The moral burden of 'slow code' resuscitation in Hong Kong and its implications for advance medical decision legislation

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'Slow codes', otherwise understood as insincere, fake, or merely performative attempts at resuscitation, have been almost universally condemned in the literature as unethical. The American College of Physicians Ethics Manual described the practice as 'deceptive', stating that "physicians or nurses should not perform half-hearted resuscitation efforts".[1] A prominent textbook on clinical ethics by Jonsen et al[2] characterised it as "dishonest, crass dissimulation, and unethical". Medical sociologist Muller similarly criticised it as "deplorable, dishonest and inconsistent with ethical principles",[3] whereas other bioethicists have argued that "patients, families, and health care professionals all need to rely on the good-faith assumption that when cardiopulmonary resuscitation (CPR) is attempted it will be done with vigour and genuine hope for success".[4]

The widespread and longstanding opposition to slow codes is evidently based on noble intentions to respect patient autonomy and preserve public trust. Nevertheless, some rebuttals to these arguments suggest that, under specific and limited circumstances, slow codes may be appropriate and even ethically defensible.[5] Moreover, a recent study reported that 69% of 237 clinicians caring for critically ill patients had witnessed the practice of slow codes.[6] In this article, we examine a specific circumstance within Hong Kong in which slow-code CPR may be morally justifiable. We argue that the ultimate moral burden should not fall on medical staff required to perform such resuscitation but rather on legislators and policymakers, who have the power to resolve this ethical dilemma at a legal level.

In 2015, the first author of this article was part of a research team commissioned to provide recommendations on future ageing-related policies for the Hong Kong Government, with a particular focus on end-of-life care. The study report was published in 2017.[7] In Hong Kong, although do-not-attempt-cardiopulmonary-resuscitation (DNACPR) orders and advance medical directives (AMDs) are legally recognised under the common law framework and within the public healthcare system,[8] they have not been enacted as statutory law. Therefore, one primary objective of the commissioned study was to evaluate the feasibility, barriers, and issues related to legislating AMDs and DNACPR in Hong Kong.

A multi-method design was utilised, comprising 15 focus groups and eight key informant in-depth interviews with 15 doctors, 16 nurses, and 42 allied health professionals, as well as 16 focus group interviews involving 75 social care service providers. The study identified a barrier to legislating AMDs and DNACPR that arose from the Fire Services Ordinance (FSO).[9] Section 7(d) of the FSO stipulates that one of the duties of the Fire Services Department (FSD) is to "assist any person who appears to need prompt or immediate medical attention by–(i) securing his safety; (ii) resuscitating or sustaining his life; (iii) reducing his suffering or distress".[9] This provision directly impacts paramedics working in emergency ambulance services because all public emergency ambulances in Hong Kong operate under the FSD. Even if resuscitation is regarded as an invasive life-sustaining treatment that may harm patients who are already imminently and irreversibly dying, and thus potentially conflicts with the third duty of reducing suffering or distress as stipulated in the FSO, the common interpretation of the law is that FSD paramedics remain legally obligated to perform resuscitation. This obligation is further complicated by ambiguity in the phrasing of the duty clauses—as it remains unclear whether lawmakers intended the clauses to function as an 'and' or an 'or' statement. If an 'or' statement were obviously intended, paramedics would have greater discretion; however, due to this uncertainty, it is reasonable for paramedics to err on the side of caution to avoid violating the law.

On the other hand, as previously mentioned, AMDs and DNACPR orders are recognised in Hong Kong under the common law framework.[8] The Hospital Authority, the statutory body managing all public hospitals in Hong Kong, issued the DNACPR guidelines for end-of-life patients with AMDs or DNACPR orders in 2014 and extended

these guidelines to include non-hospitalised patients with such orders in 2020.[10] However, due to the FSO's mandate to resuscitate or sustain life and the exclusion of the FSD from the Hospital Authority's DNACPR guidelines, an ethical dilemma has arisen for FSD paramedics. Although this phenomenon has not been well documented in the literature, possibly due to legal risks, several key informants in the commissioned study revealed that it was not uncommon for FSD paramedics to experience moral distress caused by the conflict between the duty to resuscitate and the moral obligation to respect patients' autonomous wishes to refuse CPR.[7] As a result, some paramedics reportedly engaged in slow codes by performing a less vigorous and less prolonged version of resuscitation on end-of-life patients.

