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HA Guidelines on Advance Medical Directives (AMD) for Refusal of Life-Sustaining Treatment

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Abbreviations

ACP	Advance Care Planning
AMD	Advance Medical Directives
ANH	Artificial Nutrition and Hydration
BPG	Best Practice Guidelines
CPR	Cardiopulmonary Resuscitation
DNACPR	Do-Not-Attempt Cardiopulmonary Resuscitation
eAMD	electronic Advance Medical Directives
EOL	End-of-Life
eHRSS	Electronic Health Record Sharing System
HA	Hospital Authority
HKAM	Hong Kong Academy of Medicine
LST	Life-Sustaining Treatment
MHO	Mental Health Ordinance
Ordinance	Advance Decision on Life-Sustaining Treatment Ordinance
PVS	Persistent Vegetative State
RMP	Registered Medical Practitioner

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1. Introduction

- 1.1 A mentally capable adult has the right or autonomy to refuse medical treatment. When facing advanced irreversible diseases, patients may choose to make an Advance Medical Directive (hereafter referred to as **AMD**) (which is also known as Advance Directive or “AD”) for refusal of Life-sustaining Treatment (**LST**) under specified preconditions which will come into effect when he/she becomes incapable of making medical decisions. For patients who are imminently dying but without an Advance Medical Directive, doctors may withhold or withdraw LST that are not in patients’ best interests, and this is legally and professionally acceptable. This is not euthanasia which is defined as direct intentional killing of the patient as part of the medical care provided. Euthanasia is unethical and illegal in Hong Kong [1].
- 1.2 AMD is used for advance refusal of LST under specified preconditions to reduce unnecessary burden and suffering when death is imminent but does not prevent basic care such as assistance in oral feeding, providing clothes to keep warm, or palliative care. AMD is not for request of specific treatment, including requesting administration of substances to end the life of the AMD maker. An AMD purporting to refuse basic care and palliative care, or to request assistance in ending the AMD maker's life is of no effect under the Advance Decision on Life-sustaining Treatment Ordinance 《維持生命治療的預作決定條例》 (hereafter referred to as the **Ordinance**).
- 1.3 Under common law, a valid and applicable Advance Medical Directive is legally binding in Hong Kong. The Ordinance was passed by the Legislative Council on 20 November 2024 and gazette notice was published on 29 Nov 2024, and is expected to come into effect after 18 months. The Ordinance makes statutory provisions for the making, revocation and operation of AMD to refuse LST and of do-not-attempt cardiopulmonary resuscitation (**DNACPR**) order with continuing effect.
- 1.4 In making an AMD, the legal requirement as stipulated in the Ordinance includes four conditions:
 Condition 1: The maker of the AMD must be an adult and is mentally capable of deciding on a life-sustaining treatment
 Condition 2: The AMD must be made in writing with the instructions clearly written
 Condition 3: The AMD must be signed by the maker with date of making inserted
 Condition 4: The maker must sign the AMD in the presence of not less than 2 witnesses, one of which must be a registered medical practitioner who provides information and explanation to the maker. Both witnesses must be adults with no vested interests. The details are provided in this Guidelines.
- 1.5 For DNACPR, the Ordinance has excluded episodic DNACPR which will be automatically invalidated upon patient’s discharge from hospital. In this Guidelines, the term “DNACPR order” refers to DNACPR with continuing effect unless otherwise specified. The principle of “cautious making, easy revoking” is adopted for the patient

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advance decision documents so that patients are adequately protected in the making process, yet with easy voluntary revocation after making.

1.6 The Ordinance provides the following forms for 3 categories of preconditions:

1.6.1 Two types of model AMD forms:

- (a) A full form for refusal of CPR and/or other LST;
- (b) A short form for refusal of CPR only.

The model AMD forms can be in paper form or in electronic form only when the relevant provisions under Part 6 of the Ordinance relating to the making and revocation of AMD by electronic means have come into operation.

1.6.2 Three types of statutory DNACPR order forms:


- (a) AMD-based DNACPR order for adult patients with an underlying AMD (no third co-signer required);
- (b) non-AMD-based DNACPR order for mentally incapable adult patients (third co-signer required unless he/she is not secured despite reasonable effort);
- (c) non-AMD-based DNACPR order for minor patients (third co-signer required).

For all types of DNACPR order forms, prescribed DNACPR order continuation sheets are available for further extension of the effective period of the DNACPR order.

DNACPR orders can only be made in paper form. There is no provision for electronic storage or making of DNACPR order.

** To ensure a smooth transition of forms, doctors are recommended to use the relevant AMD and/or DNACPR forms under the Ordinance even before the Ordinance comes into effect.*

1.7 The Hospital Authority (**HA**) advocates for advance care planning, a communication process with patients and their family members for consensus building before decisions on LST. For the purpose of co-signing the DNACPR order for mentally incapable adults and minors, the Ordinance has defined the terms “responsible persons” and “eligible persons” (refer to Appendix I). When the responsible persons are not available, an eligible person may serve the purpose. For adults, the responsible persons include the immediate family members, the cohabitants and the legal guardian; for the minors, the responsible persons include the parents and the legal guardian; while the requirements for eligible persons are the same for adults and minors. In this document, the term “family/family members” is generally used, but for patients with no family members, the context may also extend to other responsible or eligible persons as defined by the Ordinance.

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1.8 In order to remove legislative impediments to the operation of AMD and DNACPR and to facilitate dying in place, the following related Ordinances are also amended, namely:

- 1.8.1 Fire Service Ordinance (Cap 95);
- 1.8.2 Coroners Ordinance (Cap 504);
- 1.8.3 Births & Deaths Registration (Cap 174);
- 1.8.4 Mental Health Ordinance (Cap 136).

1.9 The HA released the first version of the Guidance for HA Clinicians on Advance Directive for Adults on 8 July 2010 and the latest revised version (4th version) on 1 September 2020. The Guidance for HA Clinicians on Advance Directive for Adults has served as practical guidelines for HA doctors when the Advance Directive is legally binding under the common law framework. In 2019, the HA has established a Task Force under the HA Clinical Ethics Committee to contribute to the Government on the legislation process of Advance Medical Directives.

1.10 In response to the enactment of the Ordinance, the Hong Kong Academy of Medicine (HKAM) has released the Best Practice Guidelines (BPG) on Advance Medical Directives in April 2025. Based on the BPG, the HA has revised the last version of “Guidance for HA Clinicians on Advance Directives in Adults” to this current version of “HA Guidelines on Advance Medical Directives for Refusal of Life-Sustaining Treatment” to keep the staff abreast of the changes and implications on HA [2].

2. Scope and objectives

2.1 The HA supports Advance Care Planning (ACP) for patients with serious illnesses and AMD making for the preconditions in the model AMD form.


2.2 The HA Guidelines on AMD for refusal of Life-Sustaining Treatment should be read by all treatment providers in the HA setting (registered medical practitioners including doctors under limited or special registration, interns, registered dentists, registered nurses and enrolled nurses) and allied health.

