5

Advance Directives: The Thai Context

THITINANT TENGAUMNUAY

Recognising the principle that an individual's autonomy and dignity are to be respected, the law of Thailand provides the right for patients to make advance decisions concerning their future medical treatment. Advance directives (AD) are used by terminally ill patients to specify their wishes in the event that life-saving medical interventions would be considered futile, merely prolong death, or cause unnecessary suffering. Thailand is among the growing number of countries globally to have enshrined within its laws a well-regulated framework for the use of ADs. However, there is no single template or concept of the format of an AD, an absence that has the potential to undermine the effective application of ADs in practice. Furthermore, within Thai culture, clear tensions exist between the principle of individual autonomy and the importance and influence of the family in determining the extent to which their relatives' wishes expressed within an AD are upheld. This chapter explores these tensions between competing desires and interests and how they complicate the effective implementation of ADs.

The chapter begins with an outline of the legal regulations guiding the use of ADs in Thailand (Section 5.1). Section 5.2 explores the challenges posed to medical professionals involved in the implementation of ADs, and considers sociocultural values such as familism, which enables the patient's family to exercise influence in the context of ADs. The discussion in Section 5.3 identifies some particular problems of ADs in Thailand and concludes that effective implementation requires more than legal backing; it requires the introduction and implementation of formal procedures such as a system for registering ADs. A registration system would help to ensure that the legal framework for ADs, implemented in response to the recognition of the right of terminally ill individuals to autonomy as they approach death, and to be enabled to die with their dignity intact, can be achieved in practice.

https://doi.org/10.1017/9781009152631.007 Published online by Cambridge University Press

5.1 The Legal Framework: Background, Scope and Conditions of ADs in Thailand

5.1.1 Background of Thai Laws on ADs

Since 2003, the notion that individuals may aspire to achieving a 'good death', aligned with the principle of a patient's right to refuse medical treatment, has generated robust debate between medical professionals, legal scholars and practitioners. Before the introduction of Universal Health Coverage (UHC)[1] in 2002, the high costs of medical treatment imposed considerable financial burdens on most Thai people. The ability to access medical and health services was therefore regarded as a matter of "luck"[2]; few people therefore even considered the idea that in the event of a diagnosis of a terminal illness, they might wish to refuse medical treatment, or that such treatment might prolong the dying process and cause the terminally ill patient unnecessary pain and suffering. Unlike some other countries where health and human rights groups have been advocating for patients' rights – especially the right to refuse medical treatment – most Thai people are unfamiliar with the principle of the right of patients to self-determination. Thailand's Constitution recognises the principle of individual autonomy and the rights of human dignity, yet, the notion that some people might wish to refuse medical treatment has been characterised by some people – including some within the legal profession – of representing a threat to public order and morals; refusal of treatment was therefore void under Thai law.

The issue of patients' right to refuse life-saving medical treatment was explicitly raised in 2003, when the Ministry of Public Health submitted a legal question to the Office of the Council of the State (OCS), a body which functions as a legal consultant for state agencies.[3] The question concerned a case involving a member of the Jehovah's Witnesses faith community, who made an AD stipulating that they wished to refuse blood transfusions as part of any life-saving treatment. Medical

[1] The UHC was the public health scheme provided for all Thai citizens to get access to medical treatment with the fixed fee of thirty bahts. See National Health Security Office, "Philosophy and Background", http://eng.nhso.go.th/view/1/Philosophy_Background/EN-US.

[2] V. Ungprapan, "The Perspectives of Thai Lawyers on Refusal to Treatment and Good Death" in S. Boonchaleamvipas (ed.), *Understanding Article 12 of National Health Act 2007* (Bangkok: 3D Printing, 2016), p. 12.

[3] Office of the Council of State, "Council of State", www.krisdika.go.th/web/office-of-the-council-of-state/philosophy-mandate-and-organisation-chart.

https://doi.org/10.1017/9781009152631.007 Published online by Cambridge University Press

professionals were undecided as to whether they should follow such a directive, or should prevail in providing the blood transfusion treatment to forestall any criminal liabilities. Responding to the concern of medical professionals, the OCS suggested that in cases where blood transfusion was a critical element of the life-saving treatment, doctors must provide the blood transfusion, even though doing so went against the patient's expressed will. Medical professionals are dutifully and legally bound to save a patient's life, so to follow the patient's will, and to therefore cease to provide life-saving treatment, would be construed as having breached Thai law, and hence, they might be criminally liable for failure to provide life-saving treatment.[4] The OCS argued that implementation of the patient's will – here specifically, allowing the patient to refuse treatment – could potentially ruin the existing positive relationships between doctors and patients. More so, to implement a patient's AD to withhold life-saving treatment would represent an act of non-compliance with medical ethics, which stipulate that doctors must act to save life. And finally, it was argued that for doctors to observe patients' right of autonomy would also conflict with the concept of the good Samaritan, a humanistic principle which holds that a person should help others – including strangers – who are in danger. Several doctors disagreed with the OCS' legal advice, arguing instead that allowing the implementation of a patient's AD in no way represented a threat to public order and morals, but should instead be respected as the exercise of a patient's right to autonomy.[5]

