Introduction

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Population ageing, which has been described as one of the four global demographic "megatrends",[1] is quickly becoming a concern for many countries around the world. The growth in the size and proportion of the elderly has many implications, including the fact that there has been, and will continue to be, a significant growth in the number of individuals who are living longer, and because of that, living with chronic health conditions that often accompany advanced age. With this comes the need to make decisions about the extent to which one wishes to continue receiving treatment towards the end of life, as well as the nature of such treatment. Unsurprisingly, therefore, the development of the advance directive (AD) has been the focus of ongoing discussion in many jurisdictions. In this volume, the AD is defined as a statement in which a competent person makes an advance decision in matters concerning their health and welfare, which is to be implemented in the event that the person becomes incompetent (loses capacity) in the future. In the following, we begin with an explication of ADs in a broad, international context, laying out the origins of the concept and how this is developing over time, as well as some of the conceptual and practical challenges that arise when ADs are implemented.

I.1 Advance Directives in Context: Origins and Challenges

The fundamental idea and purpose of an AD can be usefully understood by invoking the mythical tale of Odysseus and the Sirens in Homer's epic poem *The Odyssey*.[2] Odysseus is warned that his ship will sail past the Sirens, who will attempt to incapacitate the crew and lure them to

[1] United Nations, Department of Economic and Social Affairs, Population Division, *World Population Ageing 2019: Highlights* (ST/ESA/SER.A/430) (New York: United Nations, 2019).

[2] Homer, *The Odyssey: XII Scylla and Charybdis* (Oxford: Clarendon Press, 1963).

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shipwreck. The crew plug their ears so they cannot hear the Sirens' fatal song, but Odysseus opts to hear their call – yet, before they reach the Sirens, he directs the crew to bind him to the mast and to not release him if he so requests. The crew honour Odysseus' directive, binding him tighter to the mast when, under the influence of the Sirens, he urges the crew to release him. Odysseus is freed only when the danger has passed.

Odysseus' tale captures the central elements of ADs as we currently recognise them: a directive that is issued by the person to whom it will apply in the future, and who issues it in advance of losing the capacity to make the relevant decision at the critical time. Moving on from ancient mythology, the modern idea of the concept of the AD as conceived in a healthcare setting is typically traced back to the late 1960s and the work of Luis Kutner, an American human rights lawyer and co-founder of Amnesty International. Kutner acknowledged that some patients will not wish to receive life-sustaining treatment, but that they may have lost the ability to convey their wishes at the critical time. "How then can the individual patient retain the right of privacy over his body – the right to determine whether he should be permitted to die, to permit his body to be given to the undertaker?"[3]

In answer to this question, Kutner's "suggested solution is that the individual, while fully in control of his faculties and his ability to express himself, indicate to what extent he would consent to treatment".[4] He offered various labels for this solution, amongst them the "living will" and, notably, the "body trust". Regarding the latter, Kutner drew on an established legal concept, suggesting that an AD is analogous to a conditional or revocable trust, with the patient's body being the "property" that is entrusted, the patient being the beneficiary of that property, and the doctor positioned as trustee and thus acting in accordance with the patient's prior consent.[5] According to Kutner, such a trust could be revoked by the patient, presumably once they regain control of their "faculties", as Kutner puts it.

As this volume will demonstrate, Kutner's idea has increasingly gained support internationally in a variety of different ways, but notably his analogy has not: the concept of a trust is not typically said to ground the

[3] L. Kutner, "Due Process of Euthanasia: The Living Will, A Proposal" (1969) 44(1) *Indiana Law Journal* 539, 550.
[4] Ibid., p. 551.
[5] Ibid., p. 552.

legitimacy of ADs. Rather, there is a settled view within the international community of bioethicists and medical lawyers that advance statements tend to derive their authority from the idea of respect for autonomy, or self-rule, interpreted specifically through the notion of "precedent autonomy" – a specific instantiation of the broader value of autonomy that captures the idea, applicable in some limited circumstances (i.e. where the loss of one's decision-making capacity is anticipated), that it is justifiable to set a precedent for oneself in the future through the exercise of one's autonomous decisions in the present.[6] As an English judge, Munby J, suggested, ADs involve "nothing more or less than the embodiment of the patient's autonomy and right of self-determination".[7] This view is not restricted to England; it is widely invoked in laws formulated in North America and in Europe. As we will see later in this volume, the value of autonomy has been an important, though often complex, component of more recent developments in some Asian countries.