2.3 The HA Guidelines should be read together with the other HA Guidelines on decision making for patients facing life limiting illness or at end of life (EOL) which are being revised simultaneously:

2.3.1 HA Guidelines on Life-Sustaining Treatment in Patients Approaching End of life 2025 for ethical considerations including assessment of patient’s best interests.

2.3.2 HA Guidelines on Do-not-attempt Cardiopulmonary Resuscitation 2025 for guidance on DNACPR with continuing effect i.e. AMD-based DNACPR forms, non-AMD-based DNACPR forms for mentally incapable adults and minors and episodic DNACPR forms.


2.3.3 HA Guidelines on Advance Care Planning 2025 for the communication process with patients and their families before making AMD and DNACPR.

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- 2.4 In parallel, the HA has revised the existing AD and non-hospitalised DNACPR forms to comply with the Ordinance.
- 2.5 The HA Guidelines not only cover the paper AMD but also the electronic image of the paper AMD stored in Electronic Health Record Sharing System (eHRSS) which will be designated as the electronic system for the purpose of the Ordinance. When the relevant provisions under Part 6 of the Ordinance relating to the making and revocation of AMD by electronic means are about to come into operation, further guidance will be provided.

3. Revision of existing HA AD and non-hospitalised DNACPR forms and transition to new HA forms

- 3.1 There is grandfathering of the existing HA Advance Directives (AD) forms since inception in 2010, and the latest versions include:
- 3.1.1 Advance Directive (To refuse CPR when suffering from terminal illness) (HA9612/MR)
- 3.1.2 Advance Directive (HA9610/MR)
- 3.2 For patients who would like to make a new AMD, the following HA AMD forms should be used:
- 3.2.1 Advance Medical Directive for refusal of CPR only (HA9632/MR) – to cover all three preconditions and not just terminal illness (Appendix IIa)
- 3.2.2 Advance Medical Directive for refusal of CPR and/or other Life-Sustaining treatment (HA9630/MR) – to cover all 3 preconditions (Appendix IIb)
- 3.3 The HA AMD forms follow the model form as provided by the Ordinance. HA has no provision for non-model AMD forms i.e. forms catering for other preconditions not in the model form and making of non-model AMD is not allowed in HA setting.
- 3.4 The HA DNACPR for non-hospitalised patients (HA9614/MR) will be replaced by the forms in a format as prescribed by the Ordinance, including:
- 3.4.1 AMD-based DNACPR form for adult patients with an AMD for refusal of CPR (Appendix IIIa);
- 3.4.2 non-AMD-based DNACPR for mentally incapable adult patients (Appendix IIIb);
- 3.4.3 non-AMD-based DNACPR for minors (Appendix IIIc);
- 3.4.4 DNACPR continuation form for further extension of (3.4.1) or (3.4.2) and (3.4.3) respectively (Appendix III d).
- 3.5 Please note that the DNACPR forms for mentally capable adults, mentally incapable adults and minors are separated and not in a combined form as in DNACPR (HA9614/MR). The concept of AMD-based and non-AMD-based DNACPR is introduced to differentiate DNACPR as a free choice of mentally capable adult (AMD-based) and the DNACPR made based on patient's best interests for mentally incapable

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adults and for minors (non-AMD-based).

- 3.6 The new HA DNACPR forms should be used for patients newly put on DNACPR order with continuing effect. Despite that they would only be recognised by the ambulance crew as binding after the Ordinance has come into operation, HA should start to use them as soon as possible so as to allow a progressive transition for vast majority of patients. For patients who are still holding the DNACPR (HR9614/MR) forms, early arrangement has to be made so that when the Ordinance has come into effect, all of them will have already held the new HA DNACPR forms. (Table 1).


Table 1: Transition of HA AMD and DNACPR forms

Forms	18 months of working window	When ADLST Ordinance comes into effect
Existing HA AD	Remain valid, no need to change unless making new AMD	
New HA AMD	Start to use for patients making new AMDs (model format)	
Existing HA non-hospitalised DNACPR	<p>Can continue to use, fading out as patients passed away</p> <p>Not recognised by FSD but recognised by HA</p> <p>Early arrangement for changing to new DNACPR is recommended</p>	<p>Already converted to new DNACPR forms for patients who are still alive</p> <p>Recognised by FSD and all treatment providers</p>
New prescribed DNACPR order with continuing effect	<p>Start to use for new patients</p> <p>Not recognised by FSD but recognised by HA</p>	<p>Mandatory use for all patients</p> <p>Recognised by FSD and all treatment providers</p>

4. Mental capacity for making decisions on LST

(adopted from Section C, BPG on AMD, HKAM 2025)

- 4.1 Under common law, all adults are presumed to have mental capacity, unless proven otherwise, to make decisions regarding their medical treatment.
- 4.2 Mental capacity is time and task-specific.
- 4.3 Under the Ordinance, an adult is mentally capable of deciding on LST if he/she is able to do the following at the time of making the AMD:
- 4.3.1 Understand the information relevant to the AMD in one's own situation; and
- 4.3.2 Retain that information; and
- 4.3.3 Use or weigh the information in decision-making for refusing LST; and
- 4.3.4 Communicate his/her decision to refuse LST by any method.
- 4.4 Reasonable efforts should be made to remove barriers before concluding on the mental


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capacity, for example by providing hearing aids to patients with hearing impairment; providing writing pads for patients with difficulty in speech; providing a translator for patients with language barriers; making use of lucid intervals for communication; or replacing jargon with layman terms. The maker should not be unjustly judged or assumed to be mentally incapable solely because of his/her age, appearance or certain behaviour.

- 4.5 For purposes of determining mental capacity, adults who are able to retain the relevant information for a short period are still considered capable of retaining the information.
- 4.6 If a mentally capable adult who has been properly informed of the consequences of refusal of LST, including when this puts his/her life at risk, proceeds to make his/her decision to refuse LST in advance, such decision should be respected even when the decision appears to be unwise or commonly considered to be not in the patient's best interests.
- 4.7 When the mental capacity of the patient is in doubt, for example, he/she may be under the influence of drugs, or suffering from cognitive disorders impeding decision-making on LST, the doctor should defer making the AMD. Some of these influencing factors may be temporary and treatable, and discussion on AMD may be resumed in due course. The doctor may seek advice from relevant medical experts when mental capacity of the patient remains doubtful.

5. **Life-Sustaining Treatment** (*adopted from Section D, BPG on AMD, HKAM 2025*)

- 5.1 LST refers to any treatment that has the potential to postpone death. The list may include, but not exhaustive, of the following:
 - 5.1.1 CPR;
 - 5.1.2 artificial ventilation;
 - 5.1.3 transfusion of blood products;
 - 5.1.4 cardiac pacing;
 - 5.1.5 vasopressors;
 - 5.1.6 specialised disease specific treatment such as chemotherapy, dialysis;
 - 5.1.7 antibiotics for life threatening infection;
 - 5.1.8 artificial nutrition and hydration (ANH).
- 5.2 Withholding or withdrawing LST allows natural death to occur eventually without the burden of non-beneficial treatment or in accordance with the patient's wish [3]. Futile or non-beneficial treatment refers to a treatment which is of no benefit, cannot achieve its purpose, or is not in the person's best interests [4].
- 5.3 There may be other invasive interventions or treatment that do not qualify as LST and yet the patient may consider as burdensome, for example airway clearance by suctioning, application of physical restraint etc. Although these interventions or treatment are not considered LST and hence cannot be refused under an AMD, patient's preferences could be discussed and documented in the ACP.


