HONG KONG ACADEMY OF MEDICINE
香港醫學專科學院

BEST PRACTICE GUIDELINES ON ADVANCE MEDICAL DIRECTIVES

Hong Kong Academy of Medicine
Professionalism and Ethics Committee
Task Force on Advance Medical Directives

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Foreword

The Hong Kong Academy of Medicine (the Academy) is committed to upholding the highest standards of medical professionalism and ethical integrity. In a time where societal expectations on autonomy and dignity in healthcare continue to evolve, the enactment of the Advance Decision on Life-Sustaining Treatment Ordinance represents a milestone for the society. It affirms not only the legal rights of individuals to make decisions about their own medical care but also the responsibility of healthcare professionals to respect and support those choices.

The set of *Best Practice Guidelines on Advance Medical Directives* serves as a vital instrument in bridging law, ethics, and clinical practice. Developed under the auspices of the Academy's Professionalism and Ethics Committee, this document reflects our collective aspiration to foster compassionate, patient-centred care at the most critical junctures of life. It offers clarity and direction to our Fellows, medical and healthcare practitioners in applying the Ordinance with due diligence, sensitivity, and professional judgement.

The set of guidelines is more than a clinical resource—it is a reaffirmation of the values that define our profession: respect, trust, and the unwavering dedication to do what is right for our patients. The Academy remains steadfast in its role to embrace these principles. We also encourage feedback from our practitioners on the contents of the guidelines, which are expected to be regularly updated and refined in future.

I would like to congratulate and thank to Dr. Doris Tse and everyone who have contributed to this important work. We look forward to continued dialogue and collaboration in nurturing an ethical and resilient healthcare system for Hong Kong.

Professor Philip Kam-tao Li
President
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Preface

To further promote medical professionalism and ethical practice among Fellows and specialist trainees, the Hong Kong Academy of Medicine established the Professionalism and Ethics Committee (PEC) in March 2019. The PEC has since set up six task forces to cover specific areas, developed relevant best practice guidelines and organised educational activities, where appropriate, from the perspectives of professionalism and ethical clinical practice for medical and dental practitioners. The Task Force on Advance Medical Directives is one of the six.

Healthcare practitioners have an ethical duty and play a crucial role in respecting and upholding patients' rights to self-determination as well as taking active steps to help patients implement their wishes as smoothly as possible. In this regard, Advance Medical Directives (AMDs) are essential tools designed to ensure patients' end-of-life healthcare choices would be honoured at a time when they can no longer communicate their decisions. The introduction of the Advance Decision on Life-Sustaining Treatment Ordinance (the Ordinance) by the Government of the Hong Kong Special Administrative Region in November 2024 marks a significant milestone for Hong Kong. This legislation provides a clear legal framework for AMDs and Do-Not-Attempt Cardiopulmonary Resuscitation orders, thereby enhancing patient autonomy and providing legal protection for both patients and healthcare providers. The Ordinance underscores the importance of patient-centred care and empowers terminally ill patients with greater control over their own decisions at the end of their lives.

In this context, the Task Force on Advance Medical Directives under the PEC has compiled this set of guidelines to equip healthcare practitioners with the necessary knowledge to navigate the complex process of AMDs in the legal, ethical, and practical dimensions. By adopting these best practices, healthcare practitioners can enhance the quality of care of the terminally ill patients and reduce potential conflicts with their relatives.

We wish to congratulate and thank Dr. Doris Tse and members of the Task Force for their time and efforts in compiling this set of practical guidelines and hope that it will serve as a valuable resource in fostering a deeper understanding and more effective implementation of AMDs. The present document will be subject to regular review and update whenever necessary.

Special thanks to Mr. Albert Lam for his invaluable assistance in reviewing this document.

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Abbreviations

ACP	Advance care planning
AMD	Advance Medical Directive
ANH	Artificial nutrition and hydration
CPR	Cardiopulmonary resuscitation
DNACPR	Do-not-attempt cardiopulmonary resuscitation
LST	Life-sustaining treatment
MHO	Mental Health Ordinance
PVS	Persistent vegetative state
RMP	Registered medical practitioner

A. Introduction

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 AMD, 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 and physician assisted suicide are unethical and illegal in Hong Kong[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, or provision of substances, or of other assistance in ending 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 Ordinance.

3. Under common law, a valid and applicable AMD is legally binding in Hong Kong. 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 **Ordinance**) was passed by the Legislative Council on 20 November 2024 and gazetted on 29 November 2024 and is expected to come into effect after 18 months. The Ordinance makes statutory provisions for the making of AMD to refuse LST and its operation, and the operation of do-not-attempt cardiopulmonary resuscitation (**DNACPR**) orders on a continuing basis. The Ordinance has excluded episodic DNACPR orders which are automatically invalidated upon patient's discharge from hospital. In this Guidelines, the term "DNACPR order" refers to continuing DNACPR order unless otherwise specified. The principle of "cautious making, easy revoking" is adopted for patient advance decision documents so that patients are adequately protected in the making process, yet with easy voluntary revocation after making.

4. The Ordinance prescribes the following forms for 3 categories of preconditions:

   4.1 The 2 types of model AMD forms:
   - a. A full form for refusal of cardiopulmonary resuscitation (**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 (when the designated electronic system is in operation).

   4.2 The 3 types of statutory DNACPR order forms:
   - a. AMD-based DNACPR order for adult patients with an underlying AMD;
   - b. Non-AMD-based DNACPR order for mentally incapable adult patients;
   - c. Non-AMD-based DNACPR order for minor patients.

   For all 3 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] Code of Professional Conduct, The Medical Council of Hong Kong, last revised in October 2022.

B. Purpose of the Best Practice Guidelines

1. Based on the Ordinance, the Best Practice Guidelines on Advance Medical Directive (hereafter referred to as **Guidelines**) are issued by the Professionalism and Ethics Committee, Hong Kong Academy of Medicine, to provide a concise guidance for all doctors in conducting advance care planning, making of advance medical directive (**AMD**) and do-not-attempt cardiopulmonary resuscitation (DNACPR) orders, dealing with doubts and conflicts and on the protection for treatment providers. All doctors should be familiar with this Best Practice Guidelines.

2. The Guidelines refer to the paper version of AMD and DNACPR orders. A designated electronic platform, the Electronic Health Record Sharing System (hereafter referred to as eHealth), will be configured for electronically made AMD (eAMD) in future. Meanwhile, eHealth will be deployed as the platform for storage of electronic copies of AMD made in paper form. The principles and requirements for eAMD will mirror those established for paper version AMDs. There will be no electronic making and / or storage of DNACPR orders.

3. The Guidelines are not intended to replace any institutional policies or guidelines established by organisations for their internal operations and standards.

4. Case scenarios are included for illustration and to facilitate understanding, and should not be taken as prescribed answers, or a substitute for appropriate professional judgement.

5. The related Parts, Divisions and Sections of the Ordinance are put in parentheses against the Guidelines where applicable for easy reference.

C. Mental capacity for decision making on life-sustaining treatment

(The Ordinance Part 1 Section 3)

1. Under common law, all adults are presumed to have mental capacity, unless proven otherwise, to make decisions regarding their medical treatment.

2. Mental capacity is time and task-specific.

3. Under the Ordinance, an adult is mentally capable of deciding on life-sustaining treatment (LST) if he / she is able to do the following at the time of making the advance medical directive (AMD):

   3.1 Understand the information relevant to the AMD in one's own situation; and

   3.2 Retain that information; and

   3.3 Use or weigh the information in decision-making for refusing LST; and

   3.4 Communicate his / her decision to refuse LST by any method.

4. Reasonable efforts should be made to remove communication barriers before concluding on the mental 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.