While not binding, the legal opinion of the OCS is the starting point for debates over which patients' rights require legal protection. This legal issue was of particular concern to a number of public health professionals,[6] presumably because of the serious implications for their possible criminal liabilities. The debate led to much discussion about, and the drafting of specific legislation on ADs, in 2004, one year after the OCS had rendered its legal opinion. Notably, the drafting committee included representatives of the medical professions.[7] The subsequent introduction of the National Health Act in 2007 incorporates ideas that

[4] Memorandum of Office of the Council of State 250/2546.
[5] Ungprapan, note 2, pp. 15–16.
[6] See N. Kamnuan, *Legal Problems regarding Physicians' Duties and Ethics upon Patients' Refusal of Treatment before Death*, LLM thesis, Dhurakij Pundit University (2015).
[7] Correspondence of the Secretariat of the Cabinet นร 0503/11888 dated 20 August 2004 to Office of the Council of the State.

emerged from the drafting process, and Article 12 explicitly gives recognition to a patient's right to self-determination in the context of ADs. The details of the AD regime were further clarified in a ministerial regulation of 2010.[8]

5.1.2 Scope and Conditions of ADs under Thai Laws

Article 12 of the National Health Act 2007 states that a person has the right to make an AD setting out their desire "*to refuse any futile health services which simply prolong death or cause suffering*". Public health professions are exempted from any liabilities arising from their actions taken in accordance with fulfilling the patient's expressed will. Article 12 seeks to preserve the human dignity of a patient, as enshrined in the Constitution's specific mandate for the protection of patient autonomy over their lives and bodies. It gives patients the right to refuse medical treatment and to have a "good death", rather than to accept life-prolonging treatment involving the use of medical technologies that would likely cause further pain and suffering but which would ultimately prove futile.[9] The scope of an AD is therefore limited to ensuring that a patient has some control over their dying and can experience a "good death".[10] In other words, an AD explicitly sets out the patient's refusal of medical treatment. An AD will only be implemented if (i) the patient is in a terminally ill stage; or (ii) the patient has an incurable disease for which medical treatment will merely prolong an inevitable death, including a persistent vegetative state.[11] In cases where the patient remains conscious and retains the capacity to communicate, the medical professional responsible for the treatment of such a patient must ask for the patient's confirmation of their wish as expressed within the AD, prior to implementing their will.[12] It must be noted that Article 12 does not allow for either "mercy" killing or active euthanasia, but is applicable solely within the context of a strictly defined "end-of-life" scenario.

[8] Ministerial Regulation on Conditions and Processes to Apply an Advance Directive to Refuse Futile Medical Treatment Which Merely Prolongs Death or Causes Suffering 2010.

[9] Y. Phoopradab, "Good Death: The Right that Everyone Deserves and the Practical Problems", www.krisdika.go.th/data/activity/act13459.pdf.

[10] The concept of a "good death" in the Thai context is discussed in further detail in Section 5.2.

[11] Section 2 of the ministerial regulation.

[12] Section 6(1) of the ministerial regulation.

https://doi.org/10.1017/9781009152631.007 Published online by Cambridge University Press

Its use is limited to the right to refuse to accept treatment when the disease has progressed to the stage where treatment is futile and/or causes further suffering.

Thai legislation does not prescribe a specific formal format for an AD; Article 12 merely requires a written statement to be made while the individual is conscious, of sound mental capacity and has full understanding of their actions and the consequences. There is no requirement that medical or legal personnel should be involved or present; a person can make an AD, alone, without having to consult public health professionals. The practical difficulties involved in establishing whether an AD was made when its maker possessed the mental capacity to make such a momentous decision is an issue to be discussed in a later section, but in theory or practice, Thai laws do not require an assessment of mental capacity at the time of writing the AD. Ministerial regulations merely provide guidelines on the information to be included in an AD:[13]

- The personal biodata information of the person who makes the AD, namely name and surname, age, national identification number, and address or contact number.
- Date the AD was made.
- Name(s), surname(s), and national identification number(s) of a witness/witnesses, and their relationship to the person making the AD.
- The specific medical services or treatment that the patient does not wish to receive.
- In cases where individuals have requested another person to write or type the AD on their behalf, the surname and national identification number of that person should be stated.
- The signatures or fingerprints of the person who makes the AD and that of the witness/witnesses.

It must be noted that the ministerial regulations require only that the intentions of the patient making the AD are clearly stated; other requirements, such as stating the name of the witness and their signature, are solely intended as guidance on how to make a clear AD. It is an illustrative, rather than an exhaustive list, and as such, the AD is valid whether it provides less – or more – information than the AD guidance suggests. It stipulates only that the AD be in the form of a written statement and clearly indicates the individual's will.

[13] Section 3 of the ministerial regulation.