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6. Role of doctor in making of Advance Medical Directive

(adopted from Section F, BPG on AMD, HKAM 2025)

- 6.1 The AMD form must be properly completed, signed and dated. The Ordinance has provided model AMD forms for use, covering certain specified preconditions (*The Ordinance Schedule 2*). While the use of model AMD forms is not compulsory under the Ordinance, it is strongly preferred and should be encouraged.
- 6.2 The doctor involved in making of the AMD must be a registered medical practitioner (**RMP**), registered under the Medical Council of Hong Kong in accordance with the provisions of the Medical Registration Ordinance (Cap 161). Doctors under limited / special registration are included.
- 6.3 The signing RMP must be satisfied that the patient is an adult mentally capable of deciding on LST at the time of signing the AMD. As a matter of good practice, the RMP should also ensure that the patient is not under undue pressure or coercion in signing the AMD, and the RMP should not press the patient to sign the same.
- 6.4 The signing RMP has to provide sufficient and relevant information for the patient to make an informed decision in making AMD. The scope and the depth of the information are different from making a contemporaneous informed consent to a specific treatment procedure. The information should include the nature of an AMD and the nature of following the instructions of not performing certain LST under the specified precondition(s). (*e.g.* that it will result in the natural death of the patient due to the underlying condition).
 - 6.4.1 The nature and effect of making an AMD:
 - (a) An AMD is a legally binding document made by the patient voluntarily while mentally capable for advance refusal of LST.
 - (b) Withholding of LST allows natural death to occur due to the underlying precondition.
 - (c) An AMD will only come into effect when patient is mentally incapable and the AMD is assessed to be valid and applicable.
 - (d) The patient can revoke the AMD at any time as long as he/she is mentally capable. The AMD cannot be revoked by other persons although the decision to revoke can be conveyed to healthcare professionals in the presence of an adult witness.
 - 6.4.2 The preconditions for applying the AMD


The model AMD form covers the following preconditions (a), (b) and (c). Non-model AMD form has to be used for preconditions beyond this scope.

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- (a) Terminally ill: A person is terminally ill if he/she is suffering from
- advanced, progressive, and irreversible disease; and
 - having a short life expectancy in terms of days, weeks or a few months; and
 - only with death postponed by applying LST, e.g. advanced cancer.
- (b) Persistent vegetative state (**PVS**) or irreversible coma
- A person is in PVS if he/she suffers from severe brain damage resulting in a persistent state of unawareness of self and his/her surroundings with the inability to give purposeful response to his/her surroundings (excluding reflexive behaviour*) and yet maintaining a state of wakefulness with sleep-wake cycles, provided that there is no hope of regaining awareness of self and surroundings.
 - A person is in irreversible coma if he/she suffers from severe brain damage resulting in a persistent state of unawareness of self and his/her surroundings with inability to give purposeful response to his/her surroundings (excluding reflexive behaviour*) provided that there is no wakefulness with sleep-wake cycles and there is no hope of regaining wakefulness and awareness of self and surroundings. **Examples include spontaneous movement with no discernible reasons, reflexive movements such as brainstem reflexes, and generalised arousal response.*
- (c) Other end-stage irreversible life limiting conditions
- This condition does not fall under (a) or (b) but is progressive and irreversible, has reached the end-stage of the condition and limits the survival of the patient.
 - For example, patients with end-stage renal failure, motor neuron disease or chronic obstructive pulmonary disease who are not terminally ill (because the patient's survival may be prolonged by dialysis or assisted ventilation), irreversible loss of major cerebral function and extremely poor functional status but not falling into (b), e.g. severe stroke or advanced dementia.

6.4.3 The LST refused and the effect of refusal

- (a) The LST to be refused must be specified clearly on the AMD (refer to Section 5 for examples).
- (b) The patient cannot refuse (i) basic care (such as oral feeding) or (ii) palliative care, or request physician-assisted suicide and euthanasia. An AMD purporting to refuse basic care and palliative care, or to request physician assisted suicide or euthanasia will be of no effect. It is a good practice to

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reassure patient that signing an AMD will not lead to abandonment, and palliation will be provided for symptom control.

- (c) In the full AMD form, there are separate sections for each of the 3 categories of preconditions, and under each category of preconditions, the available options include the following:


- Refusal of CPR;
- Refusal of other LST (to be specified);
- Refusal of all LST except for ANH;
- Refusal of all LST.

The option of refusal of all LST except for ANH allows for separate decision on ANH provision based on patient's clinical indication and best interests when the patient becomes mentally incapable.

- (d) Caution should be exercised when the patient expresses a wish for blanket refusal of ALL LST. The RMP should explore the underlying reasons for blanket refusal and give sufficient explanation and information on the spectrum of LST to clarify any misconceptions or misunderstandings.

6.4.4 The case of ANH

- (a) ANH is considered LST and could be refused by mentally capable patients under an AMD in various specified preconditions. ANH could be in the form of feeding via tubes inserted into the stomach or small intestine, or a tube inserted into the vein or under the skin [5]. However, it could be contentious to withhold or withdraw ANH in patients with PVS, irreversible coma or severe dementia even in the presence of AMD. These patients are not expected to die immediately after withholding or withdrawal of ANH and may be perceived as dying from starvation instead of dying from underlying disease. Some patients may prefer to consider artificial nutrition from artificial hydration separately (e.g. refusing Ryle's tube feeding but not subcutaneous hydration as there may be different considerations in risk and benefits).
- (b) The PVS or irreversible coma may take investigations, time and expertise to establish the diagnosis. Because of the diagnostic challenge, it is likely that the patient would be put on ANH prior to the establishment of the diagnosis, and hence involving withdrawal (instead of withholding) if the patient's advance refusal is to be respected subsequently. Patients with PVS, same as those with irreversible coma, do not have **awareness** or meaningful response to the surroundings; but in contrast, patients with PVS have wakefulness and the presence of circadian rhythm preserved. Their family members may mistake the wakefulness such as eye opening as purposeful or meaningful.

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- (c) For patients with dementia, the patient may prefer careful oral feeding over ANH. As the patient deteriorates, he/she may not be able to make decisions while provision of fluid, food and drugs through the oral route may be increasingly difficult. A thorough ACP process will prepare the patient and his/her family members in understanding the disease trajectory and what to anticipate at end-stage dementia. In withholding or withdrawing ANH in patients in PVS, irreversible coma or severe dementia, death is not as immediate as in the case of withholding CPR in cardiac arrest. Support should be given to family members carrying the “burden of witness”, *i.e.* the burden of family members in witnessing the length of time taken for the person to die and / or distressing changes in the patient’s appearance during the process. Comfort care should be continued [6].
- (d) In case of serious dispute even in the presence of AMD, it is advisable to seek opinion from hospital management, local ethics committee and/or legal advisers, who may decide whether to submit an application to the court to seek a declaration.