5. For purposes of determining mental capacity, adults who are able to retain the relevant information only for a short period are still considered capable of retaining the information.

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.

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 the making of 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.

D. Life-sustaining treatment

1. Life-sustaining treatment (LST) refers to any medical treatment that has the potential to postpone death. The list may include, but not exhaustive, of the following:
   - cardiopulmonary resuscitation;
   - artificial ventilation;
   - transfusion of blood products;
   - cardiac pacing;
   - vasopressors;
   - specialised disease specific treatment such as chemotherapy, dialysis;
   - antibiotics for life-threatening infection;
   - artificial nutrition and hydration.

   Withholding or withdrawing LST allows natural death to occur eventually without the burden of futile or non-beneficial treatment or in accordance with the patient's wish[2]. 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[3].

2. 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 advance medical directive, patient's preferences could be discussed and documented in the advance care planning (refer to Section E).

[2] Treatment and care towards the end of life: good practice in decision making. GMC May 2010. Accessed 20 February 2025. https://www.gmc-uk.org/professional-standards/the-professional-standards/treatment-and-care-towards-the-end-of-life/guidance#:~:text=You%20must%20give%20patients%20who,situations%20and%20decisions%20about%20care.

[3] Kopar PK, Visani A, Squirrell K, Brown DE. Addressing futility: a practical approach. Crit Care Explor 2022;4:e0706.

E. Advance care planning

1. Advance care planning (**ACP**) before making advance medical directive (AMD)

   ACP is the communication process whereby a mentally capable adult, the healthcare professionals and his / her family members or significant others discuss preferences for future medical and personal care when the patient no longer has decision-making capacity in order to facilitate goal concordant care and reduce conflicts in medical decision-making at the end-of-life. In the local context, ACP also includes discussions with family members of mentally incapable adults and parents or guardians of minors, and minors may join the discussion depending on their maturity. It is recommended that ACP shall precede making of AMD or do-not-attempt cardiopulmonary resuscitation (DNACPR) order.

2. ACP: Who? When? How?

   2.1 Good communication skill is a key factor in fruitful ACP. ACP is a continuous process and may involve more than one meeting among the stakeholders. Apart from doctors, other healthcare professionals may also contribute as ACP facilitators.

   2.2 The ACP process may be triggered by healthcare professionals, the patient or his / her family members. As for the timing of ACP, it is desirable to involve patients when they are still mentally capable.

   The triggering time points may include the following:

   - evidence of disease progression such as worsening of symptoms;
   - significant functional decline;
   - when the patient needs institutionalisation;
   - repeated episodes of hospital admissions or exacerbations of the chronic disease;
   - discontinuation of active disease treatment;
   - transition to palliative care;
   - or any time as preferred by the patient or his / her family.

   2.3 It is good practice to invite the patient's family members and / or significant others to join the discussion for facilitating their understanding of the patient's values and preferences, fostering consensus building, promoting shared decision-making and preventing unnecessary conflicts at end-of-life. The family also plays an important role in supporting the patient's preferred personal care with family-based decision-making being common in local culture. The family members should understand that they cannot override the AMD of the patient. If family members continue to object to the AMD, healthcare professionals should continue to persuade them to accept and respect the patient's decision and explain that ultimately the AMD is legally binding.

   2.4 If the family members are not present for various reasons, the doctor should strongly advise the patient to discuss with, or at least inform, his / her family members of the outcome of ACP.

   2.5 Do's and Don'ts in ACP

   a. Do's

   - Allow time for ACP and ensure privacy.
   - Be prepared to give information on the diagnosis, treatment options and their risks and benefits, and prognosis.
   - Facilitate the patient to express his / her views, values and preferences so as to empower his / her autonomy.
   - Be sensitive to emotions being aroused and handle with empathy.
   - Handle conflicts among family members with sensitivity.
   - Be sensitive to potential conflicts among the family members and / or significant others who are not present.
   - Identify a key family member for representing the patient / family in subsequent discussions when patient becomes mentally incapable.
   - Review patient's preferences on a regular basis.

b. Don'ts
   - Conduct ACP as a tick box exercise or a rigid process.
   - Force the patient to continue ACP even if he / she is not ready.
   - Put pressure on the patient to make decision.
   - Treat the ACP as a one-off event and close the door to future discussions.

2.6 Documentation of ACP
   - Documentation of ACP in patient's record is important for continuity of care.
   - It is a good practice to include the following in the documentation:
     - the participants;
     - anticipated disease trajectory and prognosis;
     - patient's values and preferences;
     - agreed treatment goals on personal and medical care;
     - decisions on life-sustaining treatment, including any making of AMD and DNACPR order if applicable;
     - the family member identified for future consultation.

F. Role of doctor in making of advance medical directive (AMD)

(The Ordinance Part 2 Sections 8-12)

1. The advance medical directive (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.

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.

3. The signing RMP must be satisfied that the patient is an adult mentally capable of deciding on life-sustaining treatment (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.

4. The signing RMP has to provide sufficient and relevant information for the patient to make an informed decision in making an 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 effect 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).

   4.1 The nature and effect of making an AMD:
   - An AMD is a legally binding document made by a patient voluntarily while mentally capable for advance refusal of LST.
   - Withholding of LST allows natural death to occur due to the underlying precondition.
   - An AMD will only come into effect when patient is mentally incapable and the AMD is assessed to be valid and applicable.
   - 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.

   4.2 The preconditions for applying the AMD (*The Ordinance Part 1 Sections 4-6*)

   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.

   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.

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 D 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 good practice to 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 cardiopulmonary resuscitation (CPR);
   - refusal of other LST (to be specified);
   - refusal of all LSTs except for artificial nutrition and hydration (**ANH**);
   - refusal of all LSTs.

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

d. Caution should be exercised when the patient expresses a wish for blanket refusal of all LSTs. 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.

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[4]. 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 the underlying disease. Some patients may prefer to consider artificial nutrition and artificial hydration separately (e.g. refusing Ryle's tube feeding but not subcutaneous hydration as there may be different considerations in risks 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 being purposeful or meaningful.

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

[4] National Cancer Institute. Definition of artificial nutrition and hydration. Accessed 29 November 2024. Available from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/artificial-nutrition-and-hydration

understanding the disease trajectory and what to anticipate at end-stage dementia. In withholding or withdrawing ANH in patients in PVS, irreversible coma or with 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[5].

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.

e. The UK Supreme Court 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 patients' best interests[6].

5. Signing the AMD and the role of witnesses

5.1 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.

5.2 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:

- He / she is an RMP;
- He / she is not an interested person to his / her best knowledge;
- He / she has explained to the maker the nature of the AMD and the effect of following the AMD on the maker;
- He / she is satisfied that the maker is mentally capable of deciding on LST at the time of making the AMD; and
- He / she signed the AMD in the presence of the maker and the second witness.

5.3 The second witness need not be a doctor, but must fulfil the following:

- He / she is an adult (i.e. attained 18 years of age);
- He / she is not an interested person to his / her best knowledge;
- 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.