In this specific context, we argue that slow codes do not appear to constitute the same ethical violations typically associated with the practice, for several reasons. First, paramedics engaging in slow codes could be viewed as adhering to the principle of non-maleficence because sincere but futile CPR may cause unnecessary harm to patients, particularly those nearing the end of life. It is not uncommon for full-code CPR to result in fractured ribs in such patients.[5,11] Second, although slow-code CPR may not fully honour the autonomous wishes expressed in an AMD or DNACPR order as earnestly as abstaining from CPR altogether, it prioritises the patient's autonomy more than full-code CPR. Within the spectrum of respecting autonomy, slow-code CPR arguably aligns more closely with this principle than full-code CPR, which paternalistically disregards the patient's expressed wishes. According to Beauchamp and Childress's principlism framework,[12] this situation suggests that the ethical principles of non-maleficence and respect for autonomy outweigh the principle of beneficence. Third, the common criticism that slow codes are deceptive is not entirely applicable to this specific circumstance because this argument generally assumes that the deception is directed at patients and their families. However, for paramedics in Hong Kong who are attempting to comply with the law, their primary intent is arguably not to deceive the patients and their families but to adhere to legal obligations. It is even reasonable to infer that if families also support respecting the patient's autonomous wishes, there is a greater likelihood that paramedics will engage in slow codes, reducing the need for any form of deception toward families. We acknowledge that FSD paramedics in Hong Kong could theoretically engage in slow codes to deceive families who seek to override the patient's autonomous wishes. However, such a scenario lies outside the focus of this article; a previous study has already proposed several standard approaches for managing intractable disagreements about CPR.[5] The situation in Hong Kong is particularly intriguing because, even in the absence of such familial disagreement, an ethical dilemma persists.

We argue that the moral burden should not rest with paramedics who must make decisions regarding CPR because they are compelled to navigate this ethical dilemma due to constraints imposed by the FSO. Without this ambiguous yet rigid requirement to resuscitate or sustain patients' lives, it would be easier for paramedics to honour the autonomous wishes expressed in patients' legally recognised AMDs or DNACPR orders. Instead, the moral burden should fall on legislators and policymakers to amend or, at the very least, reinterpret the law that contributes to creating this ethical dilemma.

After the submission of the commissioned report in 2017, the Health Bureau launched a public consultation in 2019 to gather views on legislative proposals concerning end-of-life care and AMDs.[13] A report summarising the consultation was published in 2020.[13] After a 3-year hiatus due to the coronavirus disease 2019 pandemic, the Panel on Health Services of the Legislative Council included the legislation of AMDs on its agenda for discussion starting in May 2023.[14] We urge the Legislative Council to seize this opportunity to ensure that the FSO does not obstruct the implementation of AMDs by creating ethical dilemmas for frontline paramedics. Ethics demand that individuals in positions of power and authority shape the environment in ways that promote and facilitate ethical decision-making. Considering the prevalent practice in Hong Kong, where end-of-life patients are typically transported to hospitals via emergency ambulances during their final days,[7] it is imperative for legislators and policymakers to address this issue if Hong Kong genuinely seeks to enhance respect for patient autonomy through the legislation of AMDs. In this context, it is encouraging to note that the Legislative Council of Hong Kong passed the Advance Decision on Life-sustaining Treatment Bill and was subsequently gazetted in November 2024. The Bill and relevant legislative amendments will permit FSD paramedics to recognise valid statutory DNACPR orders included in AMDs.[15] Specifically, once this Bill is enacted, the duty outlined in subsection (1)(d)(ii) of the FSO[9]—which obliges FSD personnel to resuscitate or sustain a person's life—will no longer apply if a valid DNACPR order exists for the individual concerned.

As Hong Kong navigates its approach to end-of-life care, it is essential for legislators and policymakers to ensure that the legal framework continues to support the effective implementation of AMDs. By doing so, they can create an environment that prioritises ethical decision-making and enhances the quality of care for patients during the most vulnerable stages of their lives.

Author contributions

RY Chung contributed to the concept of the commentary and the drafting of the manuscript. Both authors contributed to the critical review and revision of the manuscript for important intellectual content. Both authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

Both authors have no conflicts of interest to disclose.

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