I.1.1 Conceptual Challenges

However, here a first complication arises, because we should not assume that autonomy is a single, straightforward concept. A glance at the international bioethics literature reveals considerable debate over the precise nature of autonomy, with multiple accounts of autonomy being contested. This presents a challenge to advance decision-making: which version of autonomy does and should underpin, inform and constrain decisions made in advance?

There are many accounts of autonomy to choose from.[8,9] Some, taking their lead from Immanuel Kant, view autonomy in principled, objective terms: truly autonomous decisions are (only) those that align with what is objectively "right".[10] Others depict autonomy in fundamentally relational terms, where an individual's decision can be best understood in the context of their relationships. Even relational autonomy is not reducible

[6] J.K. Davis, "The Concept of Precedent Autonomy" (2002) 16(2) *Bioethics* 114.
[7] *HE* v. *A Hospital NHS Trust* [2003] 2 F.L.R. 408, per Munby J, [37].
[8] J. Coggon, "Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?" (2007) 15(3) *Health Care Analysis* 235.
[9] J. Christman, "Autonomy in Moral and Political Philosophy", in E.N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (2020), https://plato.stanford.edu/archives/fall2020/entries/autonomy-moral/.
[10] C.M. Korsgaard, *The Sources of Normativity* (Cambridge: Cambridge University Press, 1996).

to a single account, since it is "an 'umbrella term', covering a range of diverse perspectives".[11]

Generally, however, ADs tend not to be associated with relational or principled understandings of autonomy. Rather, ADs usually find their authority in more individualistic, liberal and subjective understandings of autonomy, as emphasised in Munby J's suggested synonym, "self-determination". According to such accounts, an AD expresses – and gains its normative force from – an individual's sincerely and strongly held beliefs and values. Viewed as such, an AD is an expression of different aspects of an individual's personal identity: their preferences, value commitments, desires and beliefs.

This view, of course, involves making a number of assumptions. First, it assumes both that individuals know and can articulate their beliefs and values, and that a person's preferences or desires in the moment will be aligned with more considered values that capture the person's "authentic" commitments over a longer period of time. Second, it assumes that an individual's wishes *should* govern decision-making, irrespective of any other countervailing ethical considerations. Once again, a glance at the extensive bioethics literature on ADs and the value of autonomy reveal that these assumptions are problematic if not interrogated closely. Notwithstanding this point, the role that the principle of "respect for autonomy" plays in grounding and justifying ADs remains largely solid.

But this is not the end of the conceptual story. Beneath this widely supported account lurks another problem. Philosophers have long pondered the nature of personal identity, asking such questions as: what makes me *me*? As with autonomy itself, there are a range of accounts available, at one end locating identity in *bodily* continuity, at the other end locating identity in *psychological* continuity, with others occupying the middle ground in which body and mind interact to constitute identity.[12] If we focus here on the two poles, however, they present problems for ADs. Bodily accounts inevitably underplay the importance of the mind (and brain) and with them the assumed ethical importance of autonomy. Psychological accounts, which arguably command greater

[11] C. Gómez-Vírseda et al., "Relational Autonomy: What Does It Mean and How Is It Used in End-of-Life Care? A Systematic Review of Argument-based Ethics Literature" (2019) 20(1) *BMC Medical Ethics* 76.

[12] A.V. Campbell, "Why the Body Matters: Reflections on John Harris's Account of Organ Procurement", in J. Coggon et al. (eds.), *From Reason to Practice in Bioethics: An Anthology Dedicated to the Works of John Harris* (Manchester: Manchester University Press, 2015), pp. 131–41.

respect, do attend to autonomy, but they present a new challenge: whose autonomy is being respected when an AD is honoured?