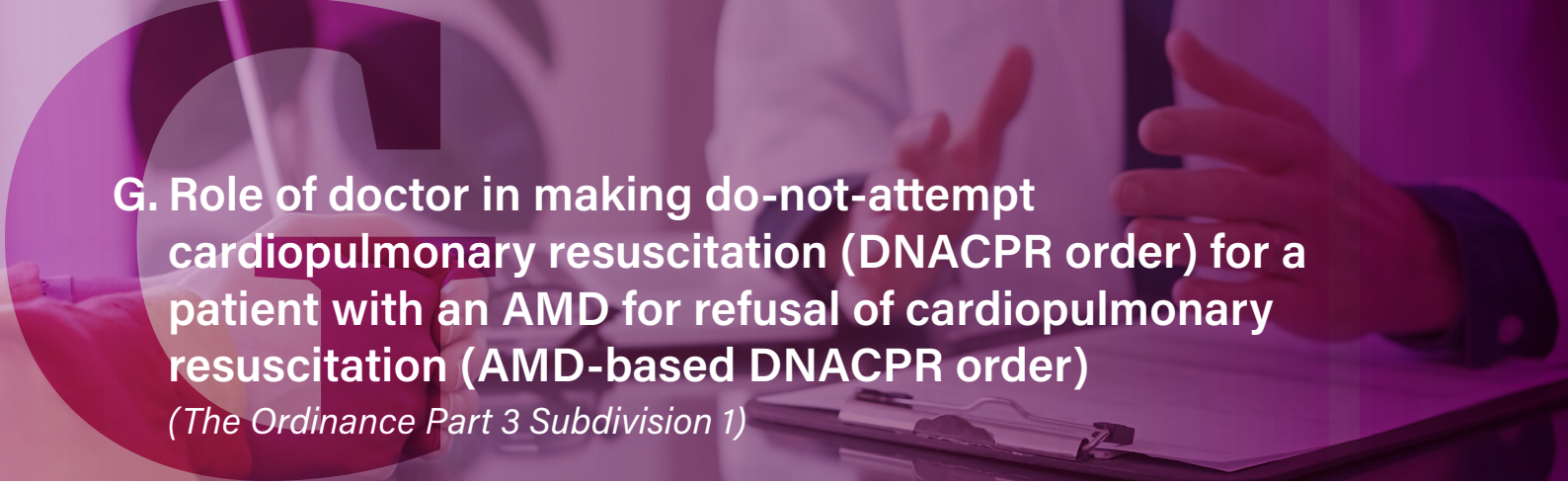
5.4 For patients who are unable to sign their names, he / she may make a mark or imprint his / her fingerprint on the AMD. The patient's chop or stamp is not accepted.

5.5 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.

5.6 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.

[5] Kitzinger J, Kitzinger C. Deaths after feeding-tube withdrawal from patients in vegetative and minimally conscious states: A qualitative study of family experience. Palliat Med 2018;32:1180-8.

[6] *An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants)* [2018] UKSC 46



G. Role of doctor in making do-not-attempt cardiopulmonary resuscitation (DNACPR order) for a patient with an AMD for refusal of cardiopulmonary resuscitation (AMD-based DNACPR order)

(The Ordinance Part 3 Subdivision 1)

1. The prescribed advance medical directive (AMD)–based do-not-attempt cardiopulmonary resuscitation (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 Ordinance Schedule 3*).

2. The DNACPR order must be signed by 2 registered medical practitioners (RMPs), one of whom must be a specialist. By signing, both RMPs confirm that:
   a. 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;
   b. both RMPs are non-interested persons; and
   c. 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.

3. 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.

4. 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.

5. There will be circumstances where 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.:
   a. The potentially incurable disease is still at an earlier stage, e.g. cancer or organ failure.
   b, The patient has not reached the stage of severe dementia which is stated as the specified precondition when signing the AMD.
   c. The patient specified persistent vegetative state 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 Section M and Figure).

H. Custody of AMD and DNACPR orders

1. After making the advance medical directive (AMD), it is the primary responsibility of the patient or his / her responsible persons to keep custody of the paper AMD and AMD-based do-not-attempt cardiopulmonary resuscitation (DNACPR) order (if completed).

2. Apart from the original paper copy of AMD and AMD-based DNACPR order, the patient may choose to make other validating copies as shown in Table 1.

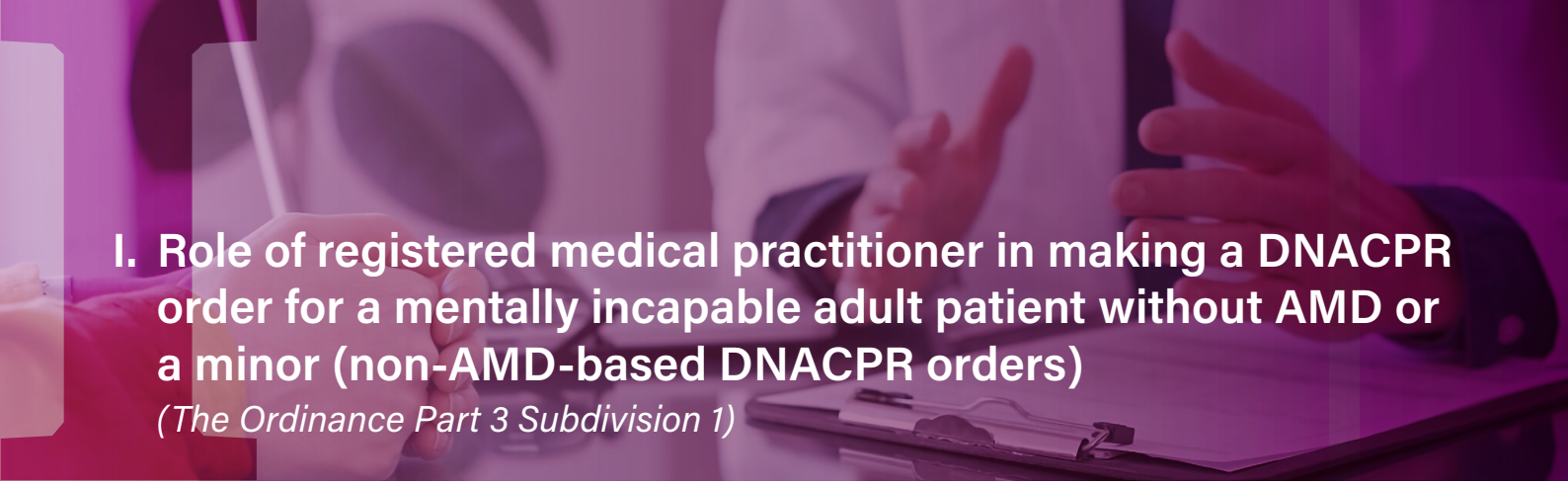
Table 1. Validating copies of advance medical directive (AMD) and AMD-based do-not-attempt cardiopulmonary resuscitation (DNACPR) order

For paper AMD, it is recommended that a digital copy is stored in the electronic platform as it can serve as the proof when the paper AMD is not available. Moreover, storage of the digital copy will trigger alert signal in the electronic platform and in the Hospital Authority Clinical Management System.

There is no limit on the number of certified true copies. Patients and their families should be educated to take note of the number and their presence to avoid confusion in future.

