Association's Declaration on End-of-Life Decisions (2020)
	China	Chinese Medical Doctors' Code of Ethics (2014)
	Japan	The Decision-Making Process for Final Stage of Life Treatment and Care (Process Guidelines) (2018)
Non-regulated	Macao	Article 150/2 of the Criminal Code (1995)
	Pakistan	[n/a]
	Saudi Arabia	[n/a]

¹ This legislation regulates psychiatric advance directives only, and not advance directives at the end of life.

² See note 1.

We begin with some general observations about each category, and then proceed to hone in on patterns that can be observed across all the jurisdictions.

17.2.1 Well-regulated Jurisdictions

The well-regulated jurisdictions are those jurisdictions with a clear set of legal rules focused on, or encompassing, ADs. These jurisdictions are described as “well regulated” simply because the legal regulation of ADs in these jurisdictions is relatively formal, and not on the basis of any normative assessment of the quality of this legal regulation.

All of the jurisdictions in this category have detailed legal rules regulating ADs, but each jurisdiction faces its own problems in terms of implementing its framework. The over-specificity of Israel’s law, for example, has led to a paradoxical limiting of its application. The scope of the law in Singapore is arguably too restrictive, and replete with too many formalities, whereas Thailand’s legal framework lands on the opposite extreme. Despite South Korea’s principled attempts to endorse patient preferences, it is comparatively difficult to execute a patient’s wishes due to the need for verification of such wishes prior to implementation, and the relative ease with which they can be overridden by family. India’s framework, which is the only one in this category that takes the form of judicial guidelines, is overly complex and administratively burdensome.

Except for Taiwan and Thailand,³ jurisdictions in this category have frameworks that are restrictively limited to patients with terminal illness and the withdrawal/withholding of futile treatment, a feature that, as will be discussed, appears to be common among the Asian jurisdictions in this book. In addition, despite the detailed frameworks in these jurisdictions, there generally appears to be a low level of awareness and take-up of ADs.

17.2.2 Semi-regulated Jurisdictions

The semi-regulated jurisdictions are jurisdictions with other forms of regulation on ADs. Iran falls between the well-regulated and semi-regulated

³ Both Thailand and Taiwan permit ADs to be implemented for terminally ill patients, but also for patients with incurable disease for which medical treatment will merely prolong an inevitable death (Thailand) and patients with four specific clinical conditions that are unbearable, incurable and have no other appropriate treatment options (Taiwan).

jurisdictions given the legally binding nature of its Charter of Patient Rights and General Guideline of Professional Ethics, but was nonetheless placed in this category because these documents fall under the lowest, or tertiary, level of legal regulation in Iran. Turkey is also anomalous in that the guidance it has on ADs is significantly less than any of the other jurisdictions in this category, but it was nonetheless included due to the specific reference that the Turkish Medical Association’s Declaration on End-of-Life Decisions makes to ADs.

The jurisdictions in this category employ different approaches to the regulation of ADs, including the use of (i) professional guidelines in the Philippines, Hong Kong, Malaysia and Turkey and (ii) official regulations in Iran. Two additional points are worthy of note here. The first is that, interestingly, two of these jurisdictions, the Philippines and India, have a formal legislative framework for psychiatric ADs despite not having an equivalent framework for ADs governing treatment for physical illnesses, and end-of-life care in particular.

The second point is that, for some of these jurisdictions, in particular the Philippines and Malaysia, there is what can be called a “bottom-up” approach to regulation via guidelines issued by professional societies. In such jurisdictions, there are generally sociocultural and/or religious reasons why the state has not pushed to regulate ADs, or why AD legislation has failed to pass, but there is nonetheless taken to be a need for such regulation in practice. In the Philippines, for example, religious and sociocultural influences have resulted in failed attempts to pass AD legislation, but mounting pressure on healthcare resources, and the corresponding need for healthcare professionals to have the confidence to withdraw or withhold life-sustaining treatment in certain cases, have created a practical need for ADs – a need which has been further exacerbated by the onset of the COVID-19 pandemic. In response to this, hospitals have stepped in and drawn up their own institutional guidelines to regulate the making and implementation of ADs, in what can be considered a pragmatic and decentralised “bottom-up” regulatory strategy.

Similarly to the well-regulated jurisdictions, both awareness and utilisation of ADs appear to be low in these semi-regulated jurisdictions, where data are available. This is despite guidelines about ADs being in place. The authors often make the claim that sociocultural and religious influences have a sizeable effect on the acceptance and use of ADs, which indeed is a common feature across all jurisdictions, although there is a significant lack of empirical evidence about practice on the ground in the semi-regulated jurisdictions.

17.2.3 Non-regulated Jurisdictions

The non-regulated jurisdictions are jurisdictions with no AD-specific guidance, although broad principles generally exist within other regulatory spaces that pay regard to the importance of patient preferences at the end of life. The format and formality of such principles vary among the jurisdictions, although Japan is anomalous in the level of detailed official governmental guidance it has in the area of end-of-life decision-making.

Like the semi-regulated jurisdictions, there is a dearth of empirical evidence about the practice of ADs (if any) on the ground in these jurisdictions, and in some cases, evidence about attitudes towards ADs as well. In Pakistan and Saudi Arabia, the lack of sufficient empirical data on attitudes may have a particularly significant impact, given preliminary data suggesting that the perception that patients are unwilling to discuss death and end-of-life preferences may not in fact always be true, and that patients in these countries may be more willing to have end-of-life discussions and be informed of their prognosis and life-expectancy than previously thought. This, in turn, suggests that further research may support the goal of increased efforts in promoting end-of-life discussions with patients.

Once again, sociocultural and religious influences are similarly thought to have a significant effect on the acceptance and use of ADs in these jurisdictions, and, for some of them, this has resulted in a need for more training for healthcare professionals concerning ADs and end-of-life discussions with patients and family members. The latter observation is particularly important where there may be the aforementioned possibility of a misperception in patients' willingness to discuss death and end-of-life decision-making.