According to Davis, invoking the value of "precedent autonomy" can give rise to "cases where the patient decided his or her future treatment, is later treated in accord with that earlier decision, but seems somehow estranged from that decision when treatment is provided".[13] The "estrangement" is typically described in terms of the individual's mental capacity or competence: the individual making the directive has the capacity to do so, which they lack at the time that the directive is to be applied. And this sort of estrangement potentially presents a problem for ADs, as Buchanan has suggested:

> Presumably a point is eventually reached at which the degree of psychological continuity between the author of the AD and the incompetent individual is so small that the AD of the former has no authority at all over the latter.[14]

As such, there are some substantial philosophical questions attending the very idea of ADs. Should they be understood in terms of trust or autonomy? If, as is usually assumed, they are anchored in respect for autonomy, then what account of autonomy is being invoked to justify the AD and its implementation, and why should this be determinative of what should happen? And on what basis can the autonomous individual, such as Odysseus, bind the future non-autonomous individual – are these even the same person? The increasing adoption of ADs worldwide nevertheless suggests that, while some philosophers may be vexed, their concerns do not overly trouble or inhibit lawmakers, policymakers, clinicians and patients – at least in those countries, largely in the West, where regulatory frameworks have gained traction over some years, if not decades. But even if we assume there is some stable basis for honouring ADs across countries, questions remain about what follows for the local implementation of ADs.

I.1.2 Practical Challenges

The real-world adoption of ADs has presented several distinct challenges, "as they can be non-existent, uninformed, imprecise, unavailable,

[13] See note 6, p. 115.

[14] A. Buchanan, "Advance Directives and the Personal Identity Problem" (1988) 17(4) *Philosophy and Public Affairs* 277, 298.

inadequate, [and] unpredictable".[15] These sorts of problems appear to have been detected wherever efforts have been made to adopt ADs, and so it is reasonable to think that the increasing tendency for ADs to gain a foothold in different parts of the world will give rise to similar trends. Here we summarise how designing and implementing ADs in practice in those places where ADs have been examined in some detail has been a far from straightforward journey.

I.1.2.1 Which Model or Form of AD?

"Not every attempted directive will be worth the paper it is written on. And not every attempted directive will be written on paper at all".[16] An AD can take various forms. As in Odysseus' case, the directive might be issued verbally, perhaps also being captured in an audio or video recording. Alternatively, patients might set down their wishes in writing, whether in a bespoke document or in a pro forma, and either on paper or electronically. They might also (or instead) convey the information on a tag that is worn about their person – or even on a bodily tattoo.[17] Questions accordingly arise about the form an AD should take and which mechanism or model of advance decision-making is to be adopted. Not only might the precise form vary, but – to add further complexity – so too do the terms used to capture the phenomenon. Sometimes different labels are used to refer to the same essential idea – for example, the "living will" to which Kutner referred, which is still in use in some contexts,[18] may be synonymous with the "advance directive". On other occasions, apparently neighbouring terms, which deploy the same or similar words, nevertheless refer to somewhat different phenomena.

The situation in England provides a pertinent example of the terminological steps that can be deployed to specify the scope and application of an AD, and to differentiate the AD from other decision-making tools or interventions in healthcare, and in end-of-life care in particular. Fleshing out the English context also helps to demonstrate the complexity that may arise in practice more widely. In that country, the Mental Capacity Act 2005 governs advance decision-making. The Act refers specifically to

[15] R. Huxtable, "Advance Decisions: Worth the Paper They Are (Not) Written On?" (2015) 5 *BMJ End of Life Care* 1, 5.
[16] Ibid., p. 3.
[17] C. Polack, "Is a Tattoo the Answer?" (2001) 323(7320) *BMJ* 1063.
[18] T. Higel et al., "Effect of Living Wills on End-of-Life Care: A Systematic Review" (2019) 67(1) *Journal of the American Geriatrics Society* 164.

the "advance decision to refuse treatment" (ADRT) and sets out the conditions governing their validity and applicability,[19] separate from an advance statement of the person's wishes that are to be drawn upon in making a decision in the person's "best interests".[20] Here we see an immediate qualification to the scope of the AD: it is to be restricted to a decision to *refuse* a treatment or care intervention, essentially on the grounds that a person's positive requests for particular interventions (whether made in the present or in advance) can only be indicative, but not determinative.