What are validating copies?	Remarks
Original paper copy and certified true copies of AMD	• Kept by patient or entrusted person and present as needed. • Certification can be done by: a. a registered medical practitioner (RMP); or b. a solicitor within the meaning of the Legal Practitioners Ordinance (Cap. 159) and who holds a current practising certificate in Hong Kong.
Original paper copy and certified true copies of DNACPR order	• Kept by patient or an entrusted person and present as needed. • No electronic storage or making will be implemented for DNACPR orders. The ambulance crew will only recognise the paper DNACPR order made in the prescribed forms prescribed in the Ordinance. • Certification can be done by: a. an RMP; or b. a solicitor of the Legal Practitioners Ordinance (Cap. 159) and holds a current practising certificate in Hong Kong. • If the DNACPR order has been renewed by signing and appending continuation sheets to the parent DNACPR order, the certified true copies should also be updated accordingly.
Electronically stored AMD (model / non-model forms)	• A clearly legible copy of the AMD as stored in the designated electronic system (eHealth) in the form of an electronic image (e.g. PDF, JPEG), • This should be uploaded by the RMP with access to eHealth, not the maker. • The electronically stored copy can serve as a proof if the patient is unable to present the paper AMD, provided that the attending treatment provider is informed of the existence of such electronically stored AMD.
Electronically made AMD (eAMD)*	• Electronic version of AMD in eHealth made with the provided model form
Certified true copies of eAMD*	• The eAMD may be downloaded for certification. • The clearly legible printout of the eAMD can be certified by: a. an RMP; or b. a solicitor within the meaning of the Legal Practitioners Ordinance (Cap. 159) who holds a current practising certificate in Hong Kong.

* Electronic version of AMD (i.e. electronically stored / made) is only available when the designated system is in operation. The patient is at liberty to choose whether to make a paper or electronic AMD. For both versions, the patient is still allowed to keep validating copies in paper.



I. Role of registered medical practitioner in making a DNACPR order for a mentally incapable adult patient without AMD or a minor (non-AMD-based DNACPR orders)

(The Ordinance Part 3 Subdivision 1)

1. The prescribed non–advance medical directive-based do-not-attempt cardiopulmonary resuscitation (non-AMD-based DNACPR) order forms for mentally incapable adults and minors must be used respectively (*The Ordinance Schedule 2*).

2. The non-AMD-based DNACPR order must be signed by 2 registered medical practitioners (RMPs), one of whom must be a specialist. By signing, both RMPs confirm that:
   a. the patient is (i) terminally ill, in a persistent vegetative state or state of irreversible coma, and / or in any other end-stage, irreversible, life-limiting condition (within the meaning of the Ordinance), and (ii) mentally incapable;
   b. they are not aware that the adult patient has an AMD containing an instruction to refuse cardiopulmonary resuscitation (CPR);
   c. CPR is not in the patient's best interests in case of cardiac arrest;
   d. at least one of the 2 signing RMPs has explained to the responsible or eligible person (as the case may be) that performing CPR on the patient when he / she is in cardiac arrest would not be in his / her best interests;
   e. both RMPs are non-interested persons; and
   f. both RMPs agree on the effective period of the order, which should not exceed 1 year.

   Unlike the AMD-based DNACPR order, the non-AMD-based DNACPR order requires the additional signature of a responsible person who may be an immediate family member / cohabitee / guardian, or if no such responsible person can be found, any other eligible person determined by one of the two signing RMPs to be in a good position to form a view as to whether performing CPR on the patient would be in his / her best interests.

3. The DNACPR order decision should be based on the patient's best interests (*The Ordinance Part 3 Division 2 Section 32*)

   3.1 It is the role of the RMP to make medical decisions based on his / her assessment of the patient's best interests[7].

   3.2 a. There is no universal definition of the patient's best interests. The RMP should aim to arrive at what the "reasonable" patient's preferences would be if no prior wish is known by consideration beyond the medical best interests of the patient.
   b. It involves an evaluation of a basket of factors relevant to the patient:
      - clinical needs, which include the balance of risks and benefits of various treatment options and prognosis;
      - social and functional needs;
      - cultural and religious belief, wishes, life values and perceived quality of life;
      - previous preferences for medical treatment; and
      - any other factors the patient would consider if he / she were able to do so as the above list is not exhaustive.
   c. Source of information may include past medical records, family members and significant others or friends.

   3.3 The RMPs should reach a consensus with the patient's family members before completing and signing a DNACPR order. For minors, although they cannot make an AMD, some of them may be mentally mature enough to understand and participate in the discussion and their views should be taken into consideration by the RMP.

4. Role of responsible or eligible person

   4.1 Who is a responsible person for the purpose of co-signing a non-AMD-based DNACPR order?
   a. The responsible person must be an adult.
   b. For mentally incapable adult patients:
      - An immediate family member of the patient, including: (*The Ordinance Part 1 Section 2*):

[7] Mental Capacity Act Code of Practice 2007

- spouse;
- parent (whether natural parent, adoptive parent or step-parent);
- grandparent (whether natural, adoptive or step-grandparent);
- sibling (whether sibling of full or half blood, by virtue of adoption or step-sibling);
- child (whether natural child, adoptive child or step-child); or
- grandchild (whether natural, adoptive or step-grandchild).

- A cohabitee
- A guardian of the patient within the meaning of Part IIIA or Part IVB of the Mental Health Ordinance (Cap. 136); but does not include the Director of Social Welfare or any Assistant Director of Social Welfare.

c. For minor patients:
- A parent (whether natural parent, adoptive parent or step-parent); or
- A guardian of the patient under the Guardianship of Minors Ordinance (Cap. 13); but does not include the Director of Social Welfare or any Assistant Director of Social Welfare.

d. When it is impracticable to locate responsible persons under (b) and (c), the RMP may identify someone as an eligible person. A person is an eligible person if he / she is reasonably determined by the RMP as being in a good position to form a view as to whether performing CPR on the patient during cardiac arrest would be in his / her best interests. The factors to be considered by the RMP include the relationship between the person and the patient, their frequency of contact, the level of perceived closeness between them, the degree of perceived importance of the person to the patient, and he / she is willing to sign.

The RMP should also take into consideration the patient's views as to who may be an eligible person, including the prior view of an adult patient before he / she becomes mentally incapable, and the view of a minor with considerable mental maturity. The mental maturity in this context refers to the emotional and cognitive maturity of the minor in managing his / her own emotions, in making decisions logically instead of impulsively and in taking responsibility for his / her own words and actions (*The Ordinance Part 3 Division 1 Section 32*).

4.2 A responsible person should not be given the burden to assess what is in the patient's best interests, but they can provide valuable information on the patient's prior wish on medical treatment, patient's preferences on treatment limits, and patient's values.

4.3 The responsible persons should be reminded that they should refer to the patient's preferences and values and not their own.

4.4 The signature of the responsible person confirms that he / she has been advised by the RMP that performing CPR on the patient is not in the patient's best interests, and that he / she agrees with the assessment.

4.5 The responsible persons are responsible for custody of the validating copy (original or certified true copy) of the DNACPR order and for presenting to rescuers and treatment providers as proof.

4.6 When the responsible person has doubts about the DNACPR order decision in future, he / she should contact an RMP for discussion and reassessment of patient's best interests.

5. A non-AMD-based DNACPR order should be reviewed in the same manner as stipulated in Section G-4. The last expiry date of a non-AMD-based DNACPR order for minors should not fall beyond their 18th birthday, as DNACPR orders for minors are automatically revoked upon the minor attaining majority. Transition to adult care should be anticipated and prepared in advance to ensure continuity of the DNACPR order.

6. Doctors should not complete a non-AMD-based DNACPR order before having attempted to resolve any conflicts between the family members. Doctors should also note that the guardian of a mentally incapable adult or minor patient may not necessarily be the family member of the patient and in some cases, there may be difference in views. However, family members or guardians should be clearly informed that a doctor is not obliged to provide treatment that is futile or non-beneficial.

7. For mentally incapable adult patients, there may be situations where finding a responsible or eligible person to co-sign the non-AMD-based DNACPR order is impracticable or not successful despite reasonable efforts. In that case, the 2 RMPs, one of whom must be a specialist, may still sign the non-AMD based DNACPR order in the absence of such co-signer. This option is not available if the patient is a minor.