17.3 Key Comparisons: Patterns and Observations across the Jurisdictions

We now turn to discuss some of the broader patterns observed across all 16 jurisdictions in more detail. We show similarities are present across Asian jurisdictions, frequently in ways that transcend the degree of regulation in place. We also consider two significant points of variation among the jurisdictions, in terms of the level of specificity of AD regulation and the formalities involved. These patterns are of course to be expected; we would be surprised not to see significant variations amongst the jurisdictions of such a vast continent. Indeed, intra-regional

variations around the norms, values and practice of ADs are a feature of other international settings as well.⁴

17.3.1 *Conservative Features*

A clear trend across these jurisdictions is the conservative approach that has been adopted in relation to the governance and use of ADs. This approach is characterised by various overlapping features common to many jurisdictions. For example, while different forms of legal and/or professional regulation exist, the acceptability of ADs seems generally limited to patients with terminal illness, with the notable exceptions of Taiwan, Thailand and the proposed legislation for Hong Kong.⁵ In some cases, such as Singapore, South Korea and India, this is further limited to instances of determined medical futility, which, as Chan suggests, “adds little deliberative value to the decision to withdraw life sustaining treatment”.⁶

A conservative approach is also demonstrated by the requirements for further confirmation that exist in some of these jurisdictions prior to the implementation of the AD, and more generally, what appears to be a lack of concern for the implementation of the patient’s wishes in emergency situations. Thailand, South Korea and India, for example, all have procedures for further confirmation prior to implementation. Thailand and South Korea both require further verification of the patient’s wishes with the patient prior to implementation where the patient is conscious and retains capacity, and where the patient lacks capacity, South Korea requires the doctor to obtain the agreement of a second doctor, and the confirmation process typically involves a discussion with the family about the authenticity of the AD. In India, the procedures for confirming the AD are exceedingly lengthy and complicated, involving a Judicial Magistrate First Class (JMFC), the formation of a hospital medical board comprising multiple experts from various fields of medicine and the formation of a further medical board with the Chief District Medical Officer and other medical experts. While Malaysia does not have formal

⁴ See e.g. R. Horn, “‘Why Should I Question a Patient’s Wish?’ A Comparative Study on Physicians’ Perspectives on Their Duties to Respect Advance Directives” (2017) 24 *European Journal of Health Law* 523.

⁵ All three jurisdictions include some categories of patients without terminal illness. Hong Kong includes a general category of “other end-stage irreversible life-limiting condition[s]”. See note 3 regarding Thailand and Taiwan.

⁶ T.E. CHAN, Singapore, in this volume, p. 52.

procedures in place, a similar lack of concern for emergency situations is demonstrated by the fact that the Malaysian Medical Council guidelines give physicians a wide scope of discretion to continue treating the patient in their best interests until they can obtain legal advice regarding the validity of the AD. This can be a lengthy procedure due to the lack of clarity surrounding how an AD can be demonstrated to be valid in Malaysia.

A further feature is the relative lack of duties and/or punishment imposed where there is a failure to implement an AD, in particular as compared to the presence of protections against liability where ADs are carried out.⁷ Taiwan is the only jurisdiction with strict penalties for the violation of a patient's AD, but only under its Hospice Palliative Care Act 2000. Under the more recent Patient Right to Autonomy Act 2019 (PRAA), there are notably no penalties for physicians, and a very wide scope to opt out of implementing ADs without a duty to refer the patient to someone else who will implement it instead.⁸ Singapore also imposes a duty to implement an AD, but without mention of penalties if this is not complied with. India only imposes a duty on a physician to implement a psychiatric AD, with no similar duty in the case of end-of-life ADs. Not only is there no duty to implement, there are jurisdictions in which physicians are given significant discretion in deciding whether to implement at all. In Malaysia, for example, the Malaysian Medical Council guidelines only state that physicians "should" refrain from providing treatment contrary to an AD, and there is a flexibility not to comply with the AD if this decision is taken in consultation with the family. In Macao, physicians are required only to *consider* any patient wishes under Article 150/2 of the Criminal Code, and not necessarily to implement such wishes.

17.3.2 *Lack of Awareness, Understanding and/or Utilisation*

Another clear trend across the jurisdictions of this book is the general lack of awareness and understanding of ADs, even in jurisdictions where there

⁷ See e.g. Singapore, Thailand, Taiwan and Hong Kong's proposed legislation.

⁸ This is in contrast to Israel and Singapore. In Israel, a physician can conscientiously object to implementing the AD, but is required to refer the patient to another physician who is able to do so. See further M. BENTWICH, Israel, in this volume. Singapore similarly allows a physician to register an objection against implementing an AD, but requires the physician to "take all reasonable steps as soon as practicable" to transfer the patient to someone else who has not registered an objection (see further Advance Medical Directive Act 1996, s. 10(5)).

is a clear, detailed and comprehensive legislative framework for ADs. All jurisdictions for which there were relevant empirical data indicated that there was a lack of awareness and understanding of ADs among the general public, and in several jurisdictions, such as Israel, Thailand, India, China and Turkey, there was evidence to suggest that there was an inadequate level of awareness and/or understanding of ADs among health-care professionals as well. In some jurisdictions, there were statistics demonstrating that this had translated into low utilisation of ADs.⁹

Two observations are worth making here. The first is that, while a lack of awareness and understanding of ADs is, in itself, a likely barrier to the use and acceptance of ADs, this may be a particular concern in jurisdictions where there are data showing that increased awareness may lead to a higher uptake of ADs. For example, there were studies from some jurisdictions in which a number of participants who did not previously know about ADs responded positively after being informed about them, and in some cases stated they would want to make one.¹⁰ In Macao, there were data showing that the lack of information was a main reason deterring individuals from making ADs.

The second observation is that this lack of awareness and understanding is in some cases related to, or even a result of, the lack of communication about ADs by healthcare professionals to patients. In some jurisdictions like Pakistan, Saudi Arabia and Iran, this appears to be because of a more general reluctance to discuss issues of death and dying, or end-of-life decisions, with patients due to sociocultural factors or traditions in health-care culture. In contrast, in Hong Kong the problem seems to be more of an institutional one, with a lack of effective and coordinated communication on the part of healthcare professionals regarding ADs, and in Malaysia, the professional guidance in relation to ADs is mostly reactive, without any encouraging of physicians or other healthcare professionals to initiate such discussions with their patients. The notable exception to this is the Philippines, where healthcare professionals are “instructed to carefully explain to patients how immensely useful an AD can be” as a necessary step in the delivery of healthcare.¹¹

There is one final point to make here, connected to the point about the lack of understanding of ADs. Namely that, even at the state level, the way that AD regulation has been incorporated into existing legal and

⁹ See e.g. Israel, Taiwan, Singapore, South Korea, Japan and Hong Kong.

¹⁰ See e.g. Hong Kong, Malaysia, Saudi Arabia and Turkey.