6.5 The UK Supreme Court has ruled in 2018 that there is no general requirement for the courts in England and Wales to authorise the withdrawal of clinically assisted nutrition and hydration from patients with prolonged disorders of consciousness (including irreversible coma, PVS and minimally conscious state) provided that there is a consensus between the doctors and family on the decision based on patient’s best interests [7].

6.6 Signing the AMD and the role of witnesses


6.6.1 The AMD form should be signed by the patient in the presence of at least 2 adult witnesses aged 18 or above, one of whom should be an RMP. Both witnesses should not be interested persons of the maker to their best knowledge at the time of signing (hereafter referred to as non-interested person).

An interested person of the patient refers to a person:

- (a) who is a beneficiary under the patient's will or insurance policy;
- (b) to whom the patient grants or settles any interest by means of any instrument;
- (c) who is entitled to any interest in the patient's estate should he/she die intestate; or
- (d) in whom any interest would otherwise vest by operation of the law or any instrument on the patient's death.

6.6.2 The RMP who has explained the nature of AMD, the conditions of implementing the instructions in the AMD and is satisfied that the maker is mentally capable of deciding on LST, shall serve as the first witness. By signing, the RMP has declared that:

- (a) He/she is an RMP;
- (b) He/she is not an interested person to his/her best knowledge;

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- (c) He/she has explained to the maker the nature of the AMD and the effect of following the AMD on the maker;
- (d) He/she is satisfied that the maker is mentally capable of deciding on LST at the time of making the AMD; and
- (e) He/she signed in the AMD in the presence of the maker and the second witness.

6.6.3 The second witness need not be a doctor, but should fulfil the following:

- (a) He/she is an adult (i.e. attained 18 years of age);
- (b) He/she is not an interested person to his/her best knowledge;
- (c) He/she signed in the presence of the maker and the first witness.

It is good practice for the second witness to also witness that the first witness (being the RMP) has informed the patient of the nature of AMD and effect of following it on the patient, the conditions of implementing the instructions in the AMD and the patient has signed the AMD voluntarily.

To avoid dispute in future, it is advisable that other staff with no vested interest shall sign as the second witness instead of family members, close friends or caregivers.


6.6.4 For patients who are unable to sign their names, he/she may make a mark or imprint his/her fingerprint on the AMD. The patient's chop or stamp is not accepted.

6.6.5 It is highly desirable to build consensus with family members before signing the AMD even though the patient is entitled to make his/her autonomous decision. This helps to avoid impediment to the operation of the AMD in the future. If the patient insists on making the AMD despite conflict within the family or in the absence of family members, the doctor should act judiciously with clear documentation.

6.6.6 The model AMD forms are available in Chinese and English. For ethnic minorities who are unable to read or interpret the Chinese or English forms, the RMP should read or ask an interpreter to read the contents of the AMD forms to the patient for his/her understanding before signing.

6.7 Invalid Instructions in the AMD

6.7.1 The instructions in the AMD forms must not be any request for hastening of death by administration of substances or other medical interventions i.e. physician assisted suicide or direct killing of the patient as part of the medical care provided i.e. euthanasia. Euthanasia is illegal and ethically unacceptable in Hong Kong. (Ref: Code of Professional Conduct, The Medical Council of Hong Kong, last revised in October 2022).

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6.7.2 The instructions in the AMD should not impede the provision of basic care and palliative care. Basic care refers to general care provided to a person for comfort and not involving medical instruments e.g. giving oral food and drinks, assisting oral feeding, keep warm, maintaining personal hygiene. Referral to palliative care should be considered for patients facing life limiting illnesses with complex needs.

7. Role of doctor in making a DNACPR order for mentally capable adults with AMD for refusal of CPR (AMD-based DNACPR orders)

(adopted from Section G, BPG on AMD, HKAM 2025)

7.1 The prescribed AMD-based DNACPR order form must be used for timely and easy recognition by the ambulance crew. The prescribed AMD-based DNACPR order form covers the same 3 categories of specific preconditions as in the model AMD forms. The DNACPR order must be signed by 2 RMPs, one of whom is a specialist. By signing, both RMPs confirm that:

7.1.1 there is an underlying instruction in the patient’s AMD to refuse CPR when he/she becomes mentally incapable AND the patient has now met the specified precondition;


7.1.2 both RMPs are non-interested persons; and

7.1.3 both RMPs agree on the effective period of the order, which should not exceed 1 year. The entry of specified precondition on the AMD-based DNACPR order should match with that in the AMD to avoid confusion. The patient’s signature is not required.

7.2 The signing of the AMD-based DNACPR order which confirms that the patient has met the specified precondition, will allow treatment providers to act without undue delay. Without the AMD-based DNACPR order, the ambulance crew would not be able to immediately withhold CPR as wished by the patient, and the treatment providers would have to assess whether the AMD is valid and applicable before complying with the DNACPR instruction in the AMD.

7.3 The AMD-based DNACPR order should be reviewed and signed by one RMP who is not an interested person (can be specialist or non-specialist) before the effective period expires. Extension of the DNACPR order, which also must not exceed 1 year, requires re-signing by one RMP (who does not have to be the RMP signing the initial order) after review. If needed, continuation sheets for DNACPR orders should be used for further extension after the last expiry date and attached to the parent DNACPR order. If not reviewed and re-signed, the DNACPR order becomes invalid after the effective period has passed.