Reasonable efforts may include the following: checking the guardianship status with the Guardianship Board, reviewing past medical records and verifying contact with the medical social worker system.

J. Who can revoke an AMD?

(The Ordinance Part 2 Division 1 Section 13)

1. The maker can revoke his / her advance medical directive (AMD) any time as long as he / she is mentally capable of deciding on life-sustaining treatment and not under undue influence. A properly completed and signed AMD cannot be revoked by other persons, including the maker's family members.

2. The maker may revoke the existing AMD by doing any one of the following (Table 2):

   2.1 Write a revocation (whether in paper form or in electronic form);

   2.2 Sign Part 5 of the model AMD form with the date of revocation shown;

   2.3 Burn, destroy or tear the paper AMD him / herself or by another adult in his / her presence and by his / her direction;

   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;

   2.5 Express the intention to revoke verbally in the presence of one or more adult witnesses who are present physically or by audiovisual link in real time;

   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;

   2.7 Make a new AMD; or

   2.8 Take the steps required on eHealth to remove the electronically stored AMD copy from the system.

3. For an AMD made for refusal of cardiopulmonary resuscitation, the AMD-based do-not-attempt cardiopulmonary resuscitation order is also revoked automatically upon revocation of the underlying AMD.

4. Patients should be advised to report to the registered medical practitioner as soon as practicable upon any revocation, so that the registered medical practitioner (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 certified true copies of the revoked AMD are removed and destroyed to avoid confusion.

5. For patients making 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 validating copies of the existing AMD. In any event, if multiple AMDs are available, the last dated AMD shall prevail.

6. In situations when family members only inform the RMP about the revocation when the patient presents in a mentally incapable and critical state, the doctor would not be able to ascertain the mental capacity of the patient at the time of revocation but presume that it was the case unless the contrary is proved.

Table 2. Revocation of advance medical directive (AMD)

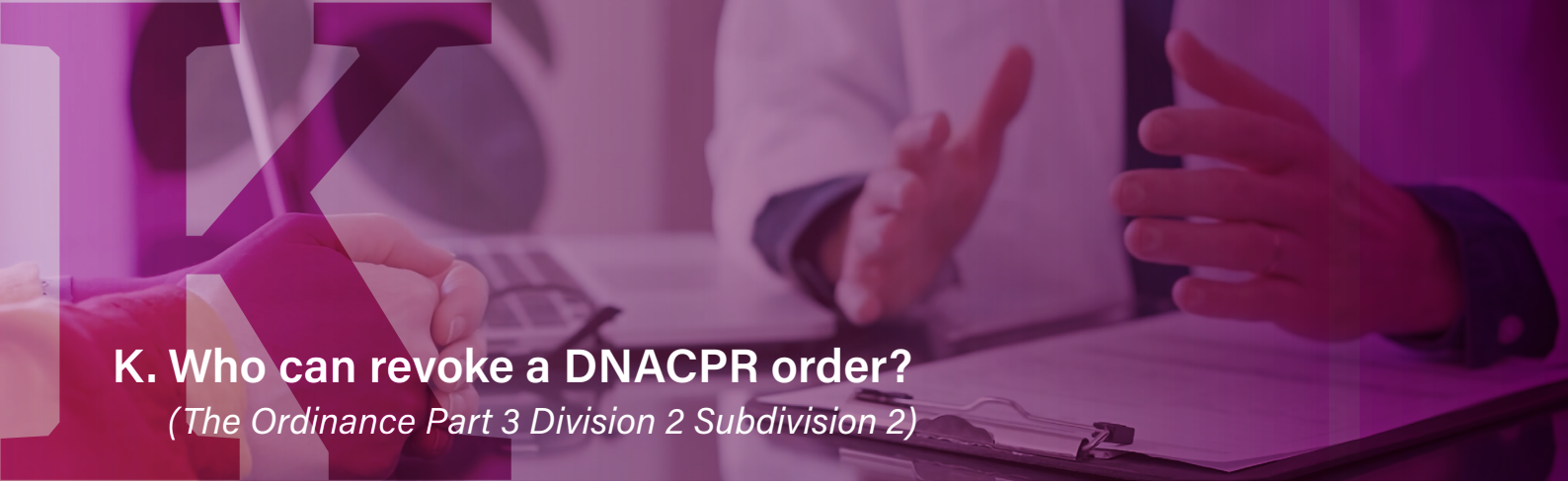
Patients have the liberty to choose to make an AMD in paper form or in electronic form (eAMD).

Upon revocation of a paper AMD, the digital copy of the paper AMD stored in the electronic platform and any other certified true copies should be removed or destroyed at the same time.

Upon revocation of eAMD, any certified printouts of the eAMD should also be destroyed at the same time.

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 (either in paper or electronic form); 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: i. verbally; or ii. by any means other than in writing or verbally	By the patient (a, b) By the patient or by 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 / most recent copy displayed) To be removed simultaneously with revocation of paper AMD	• 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 registered medical practitioner (RMP) who has access to eHealth
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 the 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.		
Electronically made AMD on eHealth* (eAMD) (only one / last copy displayed)	• 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 certified legible printout) To be destroyed simultaneously with revocation of eAMD	• Revoke by steps (b), (c) and (d) as above	• The eAMD may be downloaded for certification. • The clearly legible printout of the eAMD can be certified by: a. an RMP; or b. a solicitor within the meaning of the Legal Practitioners Ordinance (Cap. 159) who holds a current practising certificate in Hong Kong.

* 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.



K. Who can revoke a DNACPR order?

(The Ordinance Part 3 Division 2 Subdivision 2)

1. For both advance medical directive (AMD)–based and non-AMD-based do-not-attempt cardiopulmonary resuscitation (DNACPR) orders (Table 3):

   2 Registered medical practitioners (RMPs) may revoke a DNACPR order if they consider that the patient no longer meets the specified preconditions, e.g. improvement in clinical condition. 2 RMPs, one of which one must be a specialist, have to cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.

2. For AMD-based DNACPR orders:
   The AMD maker may revoke his / her AMD-based DNACPR order by doing any one of the following:

   2.1 Write a statement of revocation (either in paper or electronic form).

   2.2 Burn, destroy or tear the order or by another adult in his / her presence and by his / her direction.

   2.3 Cross out the content of and sign on each page of the order or by another adult in his / her presence and by his / her direction.

   2.4 Express the intention to revoke verbally in the presence of one or more adult witnesses who are present physically or by audiovisual link in real time.

   2.5 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 audiovisual link in real time.

   2.6 Revoke the underlying AMD of the AMD-based DNACPR order as mentioned in Section J-2.

3. For non-AMD-based DNACPR orders:

   3.1 A non-AMD-based DNACPR order can be revoked by 2 RMPs as mentioned in Section K-1.

   3.2 A non-AMD-based DNACPR order cannot be revoked by a responsible person on behalf of the patient. Queries from the responsible person should trigger further discussions or reassessment of the patient's best interests by the RMP.

   3.3 A non-AMD-based DNACPR order made for a minor patient is automatically revoked upon his / her 18th birthday. The patient may choose to make an AMD for refusal of cardiopulmonary resuscitation and / or other life-sustaining treatment, or alternatively, a non-AMD-based DNACPR order may be signed by 2 RMPs for mentally incapable adult patients with the additional signature by a responsible person / eligible person (if any). To avoid undue delay or time gaps, planning in advance of the anticipatable event is required.