¹¹ L.D. DE CASTRO et al., Philippines, in this volume, p. 203.

regulatory frameworks reflects that the procedural requirements to implement and enact ADs frequently do not appear to have been well thought out or understood. In jurisdictions like Singapore and Israel, there remains uncertainty about parallel regimes and how they apply.¹² While the Philippines does not have end-of-life AD legislation, its psychiatric AD legislation has potential conflicts with existing next-of-kin laws, suggesting the practicalities of how the law is to be implemented have not been well considered. In Hong Kong, the introduction of the proposed legislation would further exacerbate the already very piecemeal approach that is employed in this area of the law.¹³

In particular, many jurisdictions do not appear to have attended carefully to the mental capacity requirements for an AD, and how a person's decision-making capacity is to be assessed. In some jurisdictions, there are mental capacity requirements and assessment criteria, but these are problematic. In Singapore, for example, there is inconsistency between two different legislative regimes, and therefore uncertainty regarding the mental capacity threshold to be applied in the Advance Medical Directive Act. The lack of an overarching mental capacity test in Hong Kong, together with the existence of various different tests in the common law, Mental Health Ordinance and Hospital Authority guidelines, similarly results in ambiguity as to what the test for mental capacity should be in relation to the making of ADs. In India, the court in *Common Cause* does not elaborate on how soundness of mind is to be assessed, even though a specific definition and assessment process exists for psychiatric ADs. Various jurisdictions, such as Malaysia, South Korea and Thailand, do not have guidance regarding how capacity in relation to ADs should be assessed. The assessment procedures in South Korea and Thailand raise particular concern. In South Korea, the lack of requirements on how capacity should be assessed has meant that it is not uncommon for this exercise to be left to nurses or even volunteers at the registering institution, who may not have any experience in this area. In Thailand, there is no requirement for the assessment of capacity at the time of making the AD *at all*, and physicians are only required to

¹² Specifically, there remains uncertainty about how the legislative framework works in parallel with the common law (Singapore) or the judiciary (Israel). Furthermore, our reading of the Taiwan chapter is that there may also be some uncertainty about whether and how the two legislative regimes overlap in the case of terminally ill patients.

¹³ See e.g. the separate legislative frameworks proposed for ADs and continuing powers of attorney, in addition to the existing enduring powers of attorney legislation.

examine the patient at the time of receipt of the AD to see whether they were capacitous at the time the AD was made, something which is inherently difficult to do without an examination of the patient at that time.

17.3.3 *Sociocultural and Religious Influences*

The impact of sociocultural and religious factors on the regulation and practice of ADs is observable across all jurisdictions. The two most significant factors, the role of the family and the role of religion, permeated across some jurisdictions in complex ways, and so will be subjected to further analysis in Section 17.4.

Beyond these two factors, a cultural emphasis on deference to physicians was noted across many of the jurisdictions. For example, Tengaumnay describes a paternalistic culture in Thailand where Thai people commonly allow physicians to make decisions for them, and are therefore less likely to make ADs. Similarly, there is a general deference to physician expertise in Malaysia, arguably also due in part to Islamic religious influence.¹⁴ In Pakistani culture, Beg et al. describe physicians as holding an “esteemed” position. Physicians and nurses often take on a decision-making role due to various factors, including what is often a symbolic “induction” into families as directors rather than facilitators of care. There is a similarly greater role for doctors and medical paternalism in Indian culture as a result of the influence of Ayurvedic systems, although, interestingly, this has not resulted in a greater reluctance to make use of ADs. Instead, Dhru and Ghooi argue that this “preference for the role of the physician” has resulted in physicians being accorded a key role in overseeing and applying the AD regime.

17.3.4 *Variations in Specificity of Regulation*

In addition to the similarities observed previously, there were also important differences among the jurisdictions worthy of note. One such difference concerns the degree of specificity provided by AD regulations,

¹⁴ See further Malek’s argument that a contextualisation of patient autonomy according to Islamic values would include a prioritisation of the physician’s views, since physicians are generally seen to be the decision-making authority for the patient in Malaysian society in S. KAUR et al., Malaysia, in this volume, p. 188.

where concerns were expressed regarding both over-specificity and under-specificity.

In relation to concerns about “over-specificity”, South Korea and Israel both define the terminal stage chronologically, and further make a distinction between two stages of dying. Israel distinguishes between a “dying patient” (who has no more than six months to live) and a “dying patient in the final stage” (who has no more than two weeks to live), whereas South Korea differentiates a “terminal patient” (who is expected to die within a few months) from a “dying patient” (who is going to die imminently). This distinction is important in both countries because the specific definitions shape permitted actions in different ways. In South Korea, for example, an Advance Statement for Life-sustaining Treatment (ASLST) cannot be implemented until the patient is a “dying patient”, and in Israel, while certain types of treatment can be withheld from a “dying patient”,¹⁵ ventilator support, nourishment, palliative care and secondary/accompanying treatment can only be withdrawn or withheld from a “dying patient in the final stage”.

As the authors recognise, this level of specificity can be problematic. In the Israeli context, for example, Bentwich argues that the specificity of the timeline associated with these two stages of dying causes difficulty because of the ambiguity it paradoxically creates for physicians. This can be, for example, because prognoses often do not neatly fall into the categories of “less than six months” and “more than six months”, or because it is unclear whether an acute disease (like pneumonia) that can cause death within two weeks can be successfully treated, and therefore whether the designation of “dying patient in the final stage” is warranted.

On the opposing side of under-specificity (or over-flexibility), Ozeki-Hayashi et al. argue that the lack of a clear definition of when a patient would be considered to be in the “terminal stage” of illness in Japan’s process guidelines causes problems because it creates a reliance on the discretionary judgement of the healthcare professionals assessing the patient’s condition, and because of the inconsistency in application which is likely to result. It is interesting to note that while the definition

¹⁵ See in particular the distinction between “continuous” and “cyclical” treatments. The distinction between withholding and withdrawing treatment has also been made in the Japanese courts, and OZEKI-HAYASHI et al. (Japan, in this volume) refer to the belief among doctors in Japan that ventilator support cannot be removed once the patient has been placed on it, due to the doctor’s duty to continue treatment once it has been started.

of “imminent death” in Singapore is similarly left to medical discretion,¹⁶ there is a rigorous process of certification involving three medical practitioners, two of whom are specialists, and a separate panel of three other specialists if the initial three do not agree. While this complex process is likely to result in problems of its own,¹⁷ it may safeguard against some of the concerns relating to inconsistency of application.