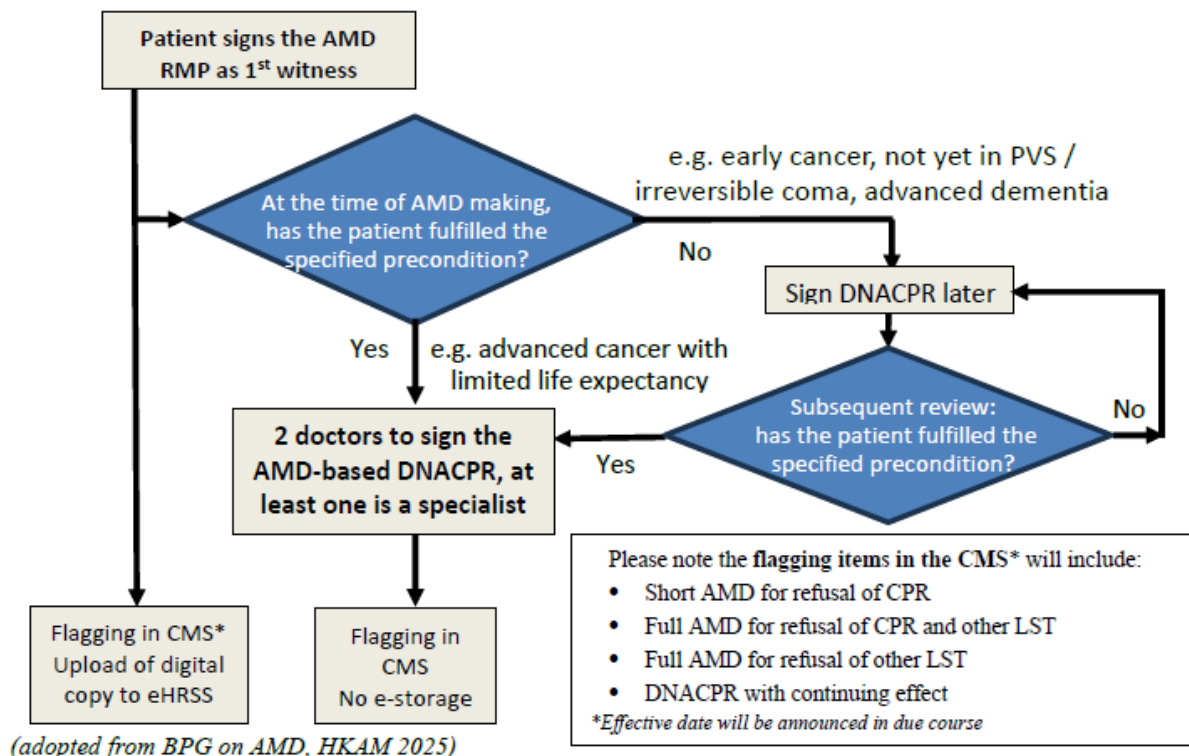
7.4 There will be circumstances when the RMPs are not able to sign the AMD-based DNACPR order at the time of making the AMD because the specified precondition has not been met, e.g.:

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- 7.4.1 The potentially incurable disease is still at an earlier stage, e.g. cancer or organ failure;
- 7.4.2 The patient has not reached the stage of severe dementia which is stated as the specified precondition when signing the AMD;
- 7.4.3 The patient specified PVS or irreversible coma as a precondition which has not yet occurred.


In such circumstances, the RMPs shall only complete the AMD-based DNACPR order at a later time and decisions should be documented in the patient’s records to facilitate subsequent review. If the patient sustains a cardiac arrest before an AMD-based-DNACPR order is made, the attending doctor has to rely on the AMD per se for action after being satisfied that the AMD is valid and applicable. (Refer to Figure 1).

Figure 1. Flow chart in making AMD-based DNACPR after AMD making



8. Use of HA CMS and eHRSS for flagging and electronic storage of AMD

- 8.1 After making the AMD with or without the AMD-based DNACPR, the RMP shall flag the following alerts in the CMS as appropriate (Refer to Figure 1):
 - 8.1.1 Short AMD for refusal of CPR;
 - 8.1.2 Full AMD for refusal of CPR and other LST;
 - 8.1.3 Full AMD for refusal of other LST;
 - 8.1.4 DNACPR with continuing effect.

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8.2 After completion of the paper AMD, other validating copies (having the same legal effect of the original paper AMD) can be made by RMP by:

8.2.1 transforming the paper AMD into a clearly legible digital copy and uploading such copy to the designated site of eHRSS for storage. RMP is recommended to do so.

8.2.2 approaching the medical record office to obtain a certified true of the original paper AMD (if so requested by the patient). While there is no limitation as to the number of such certified copies, the patient should take note of potential risks for having excessive certified copies. The certification can also be done by a solicitor practising in Hong Kong.

8.2.3 For AMD made outside HA setting and uploaded to eHRSS by the non-HA RMP, the same alerts will appear in eHRSS and CMS. The HA RMP is not recommended to upload the AMD on behalf of the non-HA RMP unless the HA RMP can ascertain and confirm that the AMD is properly completed in accordance with the Ordinance.


9. Notice of AMD and/or DNACPR order by the HA treatment providers

9.1 Patients and their responsible or eligible persons should be educated that they have the responsibility to present the validating copies of the AMD and/or DNACPR order to the treatment providers. A standard pouch is provided by HA for storage of AMD/DNACPR/ACP forms.

9.2 The AMD can be stored electronically in the eHRSS upon patient's consent, which is also a validating copy of the AMD. On the other hand, there is no electronic storage of DNACPR order and only the original copy of DNACPR order and its certified true copy are regarded as the validating copies.

9.3 Generally, there is no obligation for the treatment providers to search the patient's belongings to look for the paper forms of AMD or DNACPR order. However, if a treatment provider is informed that a copy of the AMD is or may be stored in eHRSS, he will be taken to have notice of the AMD (if the same is indeed stored in eHRSS). He may assess, depending on the circumstances including the clinical situation of a patient, whether to search the eHRSS for the AMD. For example, in a clinic consultation for minor ailments of a mentally capable patient, the doctor may not search the eHRSS if he considers that the AMD for refusal of LST will not be applicable.

9.4 However, for HA patients attending A&E or admitted as inpatient with a CMS alert of AMD (which is directly linked to eHRSS), it is recommended that the HA treatment providers should proceed to search the AMD copy stored in the eHRSS via CMS and to peruse the same. It is a good practice to confirm with the patient or the responsible or eligible persons that the patient has not revoked the AMD. A local workflow should be in place to ensure the validating copies of the AMD and/or DNACPR presented are made known to other treatment providers during the same care episode.

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9.5 Patients should not be assumed to refuse other medical treatments including the LSTs that are not being refused in the AMD. Treatments options related to the contemporary clinical condition should be discussed with the patient as appropriate.

10. Who can revoke the AMD?

(adopted from Section J, BPG on AMD, HKAM 2025)

- 10.1 The maker can revoke his/her AMD any time as long as he/she is mentally capable of deciding on LST and not under undue influence. A properly completed and signed AMD cannot be revoked by other persons, including the maker's family members.
- 10.2 The maker may revoke the existing AMD by doing one of the following (Table 2):
 - 10.2.1 Write a revocation (whether in paper form or in electronic form);
 - 10.2.2 Sign Part 5 of the model AMD form with the date of revocation shown;
 - 10.2.3 Burn, destroy or tear the paper AMD him/herself or by another adult in his/her presence and by his/her direction;
 - 10.2.4 Cross out the content of and sign on each page of the paper AMD him/herself or by another adult in his/her presence and by his/her direction;
 - 10.2.5 Express the intention to revoke verbally in the presence of one or more adult witnesses who are present physically or by audio-visual link in real time;
 - 10.2.6 Express the intention to revoke by any means other than in writing or verbally in the presence of one or more adult witnesses who are present physically or by audio-visual link in real time;
 - 10.2.7 Make a new AMD; or
 - 10.2.8 Take the step required on eHealth to remove the electronically stored AMD copy from the system.
- 10.3 For an AMD made for refusal of CPR, the AMD-based DNACPR order is also revoked automatically upon revocation of the underlying AMD.
- 10.4 Patients should be advised to report to the RMP as soon as practicable upon any revocation, so that the RMP may confirm that the patient is mentally capable at the time of making the revocation, and to allow for simultaneous updating of patient records, including removal of the electronically stored copy on eHealth. For patients keeping certified true copies in addition to the original paper copy of AMD, the patients should ensure that all the certified true copies of the revoked AMD are removed and destroyed to avoid confusion.
- 10.5 For patients who makes a new AMD, the existing AMD will be automatically revoked. It is important to remind the patient to remove and destroy at the same time all validated copies of the existing AMD. In any event, if multiple AMDs are available, the last dated AMD shall prevail. In situations when family members only inform the RMP about the revocation when the patient is already in a mentally incapable and critical state, the RMP would not be able to ascertain the mental capacity of the patient at the time of revocation but to presume that it was the case unless the contrary is proved.