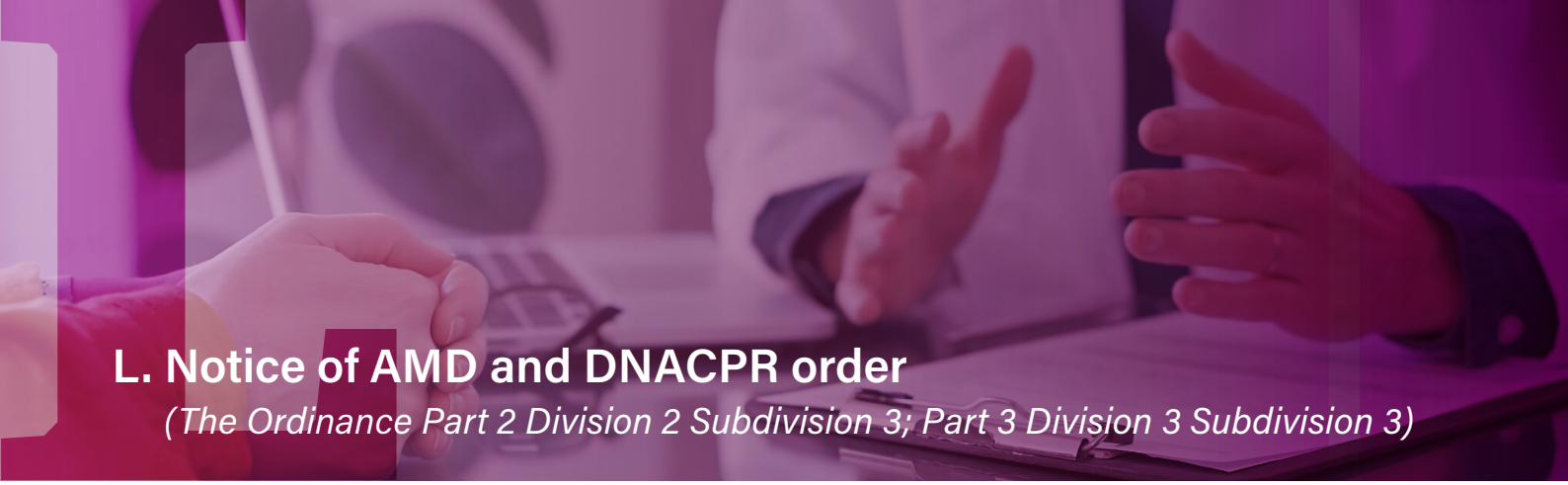
   3.4 A non-AMD-based DNACPR order made for a mentally incapable adult patient is automatically revoked when the adult ceases to be so mentally incapable.

4. The RMPs should communicate with both the patient and his / her responsible person (if any).

5. Revocation should be documented clearly in the patient's records for effective communication with other healthcare providers.

Table 3. Revocation of do-not-attempt cardiopulmonary resuscitation (DNACPR) orders

What?	How?	By whom?
Advance medical directive (AMD)–based DNACPR (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and sign on each page of the order with date of revocation inserted.	By 2 registered medical practitioners (RMPs), one of which one is a specialist*
	a. Write a statement of revocation (either in paper or electronic form). b. Burn, destroy or tear the AMD-based DNACPR order. c. Cross out the content of and sign on each page of the AMD-based DNACPR order. d. Express the intention to revoke: i. verbally; or ii. by any means other than in writing or verbally. e. Revoke the underlying AMD of the AMD-based DNACPR order.	By the patient (a) By the patient or by an adult in the patient's presence by the patient's direction (b, c) By the patient and in the presence of one or more adult witnesses (d)
* Only DNACPR orders can be revoked by 2 RMPs. The underlying AMD remains valid if the patient has not changed his/her mind. However, if the patient has revoked an AMD for refusal of cardiopulmonary resuscitation, the AMD-based DNACPR order will also be automatically revoked. In such cases, the patient should be advised to simultaneously remove and destroy all existing validating copies of the AMD-based DNACPR order and notify the treatment provider as soon as possible.		
Non-AMD-based DNACPR order for a mentally incapable adult patient (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.	By 2 RMPs, one of which must be a specialist
	Revoked when the adult ceases to be so mentally incapable.	Automatic expiry
Non-AMD-based DNACPR order for a minor patient (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.	By 2 RMPs, one of which must be a specialist
	Revoked on the 18th birthday of the patient	Automatic expiry



L. Notice of AMD and DNACPR order

(The Ordinance Part 2 Division 2 Subdivision 3; Part 3 Division 3 Subdivision 3)

1. Notice of advance medical directive (AMD) and / or do-not-attempt cardiopulmonary resuscitation (DNACPR) order refers to the treatment provider:

   1.1 Seeing the presented validating copy; or

   1.2 Being informed that an AMD is being / may be stored in eHealth and the validating copy stored in eHealth is accessible to the treatment provider. The treatment provider may decide whether to review the stored validating copy depending on the clinical indication of the patient. For example, reviewing the electronic copy of AMD is unlikely relevant or necessary for a patient seeking advice for minor ailments in a clinic setting when no life-sustaining treatment is contemplated.

2. Patients and their family members should be educated to bring along their validating copy of AMD and / or DNACPR order when admitted to a hospital or attending an RMP for review or extension of DNACPR order, or as advised by relevant specialty clinics, e.g. palliative care, oncology and geriatrics. In case the paper AMD is not available, the electronic copy stored on eHealth can serve as a validating copy.

3. For hospital admissions, a local system or workflow should be in place to ensure the validating copy of an AMD and / or DNACPR order presented is made known and accessible to other treatment providers during the same episode of care.

4. In cases where the AMD and / or DNACPR orders are not presented or made known to the treatment providers, search for the validating copies in the patient's belongings by the treatment provider is not required.

M. Operation of AMD

(The Ordinance Part 2 Division 2 Subdivision 2)

1. An advance medical directive (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.

2. For assessing the validity of the AMD:

   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 on eHealth; or
   b. A certified true copy of the AMD; or
   c. If the original copy of AMD is not in Chinese or English, a certified translation of the AMD in Chinese or English; or
   d. When the relevant functions of eHealth are in operation, the electronic AMD made and stored on the system.

   2.2 The registered medical practitioner (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 (refer to Section F).

   2.3 The AMD has not been revoked (refer to Section J).

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

   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.