The possibility of variation in physician interpretation due to the flexibility in AD regulation is also problematised more widely. Kaur et al. argue in the Malaysian context that the wording of the Malaysian Medical Council guidance provides physicians with the flexibility to disregard explicit patient wishes. In Macao, even though there is no specific regulation on ADs, the fact that physicians are only required to take patient wishes into consideration means that physicians are given wide discretion to disregard such wishes and proceed as they see fit. In cases where life-sustaining treatment is to be rejected, Raposo and Long hypothesise that physicians in Macao are likely to disregard such wishes due to the fear of potential litigation by family members.

17.3.5 *Variations in Specificity/Complexity of Formalities*

A further important but distinctive variation was observed relating to the specificity and/or complexity of the formalities placed upon the person making an AD. Here, there were jurisdictions on both ends of the spectrum of specificity and/or complexity, and the problems documented demonstrate how difficult it can be to obtain an appropriate and pragmatic balance between the two.

On one end of the spectrum, we have, for example, the jurisdictions of Singapore, India and Israel, which have very specific procedures and/or requirements in relation to making an AD, such as those relating to prescribed forms, safeguards or registration. The Singapore regime contains a number of formalities and safeguards, including a prescribed form, witnessing requirements, registration requirements, and a number of safeguards aimed at protecting the integrity and voluntariness of

¹⁶ It had been suggested that the term “imminent” be defined chronologically, for example within 6–12 months, but it was decided by the Select Committee for the Advance Medical Directive Act that this was better left to medical judgement. See further T.E. CHAN, Singapore, in this volume.

¹⁷ Such as the difficulties in implementation associated with a lengthy procedure and the need for unanimity among several professionals before the AD can be acted upon.

executing the AD. India's judicial guidelines require an AD to be signed by two independent witnesses and to be countersigned by a JMFC, following which the JMFC must preserve the AD in both paper and digital form, send a copy to the Municipal Corporate or local village council for appointment of a custodian of the AD, inform the executor's family of the AD, maintain a copy of the AD in their office and forward another copy of it to the relevant district court. This involvement of the JMFC renders the process particularly difficult, because, as Dhru and Ghooi argue, there are only a very small number of JMFCs in any given city, and these JMFCs will already be dealing with a significant backlog of cases. In Israel, it has been argued that the lengthy and complex prescribed form for ADs may be too difficult for laypersons to understand and use, in particular due to the inclusion of legal and medical jargon. Interestingly and also somewhat confusingly, it appears that this form also contains built-in options that allow individuals to include conditions (amounting to "unbearable suffering") that do not comply with definitions under the law, and it is unclear what effect the specification of these conditions might have.

On the other hand, however, a regime which is flexible in terms of the formalities it requires presents difficulties of its own. A good example of this is in Thailand. Tengaumnay claims that the regulatory procedures of this regime are so flexible that a number of specific practical problems arise, despite this approach being more supportive of patient autonomy in general terms. As there is no specific format for the AD, no requirement for medical or other witnesses and no registration system for ADs specified in the law, Tengaumnay argues that physicians are less likely to be aware of the existence of an AD without a registry, and they are likely to be uncertain about the validity of the AD, especially whether the AD was made when the individual had capacity.

17.4 Broader Considerations: The Distinctive Role of Religion and the Family in the Asian Context

Two distinctive and common features impacting on ADs were shared by many, if not most, of the Asian jurisdictions examined in this volume: the role of religion and the role of the family. As these were thought to have a significant but complex impact on the law and practice of ADs in local contexts, we offer some detailed reflections on these two broader trends. With regard to religion, the jurisdictions in this volume were defined by a range of religious traditions, which included those from Christianity,

Islam, Judaism, Buddhism, Hinduism and Jainism. One feature of several of these religions is the principle of the “sanctity of life”,¹⁸ which is particularly noteworthy in its influence in this context. However, the impact of this principle, as we shall demonstrate, is not straightforward, and religion more generally has influenced the acceptance and regulation of ADs in these jurisdictions in different ways.

17.4.1 *The Role of Religion: Sanctity of Life*

The sanctity of life operates as a key principle governing jurisdictions with Christian, Jewish and Islamic influence. While in some cases, like Israel and the Philippines, this principle is given utmost importance, it does not appear to have precluded the development of ADs. In Israel, for example, ADs were formally included as part of the Dying Patient Law 2005, despite this legislation being primarily grounded in ultra-orthodox Jewish values, which include a “commitment to preserving and saving human life, regardless of the individual’s desires”.¹⁹ The influence of such values does, however, appear to have resulted in a more restrictive scope for ADs. For example, Bentwich contends that the term “dying patient” has been defined very narrowly in the legislation, to the exclusion of patients with chronic illnesses such as dementia or amyotrophic lateral sclerosis (ALS) that do not have a clear prognosis, which appears to conform to the more orthodox view that the sanctity of life is a fundamental principle, and a key foundation of the Dying Patient Law. Similarly, Bentwich explains that the withdrawing and withholding of treatment and care is permitted in the Dying Patient Law in cases where the patients have reached the “final stage”, or where their bodies are undergoing acute systems failure, which corresponds to a *Halakhic* religious exception where refraining from treatments is allowed where “three or more systems in the human body have failed, and it is clear from a

¹⁸ We use this phrase broadly to refer to the idea, shared by several of the religious traditions discussed in this volume, that life has intrinsic value and thus that preserving life must be prioritised.

¹⁹ M. BENTWICH, Israel, in this volume, p. 23. It is interesting to note that this ultra-orthodox Jewish influence was not an inevitable consequence of the country’s religious traditions. See M. BENTWICH, Israel, in this volume for a discussion of how ultra-orthodox Judaism is not in fact the religious tradition of the majority of citizens in Israel, but how ultra-orthodox Jewish values were adopted in the Dying Patient Law primarily due to political reasons.

medical perspective that death is inevitable sooner or later”.²⁰ Similarly, in the Philippines, de Castro et al. argue that there will likely need to be a finding of medical futility before an AD could apply.²¹

Despite the heavy influence of the sanctity of life in these jurisdictions, however, there appears to be a tension between such overarching religious principles and the needs of practice on the ground, which has resulted, in some cases, in a bottom-up approach to ADs, as discussed earlier in this chapter. This is true of both the Philippines and, to a lesser extent, Israel. In Israel, Bentwich argues that there remains a tension between the Dying Patient Law, a law grounded in strict religious values, and the practice of the law on the ground, which is shaped extensively by medical professionals and the more secular perspectives of patients and their families. We might view this in terms of there being a recognised, pragmatic need for more “practical” solutions to work around the rigidity of the law. The 2014 case of *Ploni [John Doe] v The Attorney General*, where a patient with ALS requested to be disconnected from a ventilator, for example, appears to be a case where a practical “workaround” was devised by the Attorney General of Israel to try and resolve this tension.