Since the clarity of intention of an AD is required, in order to ensure the precise understanding of their intention, a patient can specify the name of a person who is able to clarify their intention as stated in the AD. Generally, the patient chooses a family member with whom they share close relationship, and who has been (unofficially) informed by the patient of their will.[14] The option to enlist the help of a trusted and familiar person is particularly helpful in cases where there is some confusion or ambiguity, and the person who made the AD is no longer in a state where they are able to explain their will. As stated previously, it is imperative that a patient who makes an AD put their signature and national identification on the document,[15] so as to enable the later identification of such persons. In some cases, while the patient might believe that the terms used in the AD are unambiguous and clear, it is possible that the language or terms employed might be confusing to the reader. In such a situation, it is envisaged that the named person would be able to clearly and correctly articulate and explain the patient's will to the doctor. The inclusion of this named person therefore serves to ensure that the AD conforms with the requirement for clarity; the named person is not authorised to make any decisions on behalf of the patient, and they play no part in proving the validity of an AD, their sole purpose being to help clarify the patient's will.

The state does not require the registration of ADs with state officials; the ministerial regulation suggests only that a patient give their AD to public health professionals as soon as possible, when receiving medical treatment.[16] Article 12 exempts medical professionals from criminal liabilities for carrying out the patient's will as set out in an AD. However, neither Article 12 nor the ministerial regulation imposes sanctions for *non-compliance* with an AD. In other words, if a doctor does not follow the patient's request for termination or withholding of medical treatment, they will not face any particular liabilities under the laws regulating ADs. This then raises questions about the actual effectiveness of ADs in Thailand, as will be further discussed in Section 5.3.

In terms of implementation, practical problems can also result from the informality of the template of an AD. While the laws require the

[14] National Health Commission Office, *Manual Guidance on Advance Directive for Public Health Professions* (Bangkok: 3D Printing, 2019), www.thailivingwill.in.th/sites/default/files/Public_health_service_manual_9_12_2562.pdf .

[15] Section 3 of the ministerial regulation.

[16] Section 5 of the ministerial regulation. This causes a problem if the patient is unconscious or otherwise incapacitated, in which case the doctor may not realise that an AD exists.

clarity of an AD, the inclusion of some important information – albeit, limited – to support the validity of an AD, such as the identification and signature of a witness, is merely a recommendation, and not mandatory. Flexibility may facilitate and perhaps encourage more people to make ADs, but an AD that does not contain sufficient information to support its validity can be the source of problems that might inhibit its implementation. When identification of witnesses is not required, the possibility arises that some people might choose to simply forgo a witness, an issue to be further discussed in Section 5.3.

The provision of palliative care, however, must continue even if medical treatment is refused.[17] There is no definition of "palliative care" within Thai laws; instead, Thai healthcare services employ the definition provided by World Health Organisation (WHO) to clarify the particular healthcare provision and duties of health professions for patients.[18] The obligation for healthcare professions to provide palliative care against the patient's expressed will raises the question of how to balance the tensions between maintaining respect for individual autonomy and enabling the achievement of a good death. The concept of "patients' rights" is conventionally based on the notion of individuals having decision-making autonomy over their own lives, in accordance with their own values. These tensions have long been the subject of debate; what, if any, are the limits to patient autonomy, and how can this be squared with medical knowledge and judgement on the best course of action (or inaction) for a patient?[19] Thailand has grappled with these tensions after the patients' right to self-determination was recognised in Article 12 of the National Health Act, in a form of ADs. Some medical professionals were concerned about their possible criminal liability under this provision; it is they, after all, who generally shoulder responsibility for their patients' healthcare, and the decision on whether to continue or terminate medical treatment should, they reasoned, be made by physicians, rather than by patients.

[17] Section 2 of the ministerial regulation.

[18] WHO has revised the definition of palliative care in 1990, 2005 and, most recently, in 2018, adding details to make the definition more accurate and to prevent misinterpretation. See World Health Organization, *Integrating Palliative Care and Symptom Relief into Primary Health Care: A WHO Guide for Planners, Implementers and Managers* (Geneva: World Health Organization, 2018).

[19] See M.J. Wreen, "Autonomy, Religious Values, and Refusal of Lifesaving Medical Treatment" (1991) 17 *Journal of Medical Ethics* 124.

In 2011, a group of physicians brought a case to court, claiming that Thai legal regulations on ADs were against public order and morals, since such rules impose burdens on medical professionals who carried the weighty responsibility of deciding whether a patient had reached the terminal stage, before implementing an AD. They must also decide what forms and nature of treatment constitute palliative care. However, the law allows medical professionals to avoid any possibility of being held criminally liable if they are acting in accordance with the patients' advance decisions. An AD was hence alleged to enable a patient to reject the evidence-based knowledge, expertise and decisions of medical professionals. The court decided that the legal rules on ADs did not impose any significant burdens on medical professionals, for under Thai law, the right to the use of an AD was not to be construed as allowing active euthanasia or mercy killing; it was instead to be interpreted as the patient's right to refuse treatment in order to die a peaceful and dignified "good death"; medical professionals merely had to respect the patient's decisions. The Thai legal rules on ADs are thus lawful and constitutional.[20]