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Table 2: Revocation of AMD

Patients have the liberty to choose to make AMD in paper form or in electronic AMD (**eAMD**) form. Upon revocation of paper AMD, the digital AMD stored in the electronic platform and the other certified true copies (if any) should be removed or destroyed at the same time. Upon revocation of eAMD, the certified photocopies of the AMD should also be removed or destroyed.

What?	How?	By whom?
Original copy of paper AMD (only one copy) And its certified true copies (can be multiple copies)	a) Write a statement of revocation; b) Sign on Part 5 of the AMD form with the date of revocation shown; c) Burn, destroy or tear the paper AMD; d) Cross out the content of and sign on each page of the paper AMD; or e) Express the intention to revoke <ol style="list-style-type: none"> i. Verbally; or ii. By any means other than in writing or verbally 	By the patient (a,b) By the patient or an adult in the patient's presence and by the patient's direction-(c,d) By the patient and in the presence of one or more adult witnesses (e)
Electronically stored paper AMD in eHealth (only one/last copy displayed) To be removed simultaneously with revocation of paper AMD	<ul style="list-style-type: none"> ▪ Take the steps required by eHealth for revoking the AMD 	By the patient or by an adult in the patient's presence and by the patient's direction, including the RMP who has access to eHealth
<p>In any circumstances, the patient should only have one AMD (whether in paper or electronic form), and as preferred by the patient, to have one or several certified true copies of the AMD and/or electronically stored copy (if AMD is made in paper form). While these validating copies may accumulate over time and not necessarily be produced on the same day as the AMD is made, it is important to remind the patient that the original and other validating copies should best be revoked/removed simultaneously to avoid confusion. This is especially important when the patient intends to revoke the existing AMD by making a new one.</p>		
Electronically made AMD on eHealth* (eAMD) (only one / last copy displayed)	<ul style="list-style-type: none"> ▪ Take the steps required by eHealth for revoking the eAMD ▪ By (a) and (e) as above 	By the patient or by an adult in the patient's presence and by the patient's direction, including the RMP who has access to eHealth
Validating copy of eAMD* (e.g. a legible printout) To be destroyed simultaneously with revocation of eAMD	<ul style="list-style-type: none"> ▪ Revoke by steps (b), (c) and (d) as above 	
<p>* Electronic making of AMD is only available when the designated system is in operation. Making and revocation of eAMD should follow the requirements of the designated electronic platform.</p>		

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11. **Operation of the AMD** (adopted from Section M, BPG on AMD, HKAM 2025)

11.1 An AMD will only come into effect or be activated when the AMD is both valid AND applicable. The validity of the AMD relates to the state and quality of the document itself, whereas the applicability relates to the clinical circumstances at the time of assessment.

11.2 For assessing the validity of the AMD:

11.2.1 A validating copy of an AMD has to be presented for notice to the treatment providers, which includes:

- (a) The original paper copy of the AMD, completed in a model or non-model form, or its electronically stored copy in the eHealth; or
- (b) A certified true copy of the AMD; or
- (c) If the original copy of AMD is not in Chinese or English, the certified translation of the AMD in Chinese or English; or
- (d) When the relevant functions of eHealth are in operation, the eAMD made and stored on the system.

11.2.2 The RMP then has to assess whether the AMD is properly completed and signed, fulfilling the legal requirements for the first and second witnesses including an RMP signing as the first witness.

11.2.3 The AMD has not been revoked.

11.2.4 There is no suspicion of foul play, e.g. falsified AMD.

11.2.5 The patient has not done anything clearly inconsistent with his/her AMD or which indicates that the patient no longer wants his/her AMD to be followed.

11.3 For the AMD to be applicable:


11.3.1 The patient is mentally incapable of making medical decisions (i.e. deciding on LST); AND

11.3.2 The patient's current circumstance meets the specified precondition under the AMD.

11.4 The AMD is not applicable if:

11.4.1 The RMP reasonably believes that the current circumstances are outside the reasonable expectations or could not have been reasonably anticipated by the patient when making the AMD; AND

11.4.2 The current circumstance would affect the patient's decision if he/she had anticipated such situation when making the AMD.

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11.5 When the treatment provider is being presented with copies of AMD with different dates of completion, or if there exists a discrepancy between the date of the stored version in eHealth from the presented hard copy (which could be due to time lag in updating the electronically stored version), unless the circumstances indicate otherwise, the RMP may assume that the last signed AMD version prevails.

11.6 In case of unresolved disputes or serious doubts, the RMP may seek advice from the local ethics committee, hospital management and/or legal advisers, who may decide whether to apply to the Court of First Instance for a declaration of validity and/or applicability of an AMD (refer to Section 13.3).

12. Dealing with non-HA and non-model AMD forms

12.1 The HA AMD forms follow the model form as provided by the Ordinance and HA doctors can only facilitate HA patients to make AMD by using HA AMD forms. No non-model AMD forms i.e. forms catering for other preconditions not in the model form, are allowed to be made in HA setting.

12.2 There is grandfathering of all HA AMD forms as completed before the enactment of the Ordinance (please refer to Section 3.1).

12.3 The non-HA forms received by treatment providers may be one of the following (in English/Chinese):


12.3.1 An AMD made by other local institutions or local RMPs in the model or non-model AMD format.

12.3.2 An AMD made overseas in English or Chinese or with certified translation into English or Chinese.

12.4 The AMD forms belong to 12.3.1 is an acceptable proof of AMD as long as it is clearly written (in particular the instructions about the specified preconditions for applying the AMD and the LST to be refused) in Chinese or English, signed and completed in accordance with all the legal requirements under the Ordinance, especially those regarding the first and second witnesses. The instructions laid down, including the specified preconditions for applying the AMD and the LST to be refused, should be presented in a clear way in the non-model AMD form. (please refer to Section 1.4).

12.5 For AMD forms belonging to 12.3.2, the HA treatment provider may have difficulty in ascertaining the validity of AMD under the Ordinance, for example, whether the legal requirement for the first witness being a RMP is fulfilled. If in doubt, the treatment provider may clarify with the accompanying persons or obtain more information from relevant sources where possible on case by case basis.