In other jurisdictions where the sanctity of life is not necessarily of utmost importance but still a fundamental principle, such as the Islamic countries of Iran, Pakistan and Saudi Arabia, this principle (i) is subject to varying interpretations with different outcomes and (ii) is not the only major religious principle that is relevant in this area. In relation to (i), Syed et al.’s analysis demonstrates that the rule requiring the preservation of life can be interpreted using a three paradigm conception of death that views the last stage of life as part of a “dying” (*al-ihṭidār*) phase, where the obligation to preserve life no longer exists because the individual “is now approaching (destined) death and therefore is not the intended subject of the obligation to preserve life”.²² Beg et al. similarly argue in the Pakistani context that while life is considered sacred in Islam, there are interpretations of this principle that are not inconsistent with ADs, such as the idea that the time of death is determined by God and thus preordained, which means that death will occur as decided by God irrespective of the patient’s treatment decision. In relation to (ii), Syed

²⁰ M. BENTWICH, Israel, in this volume, p. 28.

²¹ Although this remains unclear due to the lack of legislation on this issue. See further L.D. DE CASTRO et al., Philippines, in this volume.

²² Z.A. SYED et al., Iran, in this volume, p. 166. This would, of course, only apply to those in the dying stage, as Syed et al. point out.

et al. and Hussein and Adlan both describe a number of key Islamic principles in addition to the sanctity of life that are relevant in the discussion of ADs and end-of-life decision-making, such as the Rule of No Harm and the Principle of Hardship. Finally, while neither of these three countries have a clear legislative framework on ADs,²³ it should be noted that the analyses of the relevant religious principles in these countries would suggest that if ADs were permissible, they would likely only be permitted where the treatment in question was an artificial and futile prolonging of death.

Thus, while the sanctity of life is recognisably a fundamental religious principle shared among many of these Asian jurisdictions, the principle does not appear to have a uniform effect on how ADs are regulated or implemented in these countries. It should also be noted that, in jurisdictions where religious traditions do not necessarily emphasise the need to preserve life, the influence of these traditions on ADs has also not been straightforward. On the one hand, Tengaumnunay has argued that the Buddhist contemplation and acceptance of death as part of the impermanence of life has led to the acceptance of the view in Thailand that individuals should be able to plan ahead to achieve a “good death”. On the other, Dhru and Ghooi argue that while death is seen in Indian religious tradition and philosophy as “a union with the Divine, the greater Self”,²⁴ the desire to avoid pain and suffering is not celebrated, and the use of an AD to reject life-sustaining treatment in order to alleviate pain and suffering would thus likely not be in line with Hindu and Buddhist religious beliefs.

17.4.2 *The Role of Religion: Variation in Interpretation*

Beyond the principle of the sanctity of life, the authors reveal how the influence of religion on ADs more generally is not necessarily straightforward in their jurisdictions. In our view, one reason for this might lie in variations in the interpretation of relevant religious principles in the process of end-of-life decision-making itself. Bentwich demonstrates, for example, using Justice Elon’s judgment in the 1993 *Yael Shefer* case, that *Halakhic* law is capable of supporting different approaches to the withdrawal of life-sustaining treatment, and in particular the withdrawal of

²³ Although unlike Pakistan and Saudi Arabia, Iran’s Charter of Patient Rights does make specific mention of ADs.

²⁴ K.A. DHURU and R. GHOOI, India, in this volume, p. 124.

ventilators. Contrary to the ultra-orthodox view as represented in the Dying Patient Law, which does not permit the withdrawal of ventilators until the final stage, Justice Elon offered in that case an interpretation of *Halakhic* law that would support ventilator withdrawal if the patient was suffering.

Similarly, our sense is that there appears to be some room for interpretation in the application of key Islamic religious principles. As Syed et al. demonstrate by examining a number of rules that may either negate or favour the respect of an AD to limit life-sustaining treatments, such rules can often be subject to varying interpretations, and in some cases even used to support opposing contentions.²⁵ Beg et al. argue that the study of relevant Islamic teachings has resulted in varying attitudes towards ADs amongst the interpreters of these teachings, which they hypothesise may be a reason why AD legislation has not been discussed. As they argue, “[l]egislators may well feel that they are in no position to make decisions on such a controversial subject rooted in religious ambiguity”.²⁶

Related to the issue of interpretation is an interesting point concerning the role and significance of religious legal guidance, specifically *fatwa*, in Islamic countries. While the legal force of a *fatwa* may vary between countries,²⁷ there is little question that *fatwa* are given primary importance in Islamic countries, in particular where there is no legislation on the topic. There appear to be, however, various institutional concerns with the obtaining of “reliable and accurate” *fatwa* on healthcare issues such as end-of-life decision-making. Syed et al. argue, for example, that the unreliability of *fatwa* may be due to several reasons, including the lack of stakeholder consultation or multi-disciplinary input that goes into the making of a *fatwa* and the fact that the derivative reasoning for medical *fatwa* are rarely published and therefore difficult to analyse. Hussein and Adlan raise another concern in the Saudi Arabian context, which is the fact that the Islamic scholars who issue *fatwa* are not generally medical professionals, and as a result, a healthcare expert will be relied upon to explain the relevant issues to them. Because this healthcare expert will usually be a physician, Hussein and Adlan argue

²⁵ See e.g. the Rule of No Harm and how it may be interpreted to either support or reject ADs in Z.A. SYED et al., Iran, in this volume.

²⁶ M.A. BEG et al., Pakistan, in this volume, p. 284.