The English picture becomes even more complex, bringing with it the potential to confuse patients and professionals alike. A patient in England can make an ADRT, which may be verbal or written. They might also, separately, confer a "lasting power of attorney" – essentially appointing a proxy or surrogate decisionmaker, who is empowered to make decisions on the patient's behalf when they have lost mental capacity.[21] Patients might also be involved in (or subject to) a more specific decision, such as a DNACPR decision (do not attempt cardiopulmonary resuscitation). While DNACPR decisions are made by practitioners on the grounds of medical futility, in consultation with the patient or those interested in the patient's welfare where possible, they can also be captured in various ways, including – following a recent initiative – in a ReSPECT form.[22] Provided that they meet the relevant conditions, some such forms might amount to legally recognisable ADRTs. But forms like ReSPECT can also be described differently, as an instance of "advance care planning" (ACP). ACP overlaps with, but is distinct from, the ADRT or DNACPR decision. ACP involves a more general reflection, not merely on any specific treatment to which a patient does not consent, but also about the patient's general views, values and wishes regarding their treatment and care.[23] And, in turn, ACP may include some sort of "values history" – and these might also,

[19] Mental Capacity Act 2005, sections 24–6.
[20] Mental Capacity Act 2005, section 4(6)(a).
[21] Mental Capacity Act 2005, sections 9–14. Note, however, that a discussion of proxy decision-making is beyond the scope of this volume.
[22] C.A. Hawkes et al., "Development of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)" (2020) 148 *Resuscitation* 98.
[23] A. Mullick et al., "An Introduction to Advance Care Planning in Practice" (2013) 347 *BMJ* f6064.

on occasion, be appended to a patient's ADRT.[24] Indeed, increasingly, we see a trend internationally to encourage those involved in ACP to make an AD (where one has not been made previously) as part of good practice in planning future care of someone close to the end of life.

Thus, the variety of terms and tools available in England surely complicates efforts there to make provision for a future in which one has lost capacity. Neither patients nor professionals might be sure about where and how the patient's wishes regarding their future care should be captured. Even once this is settled, there then arises the question of what information should be captured within the relevant tool, and what protections should be added if endorsing the AD will have life-changing, even life-ending, implications? A detailed statement, which is sensitive to the patient's particular medical condition, might seem advisable,[25] and it might be judged appropriate for this to be witnessed or signed as part of a formal legal procedure. Yet, choosing a form that is too precise, detailed and voluminous might make it difficult to apply in practice – even more so if legal protections impose time or financial burdens on the person wishing to make it. And even a detailed directive might fail to speak to the situation which later arises – a risk that obviously also presents if the directive is too brief, general or imprecise. In short, there may be risks associated both with over- and under-specification, as subsequent chapters in this volume will demonstrate.

I.1.2.2 Will People Make ADs?

The accommodation of ADs in law, policy and practice will not automatically translate into their uptake. A review of the operation of the law in England suggested that public awareness of advance decisions there remains low, with research showing that only 3% of the public have made an advance decision, even though 82% have "clear views about their end-of-life care preferences".[26]

Similar findings about uptake of ADs have been reported elsewhere. Evans et al.'s systematic review of practice in Germany, published in

[24] D.J. Doukas and L.B. McCullough, "The Values History: The Evaluation of the Patient's Values and Advance Directives" (1991) 32(2) *Journal of Family Practice* 145.

[25] N. Evans et al., "A Critical Review of Advance Directives in Germany: Attitudes, Use and Healthcare Professionals' Compliance" (2012) 87(3) *Patient Education and Counseling* 277.

[26] House of Lords, Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-legislative Scrutiny* (HL Paper 139) (London: The Stationery Office Limited, 2014), p. 75, [193].