3. For the AMD to be applicable:

   3.1 The patient is mentally incapable of making medical decisions (i.e. deciding on life-sustaining treatment); and

   3.2 The patient's current circumstances meet the specified precondition under the AMD.

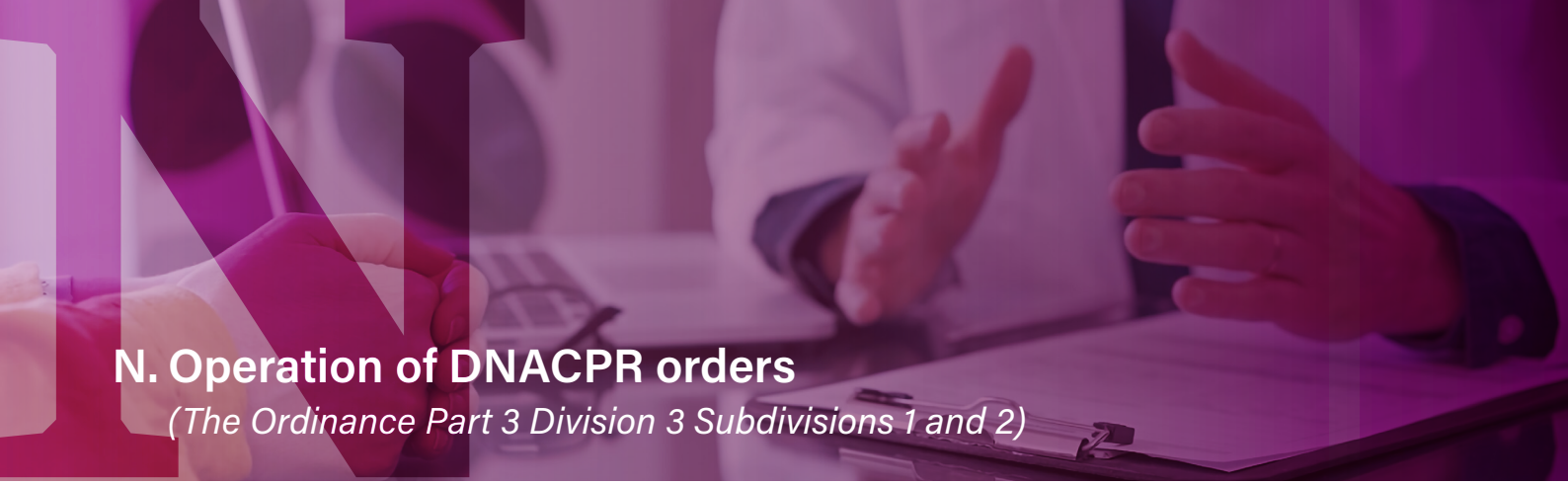
4. The AMD is not applicable if:

   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

   4.2 the current circumstances would have affected the patient's decision if he / she had anticipated such situation when making the AMD.

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.

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 P-3).



N. Operation of DNACPR orders

(The Ordinance Part 3 Division 3 Subdivisions 1 and 2)

1. A do-not-attempt cardiopulmonary resuscitation (DNACPR) order will only come into effect when:
   - 1.1 The patient is mentally incapable and in cardiac arrest; and
   - 1.2 The DNACPR order is valid and applicable.

2. A DNACPR order is valid if:
   - 2.1 The DNACPR order is brought to the notice of the treatment providers.
   - 2.2 The DNACPR order is clearly completed and properly signed as in Section G for an advance medical directive (AMD)–based DNACPR order and Section I for a non-AMD-based DNACPR order.
   - 2.3 The DNACPR order has not expired.
   - 2.4 There is no suspicion of foul play, e.g. falsified DNACPR order.
   - 2.5 For an AMD-based DNACPR order:
     a. The underlying AMD for refusal of cardiopulmonary resuscitation has not been revoked.
     b. Where an AMD has not been revoked, the patient has not done anything clearly inconsistent with the AMD and indicated that he / she no longer wants the AMD to be followed.

3. A DNACPR order is applicable unless the following circumstances exist:
   - 3.1 There are reasonable grounds for the attending registered medical practitioner (RMP) to believe that the current circumstances are not anticipated by the signing RMPs who signed or extended the effective period of the DNACPR order, and if the signing RMPs had so anticipated, he / she would not have signed and extended it.
   - 3.2 The attending RMP has made a diagnosis or prognosis that is different from that made by the signing RMPs, and reasonably believes that the signing RMPs would not have signed the DNACPR order or extended it (as the case may be) had they made the same diagnosis and prognosis;
   - 3.3 For an AMD-based DNACPR order, the attending RMP reasonably believes that, the patient did not anticipate the circumstance to arise at the time of making the underlying AMD, and had the patient so anticipated, it is likely that he / she would not have signed the AMD or made the underlying instruction.
   - 3.4 For a non-AMD-based DNACPR order, the attending RMP reasonably considers that there is any exceptional circumstance which warrants disregarding the DNACPR order, which is in the patient's best interests. As this is an exceptional situation, the attending RMP must exercise caution and clearly document the rationale and reasons behind his / her decision.

O. Non-model AMD form

1. Treatment providers may encounter advance medical directive (AMD) made in a non-model form in the following situations:

   1.1 A pre-existing AMD made before the Ordinance comes into operation that is not completed with the model form. The Ordinance provides for grandfathering of the Hospital Authority Advance Directive forms signed before the Ordinance becomes effective.

   1.2 An AMD signed for a specified precondition that falls outside the scope of the model forms (refer to Section F-4.2).

   1.3 An AMD made overseas, e.g. as presented by a traveller.

2. Any AMD made in a non-model format may be an acceptable proof of AMD as long as it is clearly written in Chinese or English, signed and completed in accordance with the legal requirements especially regarding the first and second witnesses, i.e. the first witness has to be a registered medical practitioner (RMP) (refer to Section F). The instructions laid down, including the specified preconditions for applying the AMD and the life-sustaining treatment (LST) to be refused, should be presented in a clear way (*The Ordinance Part 2 Division 1 Section 10(1)*).

3. For an AMD made overseas not in Chinese or English, the AMD can only be assessed by the treatment providers if it is a properly translated copy by certified translators (*The Ordinance Part 5 Section 59*). Even with a certified translation to Chinese or English, the treatment provider may have difficulty in ascertaining the validity of AMD, including the legal requirement for the first witness to be an RMP in Hong Kong. If in doubt, the treatment provider may clarify with the accompanying persons or obtain more information from relevant sources where possible. Even if the AMD does not fulfil all the requirements as stated in the Ordinance, it still serves as an important indication of the patient's prior wish for the doctor to consider. A doctor may decide, on a case-by-case basis, whether to honour an informed decision of the patient, or to act in the patient's best interests. In case of emergency, the treatment providers may perform LST as clinically indicated to save life first.

4. For an AMD-based do-not-attempt cardiopulmonary resuscitation (DNACPR) order, only the prescribed DNACPR form can be used. Therefore, for specified preconditions outside the scope of the model AMD forms, the prescribed DNACPR forms cannot be used and the treating practitioners have to rely on the non-model AMD for action after assessing its validity and applicability.

5. Patients may choose to switch to the local model AMD forms if applicable and feasible, especially upon modification of the instructions of the AMD.

6. Revocation of the non-model or overseas AMD should follow Section J.

P. Dealing with doubts and conflict resolution

1. Examples of doubts and conflicts

   1.1 Suspicion of offences by another person (*The Ordinance Part 4 Division 2 Subdivisions 1 and 2*):

   a. Wilful obstruction to implementation of the advance medical directive (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 do-not-attempt cardiopulmonary resuscitation (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 electronic AMD (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).

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

   1.3 The AMD presented is said to be revoked orally by the patient shortly before the patient becomes mentally incapable (refer to Section J-6).

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.

   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 life-sustaining treatment (LST) / cardiopulmonary resuscitation 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.

   2.2 Good practices

   a. Clear 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.

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

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

   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.

   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.

Q. Protection for treatment providers

(The Ordinance Part 2 Division 3; Part 3 Division 4)

1. Treatment providers refer to registered medical practitioners including those under limited or special registration, housemen under provisional registration, listed and registered 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.

2. A doctor is not liable for not performing cardiopulmonary resuscitation (CPR) in a person-in-arrest if the doctor:

   2.1 Has notice of a do-not-attempt cardiopulmonary resuscitation (DNACPR) order; and

   2.2 Honestly and reasonably believes that the DNACPR order is valid and applicable (refer to Section N); and

   2.3 Has no suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.

3. A doctor is not liable for performing CPR on a person-in-arrest if the doctor:

   3.1 Has no notice or knowledge of a DNACPR order;

   3.2 Is not satisfied that there is a valid and applicable DNACPR order (refer to Section N); or

   3.3 Has suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.

4. For a patient with advance medical directive (AMD)–based DNACPR order or AMD refusing other life-sustaining treatment (LST), a doctor who withholds or withdraws the specified LST is not liable if he / she:

   4.1 Has notice of the AMD; and

   4.2 Honestly and reasonably believes that the AMD is valid and applicable (refer to Section M).

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:

   5.1 Has no notice of the AMD and / or the AMD-based DNACPR order; or

   5.2 The AMD and AMD-based DNACPR order are deliberately concealed.

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.