Superficially, the court's decision in this case appeared to emphasise the value of patient autonomy over medical judgement, by prioritising respect for the patient's decision rather than privileging the doctors' judgements of the best course of action and treatment for the patient. However, Article 12 does not leave all decision-making power with the patient. The mandatory provision of palliative care under the ministerial regulation demonstrates continued state intervention to a certain extent, in particular in relation to the imposing of normative values about what constitutes a good death. Moreover, this insistence on continued palliative care overrides the patient's will. In practice however, such state intervention might not be harmful to most patients; should a patient decide to refuse what they consider to be ultimately futile treatment,[21] the palliative care regime usually coheres with the patient's desire for less suffering.

5.1.3 *Further Development of the AD Regime*

Apart from establishing specific legal rules for ADs in the form of the National Health Act and the ministerial regulations, the National Health

[20] Decision of the Supreme Administrative Court 11/2557.

[21] See B.L. Miller, "Autonomy & the Refusal of Lifesaving Treatment" (1981) 11 *The Hastings Center Report* 22.

Commission Office (NHCO) has published a manual (generally referred to as the NHCO Guide) which provides guidance for health service providers on dealing with ADs. Despite its 2007 introduction in the provisions of the National Health Act, the concept of an AD is not well understood among health professionals. The aforementioned court case brought in 2011 provides a salient and instructive example of the limited knowledge of some public health professionals as to the proper scope of palliative care.[22] It also revealed their prominent anxieties about the possibility of facing criminal liability should they fail in their professional and ethical duty to provide medical treatment. The claimants in this case (whom it will be recalled were medical professionals) had misinterpreted the regulations and believed that an AD enabled a patient to request a "mercy killing". The basis of their claim indicates the paucity of their knowledge and understanding about ADs, as well as a degree of uncertainty about the correct meaning of some terms (such as palliative treatment and futile treatment that simply prolongs death) contained within the ministerial regulations. Acknowledging this problem, the NHCO responded with efforts to enhance understanding of ADs, including the publication of a web-based manual which provides clarity to the concept of an AD, the conditions framing their use and implementation, as well as clarifying the definition and processes of palliative care.[23]

The NHCO's guidance manual also suggests the proper practice of public health professionals when faced with a situation where a patient has written an AD. When informed of the AD, public health professionals must first observe and confirm the mental capability of the patient to ensure that they had created the document while fully conscious of its intended outcome and were of sound mental capacity at the time of writing. It must be noted that this action constitutes guidance rather than an actual directive mandating a public health professional to conduct a preliminary assessment of the patient's mental capabilities. Such an approach is inherently problematic, however, for the mental capability of a patient at the time they provide the AD to the doctor generally does *not* always equate to the patient's mental state at the time of crafting their AD. It is possible that while the AD was made when the patient was

[22] In particular, the claimants of the case thought that the termination of medical treatment would cause the patients to suffer, while in fact, provision of food and water and/or painkilling medicines is within the scope of palliative care which, as mentioned, cannot be refused via an AD.

[23] See note 14.

conscious and cognisant of their intentions, by the time the AD was submitted to the relevant medical professional, the patient no longer had capacity. Another possible scenario is where a patient did not have mental capacity when the AD was made, but subsequently regained their mental capacity at the time of submitting the AD. In such cases, the medical professional might face difficulty in verifying the patient's capability at the time of making the AD, and therefore not be able to implement the AD.

After the preliminary assessment of the patient's capacity, the patient's will as indicated in an AD must be noted in their medical record. The physician then makes a copy of the AD and returns the original AD to the patient. Should the patient be later moved to another public health facility, another copy of the AD should be made and sent with the patient to the new public health facility.[24] The NHCO also raises public awareness of ADs through the publication of information leaflets, guidance manuals, and samples of ADs, which can be easily found on an online website which provides specific information on ADs under the supervision of the NHCO.[25]

5.1.4 *Child ADs*

Does a minor have the autonomy to make an AD of their own? This troubling question has been the subject of much debate, since Article 12 does not specify any minimum age as one of the conditions of an AD. Some lawyers have referred to the Declaration of Patient's Rights[26] in seeking answers to this question. This declaration confirms parental rights to exercise a patient's rights on behalf of their minor children below eighteen years of age, thus leading some scholars to argue that parents are therefore empowered to write an AD for their child.[27]

[24] Ibid, p. 21.

[25] See National Health Commission Office's website on advance directives at www.thailivingwill.in.th.

[26] The Medical Council of Thailand, the Thailand Nursing and Midwifery Council, The Pharmacy Council of Thailand, the Dental Council of Thailand, the Physical Therapy Council, the Medical Technology Council and the Committee of Medical License have collaborated to announce Declaration of Patient's Rights in 2015 to recognise and support patient's rights.