2012, found studies revealing 2.5%–10% of the population had ADs.[27] Citing other studies, the authors saw this range as comparable to uptake in Spain (2%) and the Netherlands (7%), but substantially lower than uptake in the United States (around 20%).[28]

Uptake may, of course, have risen in the intervening years since these studies. Yet, more recent research also points to the low incidence of ADs, at least among some patients. Sutter et al., for example, systematically reviewed studies exploring ADs amongst neurocritically ill patients.[29] They expressed concern about the "limited number of neurocritically ill patients having ADs or defined healthcare agents", given (inter alia) the high burdens imposed by such conditions.[30]

Perhaps there is a fairly straightforward way of enhancing uptake: invest in informing and educating citizens and patients about ADs, so that they can be empowered to set down their wishes. Certainly, such initiatives are underway worldwide, but there are reasons to be sceptical about the likelihood of success. Fagerlin and Schneider, in their forcefully entitled 2004 article "Enough: The Failure of the Living Will", reviewed various attempts in the United States at enhancing uptake and found them wanting:

> If after so much propaganda so few of us have living wills, do we really want them, or are we just saying what we think we ought to think and what investigators want to hear?[31]

I.1.2.3 Can People Make ADs?

The low uptake of ADs might be better understood once one considers the magnitude of the task of making an AD. How easy is it, ask Fagerlin and Schneider, for a patient to "conjure up preferences for an unspecifiable future confronted with unidentifiable maladies with unpredictable

[27] See note 25, p. 286. Although, interestingly, Horn cites data showing that in Germany, there are statistics demonstrating that 93% of the German population are in fact aware of ADs. See further 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.

[28] See note 25, p. 286.

[29] R. Sutter et al., "Advance Directives in the Neurocritically Ill: A Systematic Review" (2020) 48(8) *Critical Care Medicine* 1188.

[30] Ibid., p. 1193.

[31] A. Fagerlin and C.E. Schneider, "Enough: The Failure of the Living Will" (2004) 34(2) *The Hastings Center Report* 30, 33.

treatments?"[32] In response, approaches to making ADs that are disease specific have been proposed,[33] alongside a critical role for specialist clinical input that focuses on discussing treatments that are more predictable.[34] This approach, of course, requires the specialist clinician to be familiar with the provision that has been made for advance decision-making. Unfortunately, research has shown that professional understanding of ADs, alongside a more general awareness of this tool, remains low.[35]

Educational campaigns to better inform professionals and the public about ADs look to be an important intervention, but perhaps only as part of a general attempt to change public and professional attitudes that stress the importance of enabling and empowering people to take control of the future direction of their lives, in light of expected (or unexpected) health crises.

I.1.2.4 Will the AD Be Available When Needed?

Let us assume that an informed patient has been able to set down their wishes in the relevant way, with the relevant support. Will their statement be available to the clinicians at the point that it is needed? Here, too, there is reason to suspect that this cannot be guaranteed. Fagerlin and Schneider, again, put the point pithily: "long can be the road from the drafter's chair to the ICU bed".[36]

Suggestions to close the informational gap have looked to a role for patients' electronic medical records,[37] national registries or new storage systems to enable rapid access to information about the existence of ADs. We might think that this is particularly likely to be important in professional settings, like emergency paramedic response, where time is limited but important decisions about life-saving interventions frequently need to be made. Practices may vary, but it seems fair to suggest that systemic approaches to quickly access information about the existence of an AD will be required.

[32] Ibid.
[33] See note 25, p. 286.
[34] Cf. R. Nowland et al., "Management of Patients with an Advance Decision and Suicidal Behaviour: A Systematic Review" (2019) 9(3) *BMJ Open* e023978.
[35] See note 25, p. 284.
[36] See note 31.
[37] See note 26, p. 77, [200].

I.1.2.5 Will the AD Be Honoured?

Even if a directive can be located, its application in practice is not guaranteed. There are two related challenges here, which build on various points already considered. First, can the directive be applied in practice? Second, even if it is capable of application, will it actually be honoured as intended?