12.6 Even if an AMD has not been made in accordance with the Ordinance, it may on a case-by-case basis serve as an important indication of the patient's prior wish for the doctor to consider what is in the patient's best interests. In case of emergency and doubts about the validity or applicability of the AMD, the treatment providers may perform LST as clinically indicated to save life first.

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13. Dealing with doubts and conflicts resolution

(adopted from Section P, BPG on AMD, HKAM 2025)

13.1 Examples of doubts and conflicts

13.1.1 Suspicion of offences by another person:

- (a) Wilful obstruction to implementation of the AMD knowing that a valid and applicable AMD exists;
- (b) Intentionally or recklessly misleading the treatment provider into not complying with the AMD and/or DNACPR order. Examples may include reckless damaging or tampering with the paper AMD and/or DNACPR order; or an act to alter the status of the eAMD; and
- (c) Intentionally or recklessly misleading the treatment provider into complying with the AMD and/or DNACPR order or instrument that purports to be an AMD and/or DNACPR order. Examples may include falsification of the AMD (including eAMD and revocation record of AMD) and/or DNACPR order (including revocation record of DNACPR order).


13.1.2 Conflicts among family members or significant others on the validity and applicability of AMD or the treatment goal.

13.1.3 The AMD presented is said to be revoked orally by the patient shortly before the patient becomes mentally incapable (refer to Section 10.5).

13.2 While there is no single solution to all situations, the following guiding principles and advice on good practices shall guide the doctors in decision-making.

13.2.1 Guiding principles

- (a) Act with professionalism and be reasonable and honest in what you believe or do.
- (b) Respect the patient's autonomy and not impose your own personal values and preferences or interpretation of the patient's best interests.
- (c) A valid and applicable AMD made by a mentally capable person has to be respected and cannot be overruled by others including family members, significant others and appointed guardians.
- (d) In case of emergency and doubts, there should be a presumption to perform LST/CPR to save life or till proof of AMD and/or DNACPR order is available.
- (e) Act in the patient's best interests if the patient's prior wish is in doubt or not available.
- (f) A doctor is not obliged to provide futile or non-beneficial LST that is not in the patient's best interests.

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13.2.2 Good practices

- (a) Good documentation of the process and the rationale behind the decision-making.
- (b) Be familiar with what could be acceptable proofs of AMD and DNACPR order (such as what constitutes a validating copy of AMD and/or DNACPR).
- (c) Engage the family members of the patient for consensus building and conflict resolution before signing the DNACPR order for mentally incapable adults and minors. This consensus building process is highly desirable even when the patient is mentally capable of making an AMD. The doctor may identify the main caregiver, who can provide more information to clarify doubts if needed when the patient is mentally incapable.
- (d) Recognise that emotions are natural. Acknowledgement of feelings with empathy instead of confrontation helps to reduce tension and facilitate conflict resolution. Consider referral to other professionals for emotional and grief support while explaining that a valid and applicable AMD is legally binding and has to be respected.
- (e) If offences are suspected, report to the hospital management for further action.


13.3 In case of unresolved doubts or concerns about the validity or the applicability of the AMD, the treatment providers may:

13.3.1 Seek advice from local ethics committee, hospital management and/or legal advisers.

13.3.2 Apply to the Court of First Instance


- (a) The Court may, on application, declare whether (a) an instrument purporting to be an AMD is an AMD, or (b) whether an AMD is valid or applicable or both.
- (b) In case of dispute or uncertainty, the attending doctor, or other treatment providers, may apply to the Court for declaration without leave.
- (c) Similarly, immediate family members of the patient, the patient's cohabitee or a relevant person having sufficiently close connection with the patient (as determined by the practitioner-in-charge) may also apply to the Court without leave.

13.3.3 While determination by the Court is pending and the patient is in an urgent critical state, treatment providers are advised to provide the LST based on the best interests of the patient.

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14. Protection for treatment providers (*adopted from Section Q, BPG on AMD, HKAM 2025*)

- 14.1 Treatment providers refer to RMPs including those under limited or special registration, housemen under provisional registration, listed and registered traditional Chinese medicine practitioners, registered dentists and nurses (enrolled and registered) who provide care to the person whether or not during the course of his/her work. The protection for liability extends to both public officers and those working in private practice and includes civil liability, criminal liability and liability for professional misconduct.
- 14.2 A doctor is not liable for NOT performing CPR in a person-in-arrest if the doctor:
- 14.2.1 Has notice of a DNACPR order;
 - 14.2.2 Honestly and reasonably believes that the DNACPR order is valid and applicable; and
 - 14.2.3 Has no suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.
- 14.3 A doctor is not liable for performing CPR on a person-in-arrest if the doctor:
- 14.3.1 Has no notice or knowledge of a DNACPR order;
 - 14.3.2 Is not satisfied that there is a valid and applicable DNACPR; or
 - 14.3.3 Has suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.
- 14.4 For a patient with AMD-based DNACPR order or AMD refusing other LST, a doctor who withholds or withdraws the specified LST is not liable if he/she:
- 14.4.1 Has notice of the AMD; and
 - 14.4.2 Honestly and reasonably believes that the AMD is valid and applicable (please refer to Section 11).
- 14.5 For a patient with an AMD-based DNACPR order and an AMD for refusal of other LST, a doctor who initiates or continues LST based on the patient's best interests is not liable if he/she:
- 14.5.1 Has no notice of the AMD and/or the AMD-based DNACPR order; or
 - 14.5.2 The AMD and AMD-based DNACPR order are deliberately concealed.
- 14.6 On the contrary, if a doctor, while knowing the presence of a valid and applicable AMD, continues to give the LST refused by the patient under the AMD, he/she can be liable for assault and battery.
- 14.7 In an emergency or critical situation, and there is reasonable doubt about the existence, validity or applicability of an AMD, appropriate LST should be initiated according to clinical indications as a safeguard to preserve life. If a valid and applicable AMD is later made available, discontinuation of the relevant LST should be considered.

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- 14.8 The above protection does not extend to other liabilities, such as any negligence committed during the course of the LST.
- 14.9 The doctor should document the process and the rationale behind his/her decision-making.

15. **Consequential amendments and other related legislation**

(adopted from Section R, BPG on AMD, HKAM 2025)

To facilitate dying in place and goal concordant end-of-life care, the following related ordinances have been amended consequential to the enactment of the Ordinance or separately.