²⁷ See e.g. the contrast between Saudi Arabia, where it is unclear what the legal role of *fatwa* might be, apart from supporting evidence in some cases (like do-not-resuscitate orders), and Iran, where the Constitution recognises the legally binding nature of *fatwa* in places where there are no statute or by-laws.

that there is a risk that the physician may advocate for their own preferences in the matter, which may lead to an “indirect form of medical paternalism”, one with religious cover.²⁸

Our examination of the role of the family in these jurisdictions, to which we now turn, gives rise to similar observations. It should first be noted that the literature on the role of the family in medical decision-making in Asia tends to focus on the fact that, as alluded to in the Introduction, individual autonomy is not accorded the same primacy in Asian jurisdictions,²⁹ and that communitarian, familial models of decision-making are more common,³⁰ which seem to be contrary to the idea of the individually based AD. The chapters in this volume, however, have demonstrated that the significance of the family, as well as its relationship with ADs, challenges this essentialist, one-dimensional picture in ways that are not often expressed. Although the role of the family is recognised as being highly influential in almost all of the chapters, the *nature of*, and *justification for*, this influence is much more nuanced and complex than is typically recognised. What we can see from the patterns of influence in these jurisdictions is that the family can play different roles in medical decision-making for different reasons, which in turn has varying effects on whether or not ADs are likely to be accepted and adopted.

17.4.3 *Family-focused Decision-Making: The Authority to Decide*

The most commonly described role, and the one referred to most in the literature, is a family-based model of decision-making in which the family is seen as the authority in, and unit of, decision-making. The family model of decision-making takes two main forms in this context: (i) an approach in which the patient does not possess sole decision-making authority, with the family making shared decisions with the patient as a communal unit³¹ and (ii) decision-making directly by

²⁸ G. HUSSEIN AND A. ADLAN, Saudi Arabia, in this volume, p. 298.

²⁹ See e.g. R. Fan, “Self-determination vs. Family-determination: Two Incommensurable Principles of Autonomy” (1997) 11 *Bioethics* 309.

³⁰ D. Martina et al., “Advance Care Planning in Asia: A Systematic Narrative Review of Healthcare Professionals’ Knowledge, Attitude, and Experience” (2021) 22(2) *Journal of the American Medical Directors Association* 349.e1.

³¹ In addition to East Asian jurisdictions where this is often said to be the case, see e.g. Iran’s concept of “family centric patient autonomous” where there is active involvement and inclusion of the family in decision-making; Turkey, where the family is frequently involved in decision-making; and Saudi Arabia, where the family and patient are seen as one unit and illness is a whole-family affair.

the family in ways that can exclude the patient entirely.³² For example, the application of a family-based model means that, in some jurisdictions, physicians feel comfortable notifying only the family members (and not the patient) of the patient's condition and prognosis.³³ A more explicit example of direct family decision-making is found in Macao, where a family member, and not the patient, is responsible for signing the consent form required by the Hospice & Palliative Care Centre at the Kiang Wu hospital, which is the closest formally recognised mechanism to an AD in Macao. And, while not in relation to the making of the AD itself, Malaysian professional guidance permits a patient's wishes to be overridden by a physician in consultation with family.

17.4.4 *Family-focused Decision-Making: The Supportive Role*

A very different family-focused approach to decision-making is one where family members are accorded specific supportive roles. In particular, one supportive role is where family members are relied upon to clarify the wishes and intentions of the individual in question. In the Philippines, for example, the details of a patient's AD are verified by checking with their family members, and in South Korea, the family both assist with the verification process of an ASLST and bear witness to the patient's preferences regarding life-sustaining treatment if no ASLST exists. In Macao, the physician has conversations with the family and takes these into account when determining whether the content of the AD reflects the patient's current and authentic desires, and it is the family's reaction that Raposo and Long argue is most formative in shaping the doctor's views on this. In Thailand, individuals can specify an individual, usually a close family member, who can clarify their intentions as laid out in the AD if there is any ambiguity or confusion. While the family plays an important role in all of these jurisdictions in assisting with the interpretation of the individual's preferences at the end of life, the potential for abuse here must not be

³² In Pakistan and the Philippines, the male members of the family are the ones who make decisions on behalf of the members of the family (in the case of the Philippines, this would be the eldest male).

³³ See e.g. Singapore, where there is a not uncommon practice of collusion where families and physicians may work together to withhold a diagnosis and/or poor prognosis from a patient; and Taiwan, where the Hospice Palliative Care Act permits the physician to fulfil their obligation by merely informing the family. (The more recent PRAA requires the information to be shared with the patient, though permits physicians to share information with family unless the patient explicitly objects.)

overlooked. Apart from the Thai context, where the individual selects their representative, there is potential, in particular where the individual does not have an amicable relationship with their family, for the individual's wishes to be misrepresented or entirely overridden in these verification or clarificatory exercises.

17.4.5 *Family-focused Decision-Making: The Carer Role*

A third distinctive approach to family-focused decision-making is one in which family members adopt the role of a carer of the patient, with various implications for decision-making authority. For example, in some jurisdictions, this approach offers a justification for according an overarching decision-making responsibility to family members on the basis of a paternalistic rationale, or because doing so equates with the intrinsic expression of care within the relationship. De Castro et al. argue that, in the Philippines, it can be considered irresponsible for a family taking care of a vulnerable patient to let them make acute treatment decisions, and in jurisdictions like Pakistan and South Korea, families demonstrate their love and care by hiding the truth about poor prognoses from the patient. The family's role as carer can also lead to a corresponding reliance on the family by the individual. In the Japanese context, for example, Ozeki-Hayashi et al. argue that the psychological factor of *amae* and the character trait of *omakase* in Japan can result in the individual preferring to leave the responsibility of making difficult decisions to their loved ones and/or physicians. Finally, related to this carer role is the importance of filial piety in jurisdictions influenced by Confucianism. This can mean that the children of the individual are less willing to initiate difficult end-of-life conversations with their parents,³⁴ or that they feel the need to do everything to save their parents.³⁵

17.4.6 *Accommodating ADs in Family-Centric Societies: Some Potential Solutions*

Given the significance of the place that the family takes with regard to ADs in these jurisdictions, how have different jurisdictions come up with

³⁴ D.F. TSAI, Taiwan, in this volume.

³⁵ D. CHEUNG and R. LEE, Hong Kong, in this volume; LEE, South Korea, in this volume. See also Iran, where this is also the case, though not due to filial piety (see further Z.A. SYED et al., Iran, in this volume).

solutions to accommodate the AD, in particular in light of these different roles that the family plays?

One solution that has been adopted is to incorporate family members officially into the decision-making process. This can be in terms of receipt of information,³⁶ or in the decision-making process itself, or the wider advance care planning (ACP) process.³⁷ A second solution gives family members an official supportive or clarificatory role. The Thai regime provides a good example of this, with the option to designate an individual, often a member of the family, to clarify any ambiguities in the AD, as mentioned previously. A third solution has been to go in the opposite direction, drafting legislation that constrains the heavy influence of the family. Article 4 of Taiwan's PRAA, for example, specifically provides that the patient's family are not to prevent the physician from acting on their treatment decisions, a measure which Tsai argues provides the patient with "a rights-based form of resistance against the common phenomenon of family-based decision-making in Chinese culture".³⁸ In Hong Kong, the government's legislative proposal has stated explicitly that patient autonomy must prevail in case of conflict with family, and in India, a concern about potential abuse by family members has resulted in a judicial regime that relegates family to a secondary level of importance.