[27] S. Somjai, "Minor Patients' Consents to Euthanasia: Comparative Study of the Netherlands, Belgium, and the United Kingdom [with Thailand]" (2019) 12 *Naresuan University Law Journal* 47, 59.

Meanwhile, the NHCO guidance mentioned previously states that a person below eighteen years of age can make an AD with the permission of their parents.[28] The difference between the declaration and the NHCO guidance matters, in that in the former, parents may make an AD on behalf of their child, while in the latter interpretation, a child patient has the right to make an AD, but only with parental permission. In other words, the former assumes the patient's will, while the latter directly reflects the patient's will.

The matter of children's capacity and right to make an AD remains undecided by the courts, and in fact, has not generated much debate, presumably because children are not usually expected to have fatal illnesses in their youth; it is rare indeed to find an AD made by or on behalf of a child patient. Nevertheless, it is still of theoretical interest that a minor might be interpreted as having the capability to make an AD, albeit with parental permission. Conventionally, Thai laws recognise the incapacity of a minor to make a juristic act, and prevents a minor from doing as such for the minor's own benefit, though there are some exceptions including some personal acts that a minor must decide their own, and in which no other persons are permitted to intervene, or to pre-empt such decision, such as certifying a child's birth.[29] A minor is allowed to make a will when they reach the age of fifteen years.[30] Any will made before that, even if it lasts until a minor becomes *sui juris*, are deemed void.[31] Parents cannot make a will on behalf of their child, nor can they give permission to a child below fifteen years of age to write their own will. An AD – usually called a living will – is comparable to a typical will. The limitations placed on the juristic acts a minor is able to make are justified on the grounds that they are intended to protect a minor's benefits, and to safeguard them from those who might seek to take advantage of their young age. While the law allows a minor of fifteen years of age to make an enforceable will, there is currently no minimum age for the same minor to make an AD (even if parental permission is required), which could disadvantage rather than benefit a minor. What a "good death" means to a person is considerably subjective and personal, and the idea that parents can make an AD on behalf of their child expands parental powers over a child, which is not coherent with other

[28] See note 14.
[29] Sections 21 and 23 of the Civil and Commercial Code of the Kingdom of Thailand.
[30] Section 25 of the Civil and Commercial Code of the Kingdom of Thailand.
[31] Section 1703 of the Civil and Commercial Code of the Kingdom of Thailand.

legal provisions that preserve some rights solely for the individual, rather than the entire family. Even the other interpretation that imposes no age minimum but instead allows a minor to themselves make an AD raises doubts about the appropriateness of allowing a child to make such a grave and consequential life-concerning decision. Although the family relationship is of great importance within Thai culture, some legal rights are nevertheless personal, and should be reserved for one's own decision. I explore further the tension between the principle of autonomy and the role of family in implementing an AD in Section 5.2.

5.2 Practice, Value, Commitments and Sociocultural Influences in Thailand

With an individual's autonomy as the normative foundation of an AD, Article 12 allows the patient to make an AD by themselves, without having to obtain consent from or to discuss with other family members. A medical professional does not have to ask the patient's family for permission before implementing an AD. Even where the patient is unconscious, the only duty of a medical professional towards the patient's family is to explain the current stage of their family member's illness, and the medical process for implementing the patient's AD.[32] In cases where a patient has not made an AD, or where there are ambiguities within their AD, but the patient has not specified a named individual able to clarify their intention, it is not possible to simply appoint family members to make an AD or to make decisions about palliative treatment and/or any futile treatment that simply prolongs death for the patient. If the patient's will as stated within the AD lacks clarity, it cannot then be implemented; the patient's right to refuse treatment cannot be given by proxy to any other person, even to a close family member. The right to make an AD is preserved solely for the individual,[33] and as such stands in stark contrast to traditional Thai values of collectivism and paternalism.

[32] Section 6(2) of the ministerial regulation.

[33] There is another observation that highlights the idea that an AD is personal. The ministerial regulation indicates that an AD cannot apply when the patient is pregnant; however, it can become applicable again after the pregnancy period (section 6(4) of the ministerial regulation). Since abortion is still illegal in Thailand, albeit with limited exceptions, the scope of an individual's autonomy under Thai laws does not cover any rights over a foetus. A woman cannot make any decisions that might affect the life of a foetus. This limitation on the implementation of an AD infers that the patient's will is considerably personal, to the extent that it cannot even extend to affect the potential life of a foetus.

Like many other Asian countries, Thai society embraces the concept of collectivism rather than individualism.[34] The closeness of familial relationships makes it possible for an individual's everyday decisions to be influenced by their family. That paternalism has been embedded within Thai culture for a long time[35] is demonstrated by the traditional convention that children should respect and accept the advice of seniors.[36] This value is so deeply entrenched that Thai people allow "elites" or experts whom they believe to possess greater knowledge to make personal decisions on their behalf.[37] In the case of ADs, this would suggest that Thai individuals would be discouraged from making ADs, but would instead be inclined or persuaded to defer the decision to specialist and expert medical professionals. The perceptions of the patient's family can also influence whether the patient will make an AD, and the terms of that directive. This part explores perceptions about the "good death" in the Thai context, and discusses the tension between the principle of autonomy and the role of family in implementing an AD.