As we have already noted, vague or overly detailed directives might jeopardise their applicability and thus application. Evidence suggests that healthcare professionals are often unsure about how to interpret key aspects of the directive, or of the situation arising – how, for example, should clinicians respond if (despite anything else it might say) the directive does not directly address the specific treatment or presenting condition which is now in view? Moreover, even an apparently clear and specific directive might require some interpretation by the professionals, which has been shown to lead to inconsistent judgements.[38]

Of course, expert involvement, clarity and specificity might help to minimise uncertainty and the need for interpretation.[39] Yet, whenever interpretation *is* needed, this will be shaped by who is doing the interpreting – be they a clinician or, in contested cases, a judge.[40] In interpreting how, or if, an AD should be honoured, these professionals will always be exercising their judgement, and such judgement can be swayed – by the institutional culture, the views of colleagues, the presence of a family member, or how each individual weighs the value of autonomy against competing values like preserving life in challenging decision-making scenarios.[41,42] This is the complex reality of enacting an AD regime that might, on the surface, look compelling from a basic legal or ethical standpoint.

I.2 Advance Directives: The Asian Context

Although more than half of the world's population lives in Asia, and the elderly population in many Asian jurisdictions is growing at an

[38] T. Thompson et al., "Adherence to Advance Directives in Critical Care Decision Making: Vignette Study" (2003) 327(7422) *BMJ* 1011.
[39] See note 25, p. 285.
[40] See note 15.
[41] See note 34.
[42] L. Quinlivan et al., "Advance Decisions to Refuse Treatment and Suicidal Behaviour in Emergency Care: 'It's Very Much a Step into the Unknown'" (2019) 5(4) *BJPsych Open* e50.

unprecedented rate,[43] there is very little systematic and comprehensive information about the place of ADs in these jurisdictions. As the preceding discussion demonstrates, whilst ADs have been subject to significant reflection and analysis within academic medical law and ethics, much of the writing in this area has come from, or has focused on, jurisdictions in Europe and the Americas, many of which have detailed and well-implemented regulatory regimes for ADs. In contrast, the history of ADs in Asia looks to be a more recent one, though it is a history that also appears to be evolving quickly – in regulatory spaces or in professional practice – in a variety of ways, and at various speeds, across different countries. One of our primary aims in this book is to reveal the various dimensions of this emerging picture across the continent.

But there is also a second reason for wanting to shed light on ADs in the Asian context. The rise of ADs internationally has been the story of a growing international consensus placed on the importance of autonomy to shape new practices of decision-making in the healthcare context, and the subsequent need to invoke policies, laws and practices that accord ADs a central place in the armoury of healthcare decisions available to patients. How precisely does this consensus play out when it reaches Asian shores? Much has been written about the fact that the principle of respect for individual autonomy is not accorded the same primacy in Asian jurisdictions as it is in Western jurisdictions.[44] Relational concepts of autonomy seem to resonate more closely with the communitarian, familial models of decision-making common to Asian jurisdictions, and yet, as discussed, such concepts of autonomy are not generally associated with ADs. Equally, Asia is a continent defined by a rich variety of religious traditions, where the sanctity or prioritisation of the preservation of life has often been taken to play a decisive role in healthcare decision-making. Do these observations explain the relative lack of attention given to ADs across Asian jurisdictions? As increasing attention is given to a potential role for ADs in different Asian jurisdictions, how – if at all – is the ethical foundation of this practice made sense of, or modified, to accommodate different local models and expectations surrounding healthcare decision-making? And what are the implications of these accommodations for the practice of

[43] This is in particular true for the Asia-Pacific region, where it is projected that one in four people will be over the age of 60 by the year 2050. See further www.weforum.org/agenda/2021/10/is-asia-pacific-ready-to-be-the-world-s-most-rapidly-ageing-region/.

[44] See, for example, R. Fan, "Self-Determination vs. Family-Determination: Two Incommensurable Principles of Autonomy" (1997) 11(3) *Bioethics* 309.

ADs, and the future direction of further regulatory, professional or practical developments in Asia that we might expect to see? We hope that we might go some way to interrogating and then answering these important questions in the contributions that follow.