17.4.7 *Reflecting on the Distinctive Role of Family*

In light of the preceding discussion, what are the insights that can be gained in relation to the significance of the family in the AD context? Two related points can be made. First, as mentioned at the beginning of this section, the influence of the family, much like religion, is not unidimensional, and there are various ways in which the family can have a significant role to play in every aspect of the AD or its implementation.

³⁶ D.F. TSAI, Taiwan, in this volume; K.A. DHURU and R. GHOOI, India, in this volume.

³⁷ See e.g. Taiwan where a family member must be involved in the ACP process. See also Japanese nursing homes, some of which require a family member's signature on the AD form. In the psychiatric AD regime of the Philippines, the inclusion of the role of "supporters", who can access information and attend medical appointments, can be seen as a way to keep family members involved.

³⁸ D.F. TSAI, Taiwan, in this volume, p. 80. Note, however, that the PRAA also includes provisions that envisage a substantial amount of familial involvement. See e.g. note 33 for a discussion of how the PRAA permits the sharing of information with family as long as there is no explicit objection.

The second point is that, among these different roles, it is important to recognise an often neglected, supportive role that families play. This is in addition to, but separate from, the authoritative, decision-making role that is often taken as the norm in the literature on medical decision-making in the Asian context.

By the term “supportive role” as adopted as a family-focused approach to decision-making in this context, we envisage something much more complex than the general forms of emotional and other social and relational supports typically associated with the family in the healthcare context. Instead, this support, a kind of “support plus” as it were, is broad in scope. It might involve professionals taking steps to actively involve the family in order to bring about the best outcomes for the individual, or it could involve an individual-led approach where the person is encouraged to involve their family members in various kinds of ways. Such approaches typically involve a co-opting of family members into the decision-making process in a mediating role, as facilitators, to allow both the family and the individual to reflect on the kind of support the individual needs, and then also to identify what is best for the individual. Co-opting family members in this way takes different forms across different jurisdictions. For example, like with the Taiwanese regime, the family could be brought into the decision to make the AD as a part of the wider ACP process. As argued in the Hong Kong chapter, the AD itself might also be used as a crux upon which to engender family support for personal preferences. In this way, the making of the AD could be used to initiate family conversations about end-of-life wishes, in particular in jurisdictions where the topic of death and dying is considered difficult to broach, providing an important basis upon which meaningful and well-supported decisions about an individual’s end-of-life care can be achieved.

In this way, the construct of the “family”, as it features across these Asian jurisdictions in relation to ADs, does not need to be placed in direct contradistinction with the “individual”, as is typical in the Asian bioethics literature. The conception of the family as “support plus” renders a focus on the individual (rather than the family) as the decision-maker entirely compatible with a cultural emphasis on the family. In particular, this supportive account of the family’s role does not threaten the individual’s best interests as the goal of the decision-making process, though the identification and realisation of these interests will of course be heavily dependent on the family’s input and participation.

17.5 Making Sense of ADs in Asia: “Generative Accommodation” in Local Context

In the foregoing sections, we described some of the patterns, trends and important variations in the regulation of ADs across the jurisdictions in this volume, followed by an in-depth examination of the distinctive nature of the influence of religion and family. In light of the international backdrop to changing law and practice in relation to ADs that we presented to introduce the book, how should we make sense of the law and practice of ADs in the Asian context?

As the principled foundations and regulatory strategies of ADs have become increasingly codified and implemented internationally in recent years, an emerging pattern of response can be observed across the majority of the jurisdictions included in this volume. Whether explicit or implicit, these responses have functioned to enable ADs to gain a foothold within Asia – in its case law, in its legislative frameworks, in its professional guidelines, or in the ground-level practice of healthcare.

In our view, we might helpfully understand this pattern as one of “generative accommodation”. We take these terms in turn, beginning with the idea of “accommodation”. The concept here is that, in light of an emerging international consensus in healthcare practice and regulation regarding the value of an AD and its underlying ethical principle of respect for patient autonomy, most of the jurisdictions in this volume have responded in a way that suggests these key concepts and principles are similarly being viewed as important and worthy of incorporation into their own local contexts, whether it be in the form of legislative frameworks, case law, guidelines or practice requirements. A reasonable query at this stage might be why and how we have determined that this is a form of accommodation, rather than something that is more indigenous to the jurisdiction in question. Our view that this adoption can generally be seen as a form of accommodation results from three key reasons.³⁹ The first is that, while the increase in emphasis on patient autonomy internationally began around the 1950s, the various forms of regulation of ADs and end-of-life care in the jurisdictions of this volume have been put in place or decided upon relatively recently, from the 1990s at the earliest. The second reason is what is, in most cases, an apparent lack of congruence or alignment of the concept of ADs and patient autonomy

³⁹ While none of these reasons on their own are determinative, together they point away from a conclusion of indigenous development.

with local value commitments or beliefs, such as a heavy emphasis on familial involvement in medical decision-making or religious beliefs that prioritise the preservation of life over other values such as autonomy or individual rights. The final reason is that, apart from a general cultural acceptance in some jurisdictions of death and the importance of a good death, we have not observed strong evidence of any indigenous evolution of the concept of an AD, for example, on the basis of bioethical principles that have also developed importance locally. Indeed, what we do see across the chapters is a broad pattern of internationally agreed-upon ethical principles that are visible across the jurisdictions.

Having said that, however, the qualifier “generative” is equally, if not more, crucial to our understanding of ADs in Asia. We use the term “generative” to refer to the distinctive, locally specific approaches that have arisen, been set in motion, or been proactively produced in ways that are unique to these jurisdictions as they marshal their own commitments and expectations alongside this emerging international consensus. That is, in dealing with the sorts of ways in which the concept of ADs and patient autonomy may be incongruent or even in conflict with local values and/or beliefs, different types of solutions have been created to allow such concepts to exist and develop in these local contexts.