Long before Thai laws adopted the concept of a "good death" and recognised a patient's right to refuse medical treatment, public opinion emphasised the duty of medical professionals to treat patients, despite the fact that an AD had been made stipulating the patient's refusal of futile treatment. A 1984 survey revealed that a majority of the public at that time considered a doctor who terminated life-saving treatment according to a patient request made in advance was guilty of *committing a crime*; 71.8% of those surveyed regarded termination of treatment as murder while 24.3% thought that the doctor should be held liable for having committed a minor offence; only 3.4% believed that the doctor should be free of any criminal liability.[38] The later public survey in 1995 indicates

[34] For more information about collectivism and individualism, see G.H. Hofstede, *Culture's Consequences: Comparing Values, Behaviours, Institutions, and Organizations across Nations* (Thousand Oaks, CA: Sage Publications, 2001).

[35] For further historical details on paternalism and Thailand's politics, see T. Chaloemtiarana, *Thailand: The Politics of Despotic Paternalism*. (New York: Cornell University Press, 2007). While this discussion is grounded in politics, the strong tradition of paternalism is observable across contexts.

[36] O.F. Von Feigenblatt, "The Thai Ethnocracy Unravels: A Critical Cultural Analysis of Thailand's Socio-political Unrest" (2009) 1 *Journal of Alternative Perspectives in the Social Sciences* 583.

[37] G. Buchenrieder et al., "Participatory Local Governance and Cultural Practices in Thailand" (2017) 3 *Cogent Social Sciences* 1, 6.

[38] V. Ungprapan, P. Pengpaiboon, and A. Boonkerd, "To Let Patients Die in Peace and Criminal Liabilities" (1986) 42 *Bot Bundit* 111.

the changing perspectives, as respondents indicated more positive responses towards a "good death" - the termination of treatment requested in advance by a patient was not considered a crime by the majority (67.4%) of respondents.[39]

Although both studies discussed previously were conducted well before the passing of the National Health Act, they show how substantively public opinion can change from one extreme to another within the course of a decade. With growing understanding that some medical treatment is futile and cannot cure the patient's illness but will merely prolong their death, and thus cause more suffering, the termination of treatment has become more acceptable to the Thai public. Apart from the concepts of collectivism and paternalism embedded in Thai society, Thai culture and norms also draw heavily from Buddhism,[40] which prompts adherents faced with the prospect of death, to always recall the uncertainty of life, and to learn to let go of the materiality of life. The concept of a "good death" is consonant with most Thai beliefs that in cases where no treatment can cure the particular illness, a person should die peacefully rather than be forced to undergo futile treatment that merely prolongs their suffering.[41] The concept of good death and the recognition of the patient's right to self-determination have their origins in Western countries, which generally rests on cultures of individualism, and which promote awareness of citizens' rights and freedoms. As discussed previously, Thai culture fosters paternalism: most people tend to believe in the superiority of expert knowledge and unquestioningly obey seniority, norms that conflict with the principle of individual autonomy, which supports an individual's right to make an advance decision concerning their medical treatment, especially where it leads to death. Buddhism's strong focus on the truth of impermanence and the contemplation of death, however, may have contributed to acceptance of the view that individuals should be permitted to plan ahead to enable them to achieve a "good death". It is thus the influence of Buddhism that led Thai laws to adopt Western ideas of the "good death" and ADs.

More recently, empirical studies conducted in 2017 and which explored patients' views of ADs found that only 1.4% of those surveyed

[39] V. Ungprapan and W. Chairattanamanokorn, "Right to Die in Cases of Patients with Hopeless Recovery" (1998) 4 *Journal of the Association of Researchers in Social Science* 27.
[40] P. Niffenegger, S. Kulviwat, and N. Engchanil, "Conflicting Cultural Imperatives in Modern Thailand: Global Perspectives" (2006) 12 *Asia Pacific Business Review* 403, 405.
[41] See note 9.

held negative perceptions of their use, although it was also found that most participants were unaware of their legal right to make an AD until they were informed about this during the study. Nearly half (42.9%) of participants had limited knowledge about ADs, while 38.6% had 'moderate' knowledge, and only 18.6% were highly knowledgeable.[42] Interestingly, after being informed of their right to do so,[43] over half (57.1%) of all participants decided to make an AD, suggesting that general attitudes towards ADs continue to be positive.