In summary, then, this volume aims to present the first systematic comparative study of ADs in Asia. In order to be both comprehensive and representative in our coverage, we have chosen to include 16 Asian jurisdictions, selecting this sample to take into account various parameters, such as sociocultural influences, religion, and economic status. While the term "Asia" is often associated primarily with East or South/Southeast Asia, with Middle Eastern and West Asian jurisdictions tending to be excluded, we are of the view that adopting this approach would fail to do justice to the breadth of jurisdictions that are correctly identified as being part of the Asian continent, and the richness of the different social, cultural and legal characteristics of this part of the world. Thus, by choosing a wide range of jurisdictions and sociocultural contexts from across the entirety of the Asian continent, we hope to showcase the diversity of views on this issue within Asia. Selecting 16 Asian countries out of a possible 48 countries recognised by the United Nations, a sample that was necessarily limited by accessibility and feasibility, will inevitably mean that there will remain gaps in our understanding. However, by taking a broad-brush approach to the selection of the countries we have chosen, we hope to mitigate the impact of these absences to the greatest degree possible.

The 16 jurisdictions covered are presented in the following three broad categories, which we have chosen to give a robust but basic structure to the insights of the book as a whole:

1. "Well-regulated": this category includes jurisdictions with a clear set of legal rules on or encompassing ADs. It should be noted that the term "well" refers only to the fact that there is comparatively formal regulation of ADs in these jurisdictions, rather than any normative assessment about the quality of such regulation. This category includes the jurisdictions of Israel, Singapore, South Korea, Taiwan, Thailand and India. The first five jurisdictions in this category have legislative frameworks addressing ADs, whereas regulation of end-of-life ADs in India takes the form of detailed, judicial guidelines laid down in the *Common Cause* case of 2018.[45]

[45] Psychiatric ADs in India, unlike end-of-life ADs, are regulated via statute.

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2. Semi-regulated: this category covers jurisdictions with other forms of regulation on ADs, including regulation via official regulatory documents and practical guidelines or other forms of guidance from professional societies. This category includes the jurisdictions of Hong Kong, Iran, Malaysia, the Philippines, and Turkey. While the courts in Malaysia and Hong Kong theoretically can be guided by common law case law precedent, there have not been any locally decided cases in this area of the law thus far. Thus, these two jurisdictions have been included in this category rather than the first one.
3. Non-regulated: this category covers jurisdictions where there might be, at best, broad principles contained in legislation or guidelines around healthcare that stress the importance of patient preferences in general terms, but no regulations or guidance which connects to ADs specifically. This category includes the jurisdictions of China, Japan, Macau, Pakistan and Saudi Arabia.

The contributors of each jurisdiction were provided with a broad questionnaire which prompted them to discuss key questions, including the existence (or not) of relevant legal frameworks and professional guidance, the practice of ADs (if any), and the sociocultural and religious context in which decisions regarding regulation (or lack thereof) were made. Contributors were also encouraged to consider the values and normative commitments that underlie the law and practice of ADs (or lack thereof) in their jurisdiction, and to offer critique of the local context, and the values it espouses, where appropriate. It should be emphasised that this volume does not aim to put forward, or advance, the position that ADs *should* be applied in the Asian region. Rather, contributors in each jurisdiction were asked to explore and critique the local directions of travel in relation to ADs, and to do this without being prejudiced by any particular normative ideal.

In shaping the volume in this way, the following chapters provide a rich, contextual landscape of the law and practice of ADs across a number of Asian jurisdictions. The chapters explore the tensions between the secular, individual-focused form of decision-making grounded in the person's own wishes that is the AD and the key sociocultural and religious influences of that jurisdiction, as well as how these tensions are resolved in the local context. Strikingly, however, these chapters demonstrate that many of the practical challenges described here take a similar form in the Asian context.

The final chapter of this book brings the insights of each chapter together in a comparative analysis of the key issues and themes that have arisen, drawing on the experiences of these jurisdictions to better understand the phenomenon of ADs in the Asian context. In particular, this final chapter will explore the ways in which the basic idea and practice of the AD as recognised internationally has been understood, challenged, accommodated or adapted within Asian societies which espouse a broad range of ethical value commitments and distinctive approaches to healthcare practice and decision-making.