We view the extent to which an approach is generative as falling along a spectrum, with some more generative than others. Moreover, different modes of a generative approach are identifiable in ways that cut across this spectrum in quite complex ways. Taiwan presents a good example of a jurisdiction with a more generative approach, with its PRAA containing provisions that marshal the local cultural emphasis on the role of the family. Interestingly, as mentioned previously, the PRAA both recognises and affirms this role (through the requirement of the presence of a family member in the ACP process) *and* places constraints on it (through the provision that forbids family members from preventing a physician from acting on the patient’s treatment decisions). This, we argue, suggests that a significant amount of careful consideration was involved in the attempt to adopt these principles and concepts into the Taiwanese context in ways that retain their essence, but also align with local cultural values.

Also on the side of more generative approaches, Israel presents an interesting example, where we can observe two different modes of generative accommodation within the same country. The Dying Patient Law, espousing the ultra-orthodox Jewish perspective, and the judicial approach to end-of-life decision-making, exemplified by the more liberal religious interpretations of Justice Elon, demonstrate two ways in which generative

accommodation has taken place. As Bentwich points out, however, the ultra-orthodox Jewish view is not shared by the majority of Israelis, and this view fails to align with the more secular perspectives of healthcare professionals and patients. This suggests that, while both approaches are generative to some degree, the judicial approach can be said to be more so, in that these court decisions are generating comparatively liberal interpretations of Jewish principles that accommodate the idea of ADs (in the form of prior wishes) and patient autonomy, in ways that allow them to be accepted by the majority of Israelis (especially Israeli Jewish citizens), and in particular the relevant stakeholders in the end-of-life process.

The Philippines provides another example of a more generative approach, but one that manifests itself in the practical spaces of decision-making itself, in the form of grassroots change driven from within networks of healthcare professionals working in specific hospitals. This approach does not focus on aligning the idea of ADs and respect for patient autonomy with local religious and cultural values, such as the Christian commitment to upholding the value of life and cultural attitudes towards disease causation and family. Instead, healthcare professionals and the medical community have brought such concepts directly into the local practice context by way of institutional guidelines, in a way that can meet practical needs and develop good professional practice.

On the end of less generative approaches, Thailand's National Health Act recognises the principle of respect for individual autonomy and preserves the right to make an AD solely for the individual, but the over-flexibility in the rules for making an AD suggest that these concepts have not been introduced into the local context in a way that considers whether ADs can actually be successfully implemented (and respect for patient autonomy thereby upheld). Additionally, apart from the ability to designate an individual, often a family member, to clarify one's wishes as contained in an AD, the Thai regime does little to reconcile their very individually focused AD with the cultural emphasis on family, leading to what is often non-compliance with the patient's AD where family members disagree. India's complex and administratively burdensome judicial regime similarly does not adopt ADs in a way that considers the likelihood of success of implementation, although the courts do appear to have taken the role of the family into consideration, and accordingly relegated family members to a secondary role in the process due to concerns of potential abuse.

Turkey further presents an example of a less generative accommodation process, one that can be said to involve only the painting of a veneer

of common purpose and shared agreement, without substantially more. Although Turkey has ratified the Oviedo Convention, Article 9 of which requires a patient's previously expressed wishes relating to medical interventions be taken into account, there remains no legislation or formal legal regulation of ADs in Turkey. This is despite the fact that the Oviedo Convention requires signatories to make their domestic law compatible with it. Suggestions have been made, by Ulman and others, as to how domestic law might be interpreted and/or amended to provide a basis for ADs, but, thus far, the Turkish approach appears to be only a superficial endorsement of the international consensus, without any further attempt to bring this in line with its own local context. It should be noted, however, that some generative accommodation appears to be beginning to occur in ground-level practice: in recent years, professional societies have issued guidelines affirming the importance of patient autonomy, the right to refuse futile treatment and ADs, and have called for public engagement and multilateral dialogue on these issues, so as to remove cultural factors that may hinder acceptance of these ideas.⁴⁰ This suggests that, while the state has commenced the process by ratifying the Oviedo Convention, it may be networks of healthcare professionals, like in the Philippines, who are the actual drivers of change – engaging with the values and characteristics of local culture and negotiating the acceptance of autonomy and ADs within this context. In a slightly different way, other modes of generative accommodation can be formulated “on the ground” through grassroots non-governmental organisations (NGO) which are promoting change. This looks to be the case in China. Though the power possessed by NGOs is inevitably limited, and thus the degree of generative accommodation that can be achieved in this way may correspondingly be limited, Chen speculates that the advocacy work of the Beijing Living Will Promotion Association has directly or indirectly led to the Chinese Government's introduction of a pilot palliative care project in 2019.

In this way, different modes of generative accommodation encapsulate attempts to shape the “meeting ground” between international consensus and localised traditions and expectations – a much more nuanced picture than pitching Eastern healthcare practices against Western healthcare practices and identifying essential differences between them. Ways to accommodate, whether occurring explicitly or implicitly, involve picking

⁴⁰ See further Y.I. ULMAN, Turkey, in this volume.

up some elements of both components: a commitment to a certain kind of way of decision-making that is increasingly recognised and endorsed internationally but in ways that embrace local manifestations.

Different ways of generatively accommodating ADs in different jurisdictions can, we think, go a long way to help to explain the complex, multiple and different laws, guidelines and practices that are documented across this volume. Just as importantly, the Asian AD journey is likely in fact to be one of a series of unique journeys, regardless of the similarities documented. These journeys are likely to continue to evolve and take shape in ways both that reflect localised commitments, norms and expectations, and that track broader sociopolitical and sociocultural trends and phenomena within and between countries – all subject to ongoing negotiation.

We conclude with some brief reflections in relation to the implications of generative accommodation, and what might be required in the longer term of such an approach. While there may be various forms of generative accommodation, and while some forms may be more generative than others, the key goal underlying all generative accommodations should be to ensure that the adopted principles and concepts relating to ADs are worked through properly, both at the level of legislation and regulation and in ground-level practice, so that they are harmonised and coherent in the local context. It is not enough, for example, to introduce legislation or guidelines promoting patient autonomy and ADs without considering the extent to which they fit in with existing laws and principles, or to design procedures that are too complex or burdensome to realistically carry out. It is also not enough to introduce legislation or guidelines without taking steps to ensure proper operation in practice. As many authors of this volume have argued, AD legislation needs to be implemented consistently, good practice guidelines need to be developed, training needs to be provided to healthcare professionals working in the field, and awareness among both healthcare professionals and the public must be promoted, among others. In short, a failure to follow through in concrete ways with attempts at generative accommodation would be at odds with, and counterproductive to, its goals.