While Buddhism emphasises the recognition of a life cycle in the sense that death surely follows life, no human can avoid death, and should therefore be prepared to die peacefully, a philosophical approach that supports the concept of the "good death", Buddhists also enshrine some of the wider social conventions, such as the norm of gratitude towards their parents. That children should express gratitude to their parents is a deeply rooted norm in Thai society;[44] sons or daughters who hurt or kill their parents receive extremely severe public condemnation. This norm instils obedience to the parent, alongside gratitude, and can act as a restraint on some patients' children, who may refuse to allow medical professionals to terminate their parent's treatment, despite the presence of an AD. Even though the patients' families may fully understand the futility of treatment, some are afraid of attracting social condemnation for not having made every effort to keep their parents alive.[45] As noted before, Article 12 of the National Health Act enables a patient to make an AD and exempts medical professionals from criminal liability for any acts undertaken in implementing the AD. Yet, as also noted, this legal provision does not impose liabilities for acting *against* the patient's will where the patient's family decide that their family member should continue medical treatment. Medical professionals do not have legal standing to petition for the judicial enforcement of an AD. In practice,

[42] Ibid.

[43] P. Purithammachot, "Attitudes towards Living Wills and Factors Affecting Decisions to Make Living Wills of the Patients of Borabue Hospital" (2016–17) 1 *Academic Journal of Mahasarakham Provincial Public Health Office* 39.

[44] See M. Pinyuchon and L.A. Gray, "Understanding Thai Families: A Cultural Context for Therapists Using a Structural Approach" (1997) 19 *Contemporary Family Therapy* 209; C. Seefeldt and S.R. Keawkungwal, "Children's Attitudes toward the Elderly in Thailand" (1986) 12 *Educational Gerontology* 151, 151.

[45] A. Chantrawongpaisarn, "Interviewing Kitipong Urapeepatanapong: Planning the Death, Making a 'Living Will' for Good Death" (3 September 2017), www.matichon.co.th/prachachuen/interview/news_650989.

resistance from the patient's family can obstruct the implementation of an AD, as most medical professionals wish to avoid a suit brought by the patient's family.[46] To date, the laws have not been able to provide a satisfactory solution out of the impasse when there are conflicts between the desires of the patient's family and that of the patient as expressed in the AD.

This causes a fundamental practical difficulty in the implementation of ADs. As mentioned previously, the principle of individual autonomy provides the theoretical grounding for ADs, and the individual's will regarding their medical treatment is considered personal; there are absolutely no legal measures permitting family intervention. However, resistance from the patient's family can potentially induce hesitancy among some doctors, causing them to delay or abstain from implementing their patient's AD. This problem suggests that the concept of individual autonomy has not been adopted well in Thailand's legal framework for ADs. Further regulatory development is needed to ensure that ADs will be actually implemented, and that the patient's family cannot influence the physician to go against the wishes of their patient's AD. One possible solution is to adopt the ministerial regulation that proposes that individuals should identify an advocate to act on their behalf, in the event that there is a need for clarity about the patient's desire as expressed within their AD. Since the advocate will presumably share a close relationship with the patient, and is cognisant of, and understands the patient's rationale for choosing to refuse medical treatment, selecting a family member as advocate can be an interesting approach that facilitates mutual understanding between the patient and the family, and helps to diminish the family's resistance to the AD. Another possible solution is to mandate registration of ADs, as will be discussed in the following section.

5.3 Would a Flexible Format in the Design of ADs Support or Discourage Their Use in Practice?

Thai legal rules on ADs as embodied namely within Article 12 of the National Health Act and the ministerial regulations, do not require a strict format for ADs. Compared with other jurisdictions where specific

[46] MGR Online, "Fewer than 1% of Thai People Has Made an Advance Directive – Doctors Are Afraid of Legal Cases" (15 September 2014), https://mgronline.com/qol/detail/9570000105867.

https://doi.org/10.1017/9781009152631.007 Published online by Cambridge University Press

legal rules set out mandatory requirements for ADs to be regarded as legally binding documents, the Thai state imposes few requirements, making the creation of ADs a more straightforward and uncomplicated task than demanded by neighbouring states. Singapore, for instance, requires that ADs assume a fixed format, while South Korea and Taiwan insist that ADs must be registered with national authorities. Thai laws do not require ADs to have a fixed template – a simple written statement will suffice. There is no mandate for ADs to be registered, and no involvement of national authorities or public health professions is required for an AD to be deemed valid under Thai laws. This flexibility in the making of ADs might appear to be supportive of patients' right to exercise self-determination in the matter of their death. However, fewer requirements do not always ensure fewer difficulties in implementation. The fact that Thai laws merely set out a few basic guidelines for an AD can, on one hand, benefit a patient in that they can easily make an AD, but on the other hand, medical professionals can face difficulties relying on an AD. Such challenges may reduce the effectiveness of ADs in actual application. Three problems can potentially undermine Thailand's flexible rules for ADs, which are (1) uncertainty about its validity, (2) unawareness of its existence, and (3) conflicts with the patient's family.