- 15.1 When the consequential amendment provisions relating to the Mental Health Ordinance (MHO) (Cap. 136) come into operation, an AMD made by an adult patient (when he/she is still mentally capable of deciding on LST) shall prevail over any subsequent judgement of doctors or dentists in providing LST in urgent or non-urgent situations based on the patient's best interests. The definition of "mentally incapacitated person" as defined by the MHO has not changed, i.e. referring to persons with mental disorders or mental handicap who are unable to manage or administer their properties and affairs. A person with psychiatric disorder does not mean that he/she will never have mental capability to make an AMD, as long as the person is assessed to be mentally capable of deciding on LST at the time of making the AMD.
- 15.2 When the consequential amendment provisions relating to the Fire Service Ordinance (Cap. 95) take effect, it is no longer a duty for emergency personnel to resuscitate or sustain a person's life if there is a valid and applicable DNACPR. The emergency personnel shall be able to recognise a properly completed and signed prescribed DNACPR order that is within its effective period. The patient and his/her caregivers should be educated that electronic storage of DNACPR orders is not available and putting a hard copy of the DNACPR order (which must be the original paper order or a validating copy) in a designated folder or in a conspicuous spot will allow the rescuers to easily notice of the DNACPR order so as to follow the instructions therein. Under the Ordinance, rescuers are not required to search the subject person or his/her items to ascertain whether he/she carries a validating copy of DNACPR order unless given permission to do so e.g. as written on the pouch for AMD /DNACPR provided by the HA.
- 15.3 The Births and Deaths Registration Ordinance (Cap. 174) and the Coroners Ordinance (Cap. 504) have been amended to the effect that the death of a resident in the Residential Care Home for the Elderly (RCHE) or Persons with Disabilities (RCHPWD) is exempted from reporting to the Coroner if all of the followings are fulfilled: (i) the patient was diagnosed as having a terminal illness; (ii) the patient was attended to by an RMP during his/her last illness within 14 days prior to his/her death; and (iii) the cause of death stated in the certificate of the cause of death of the deceased is a natural cause.

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The term “terminal illness” is not defined under the Coroner’s Ordinance and whether or not a patient has “terminal illness” is a matter of clinical judgement of the RMP; it is not limited to advanced cancer and may cover other medical conditions that have deteriorated to the extent that death is anticipated. The amendments have come into operation on 3 June 2024.

For patients under guardianship orders, their deaths remain reportable to the Coroner despite fulfilment of the 3 conditions mentioned above.

16. Other special situations (adopted from Section S, BPG on AMD, HKAM 2025)

16.1 A healthy adult requesting to make an AMD

16.1.1 A healthy and mentally competent adult is not precluded from making an AMD. In some places, ACP is widely promoted and early conversations even with healthy people are encouraged.

16.1.2 However, making an AMD by a healthy individual may pose challenges.


- (a) It may be difficult for the healthy adult to anticipate his/her future preferences, especially in the absence of illness and other life experiences.
- (b) The doctor may also find it difficult to cover the wide scope of information on potential future health states when the AMD can become applicable.
- (c) With the potentially long interval between making the AMD and the time for its operation, the RMP should advise the patient to review his/her preferences regularly, otherwise, doctors may cast doubt on the stability of the directive.
- (d) An AMD-based DNACPR order can only be signed after the maker is assessed to have fulfilled the specified precondition in the future.

16.1.3 Some healthy adults may have special considerations. For example, those who are involved in risky activities may wish to refuse ANH or other LST in case of sudden catastrophic accidents. Unlike other preconditions such as cancer or other chronic progressive diseases, the maker may become mentally incapable of making decisions within a short time. An AMD for refusal of LST in PVS or irreversible coma may be appropriately considered.

16.2 Patient’s wish to donate tissues, organs, or body

16.2.1 Some patients may express their intention to donate their body tissue, organs or even whole body.

16.2.2 It is a good practice for the RMP to discuss with the patient further to align expectations. Though there is no strict age limit on cadaveric donation, organ donation is possible for patients as old as 75, and for tissue donation, the age limit for cornea, long bones and skin are below 80, between 16 and 60 and 10 or above respectively [8]. The underlying diseases of the patient, for example disseminated cancer, may also pose limitations.

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16.2.3 Where an agreement for the donation of organs such as the kidneys, heart or liver has been secured, investigations and organ support are required to enable brain death certification and subsequent to certification, to maintain organ viability. These actions to secure certification and successful organ donation should not be confused with the use of life support treatment for therapeutic purposes, as the use of therapeutic life support treatment may be against the instructions made in the AMD. An honest discussion with the patient and the family members will help to clarify these issues and avoid conflicts when the patient is dying.

16.2.4 The patient's wish and the decision about tissue/organs/body donation have to be documented separately from the AMD. Consensus should preferably be reached with the family members.

16.3 Patients under Guardianship orders

16.3.1 For a patient under a guardianship order, the guardian may sign the prescribed non-AMD-based DNACPR order as a responsible person to indicate his/her consensus with the RMP that CPR is not in patient's best interests.

16.3.2 However, for patients under a guardianship order, all deaths are reportable to the Coroner, including deaths in residential homes for the elderly or persons with disabilities that fulfil all the conditions for exemption of reporting (refer to Section 15.3).

17. **Summary of ethical considerations** (adopted from Section T, BPG on AMD, HKAM 2025)


17.1 All mentally capable adults can refuse medical treatment (e.g. LST in the context of the Ordinance) as long as he/she is being adequately informed and understands the effect of refusal. This is in respect for the patient's autonomy when his/her decision is made voluntarily.

17.2 All valid and applicable AMDs have to be respected and cannot be overruled by others including doctors, family members and guardians, even though in some cases, the instructions in the AMD may seem to be unwise.


17.3 Although AMD making is based on the ethical principle of respecting the patient's autonomy, it is a good practice to engage the family members in consideration of local cultural values and practices, e.g. family-based decision-making, filial piety.

17.4 For mentally incapable adults and minors who are unable to make an AMD, the doctor has to decide on the treatment based on the patient's best interests. A proxy for substituted judgement has no legal status in Hong Kong, but consensus building with family members is highly recommended.

17.5 Withholding or withdrawing LST in accordance with a valid and applicable AMD is not practising euthanasia.


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- 17.6 A patient with an AMD refusing LST should not be presumed to have also refused other medical treatment not specified in the instructions, and as such being deprived of discussions and considerations when mentally capable. It is also important that basic care and palliation for sufferings should not be neglected especially when the patient becomes mentally incapable.
- 17.7 A doctor is not obliged to perform futile or non-beneficial treatment.

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References

1. Code of Professional Conduct, The Medical Council of Hong Kong, last revised in October 2022.
2. Best Practice Guidelines on Advance Medical Directives, Hong Kong Academy of Medicine released on 11 April 2025. <https://www.hkam.org.hk/en/news/best-practice-guidelines-advance-medical-directives>.
3. Treatment and care towards the end of life: good practice in decision making. GMC May 2010.
4. Kopar PK, Visani A, Squirrell K, Brown DE. Addressing futility: a practical approach. Crit Care Explor 2022;4:e0706.
5. National Cancer Institute, Publications , NCI Dictionaries , NCI Dictionary of Cancer Terms. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/artificial-nutrition-and-hydration>.
6. Kitinger and C Kitinger. Palliat Med. 2018 Jul;32(7): 1180-1188.
7. An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants) [2018] UKSC 46).
8. Hong Kong Organ Transplant Foundation, Understanding OD, Basic OD Knowledge. <https://hkotf.org/en/odknowledge/>

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(October 2023)

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Member List of Sub-Working Group for review of AMD guidelines

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