5.3.1 Uncertainty about the Validity of an AD

As we have seen, under Thai law, a written statement by a mentally capable individual is sufficient to confirm the validity of an AD. However, the laws do not indicate how the individual's capacity is to be assessed. The NHCO guidance simply suggests that health professionals should conduct preliminary assessments to confirm the consciousness and mental state of the patient at the time the physician is presented with an AD.[47] Although the ministerial regulations suggest that an AD should be witnessed, this is not a mandatory requirement, and leaves the possibility that a patient lacking full mental capacity could proceed without a witness. This flexibility can raise concerns for medical professionals, for example, in cases where a patient allows the family to give the AD to the physician on their behalf. In such cases, the physician cannot be certain that the AD was actually made by the patient, or whether the statement was made when the patient was fully conscious and aware of the

[47] See note 14.

implications of their decision. In addition, the NHCO's suggestion that the capacity of a patient be assessed when the AD is received poses yet another problem; as discussed previously, mental capability at the time the AD is produced does not necessarily mean that the patient was mentally capable at the time of the writing of the AD.

A comparable case with an AD is the 'last will' of an individual. There are five legal formats that the last will can assume in order to be enforceable under Thai laws.[48] One such format is a document wholly written and signed by the testator.[49] This format does not require witnesses or registration, and therefore can be compared with an AD. However, the application of this form of the last will does not cause the same concern as an AD, because in cases where there is any doubt surrounding its validity, a challenge can be brought to the court. In contrast, the physician's decision-making on whether to rely on an AD is shaped by the limited time in which the case may be brought to the court.[50] In other words, the physician has to make a nearly immediate judgement on the authenticity and validity of an AD. This difficult situation can worsen if there is conflict within the patient's family over the reliance on an AD.

The requirement that an individual must register their AD with national authorities might – to some extent – resolve these problems. Registration does not only address the issue of medical hesitation and prevent a family's objection to an AD, it also provides an opportunity for authorities to examine and validate (or otherwise) the AD. It is also possible for the law to require that a physician certify that an individual who makes an AD is capable of understanding and communicating their will *at the time* of making the AD. This examination or verification can prevent ambiguity or lack of clarity that might cause problems in its later application. Medical professionals can feel more confident of the validity of an AD and will be less likely to hesitate before implementing their patient's directive. The requirements for either registration or verification from a physician can also help to protect the enforceability of the patient's will, ensuring that the principle of the patient's autonomy is pragmatically secured.

[48] Section 1655 of the Civil and Commercial Code of the Kingdom of Thailand.
[49] Section 1657 of the Civil and Commercial Code of the Kingdom of Thailand.
[50] V. Fongsiripaiboon, "Living Will: Practical Point for Doing" (2015) 432 *The Medical News* 37, 39.

5.3.2 Unawareness of the Existence of an AD

In some circumstances, a patient will not have had the opportunity to inform others that they had made an AD. Since Thai laws do not require registration, there is no record of an AD unless the patient informs the physician or other health personnel. It is possible therefore for others to be unaware of the existence of an AD, in which case, the patient's exercise of their right to make an AD fails to achieve its purpose. In some jurisdictions such as Taiwan,[51] an AD is required to be registered and recorded in the data memory of an individual's national health insurance card; this can help to provide information immediately in the event the patient is admitted to a healthcare institution.

5.3.3 Conflicts with the Patient's Family

As already mentioned, the cultural norm that children express gratitude to their parents is deeply ingrained within Thai society. This can leave medical professions with a problem whereby the patient's family is unwilling to allow physicians to terminate their family member's treatment despite the declared wishes of the AD. Although reliance on an AD is not conditional on permission from the patient's family, most medical professionals would prefer not to have to act against the family's wishes. Article 12 exempts doctors from criminal liability arising from acting in accordance with an AD, but it cannot shield medical professionals from threats of legal actions from dissatisfied families. Most physicians do not wish to undergo the exhausting judicial process, and tend therefore to accede to the wishes of the patient's family, rather than observe the patient's desires as stated within the AD.[52]

Growing recognition of the notion of a "good death" and the changing perception of Thai society towards ADs can decrease resistance from the patient's family. Apart from relying on raising awareness via education, increasing the formalities associated with ADs can also demonstrate respect for patients' wishes. Introducing mandatory registration can signal formal recognition of an AD and help raise its significance above the views of the patient's family, which will, in turn, result in greater confidence among medical professionals to act in accordance with their patients' ADs. Selecting a family member who can act on behalf of the

[51] D.F. TSAI, Taiwan, in this volume.
[52] See note 50, p. 40.

patient and help to clarify any ambiguities of the AD may also reduce familial resistance to the AD.

5.4 Conclusion

With specific legal rules for ADs, namely Article 12 of the National Health Act and the ministerial regulation, the Thai government has legislated a formal legal framework for ADs. Empirical studies indicate the changing perceptions of Thai society towards the understanding and acceptance of the concept of a "good death", and of terminally ill patients' right to autonomy. Current positive responses towards ADs will likely lead to increased use of ADs in the future. However, the lack of formalities in relation to the making of ADs under Thai laws can obstruct the application of ADs in practice, as medical professions might encounter difficulties in relying on ADs, namely uncertainty about their validity, unawareness of their existence, and conflicts with the patients' family. This chapter suggests the requirement for registration as an approach to relieve such difficulties, and to ensure that the aim of an AD to protect the patient's right to self-determination and preserve human dignity can be achieved in practice.