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.

8. The above protection does not extend to other liabilities, such as any negligence committed during the course of LST.

9. The doctor should clearly document the process and the rationale behind his / her decision-making.

R. Consequential amendments and other related legislation

(The Ordinance Part 7)

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:

1. When the consequential amendment provisions relating to the Mental Health Ordinance (**MHO**) come into operation, an advance medical directive (AMD) made by an adult patient (when he / she is still mentally capable of deciding on life-sustaining treatment [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 been 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 capacity 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.

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 do-not-attempt cardiopulmonary resuscitation (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 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 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 protective bag for AMD / DNACPR provided by the Hospital Authority.

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 either a Residential Care Home for the Elderly or Residential Care Home for Persons with Disabilities is exempted from reporting to the Coroner if all of the followings are fulfilled: (i) the patient was diagnosed to have terminal illness before death; (ii) the patient was attended by a registered medical practitioner (RMP) during his/her last illness within 14 days prior to his / her death; and the cause of death stated in the certificate of the cause of death of the deceased is a natural cause. 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.

S. Other special situations

1. A healthy adult requesting to make an advance medical directive (AMD)

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

   1.2 However, making an AMD by a healthy individual may pose challenges.
   - It may be difficult for the healthy adult to anticipate his / her future preferences, especially in the absence of illness and other life experiences.
   - 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.
   - With the potentially long interval between making the AMD and the time for its operation, the registered medical practitioner (RMP) should advise the patient to review his / her preferences regularly, otherwise, doctors may cast doubt on the stability of the directive.
   - An AMD-based do-not-attempt cardiopulmonary resuscitation (DNACPR) order can only be signed after the maker is assessed to have fulfilled the specified precondition in the future.

   1.3 Some healthy adults may have special considerations. For example, those who are involved in risky activities may wish to refuse artificial nutrition and hydration or other life-sustaining treatment (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 under persistent vegetative state or irreversible coma may be appropriately considered.

2. Patient's wish to donate tissue, organs, or body

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

   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.

   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.

   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.

3. Patients under guardianship orders (*The Ordinance Part 3 Division 5 Section 47*)

[8] Hong Kong Organ Transplant Foundation. Basic OD knowledge. Accessed 10 April 2024. Available from: https://hkotf.org/en/odknowledge/

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

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 R-3).

T. Summary of ethical considerations

1. All mentally capable adults can refuse medical treatment (e.g. life-sustaining treatment [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.

2. All valid and applicable advance medical directives (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.

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.

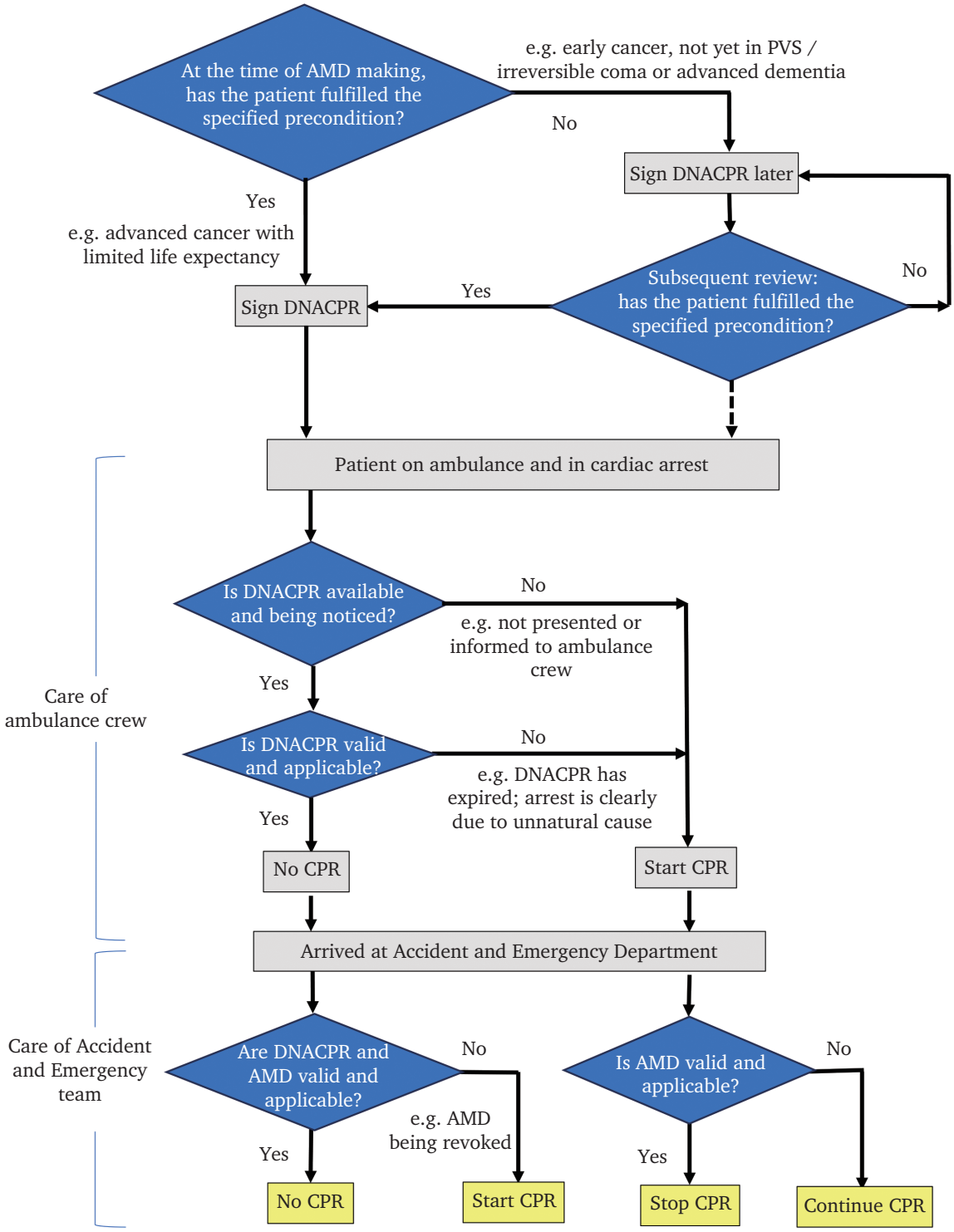
4. For mentally incapable adults and minors who are unable to make an AMD, the doctor has to decide on the treatment based on the patient's best interests. A proxy for substituted judgement has no legal status in Hong Kong, but consensus building with family members is highly recommended.

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

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.

7. A doctor is not obliged to perform futile or non-beneficial treatment.

Figure. An illustration of patient journey after making AMD for refusal of CPR
Abbreviations: AMD, advance medical directive; CPR, cardiopulmonary resuscitation; DNACPR, do-not-attempt cardiopulmonary resuscitation; PVS, persistent vegetative state



U. Case scenarios

Scenario 1

A 65-year-old retired security guard is recently diagnosed to have cancer with local metastases. His doctor explains to him that with appropriate treatment, there is a reasonable chance of control of the disease and prolongation of survival. However, the patient refuses further treatment as he is aware of the poor experiences of other people. He is a singleton with no family members or close friends and he has nothing to worry about even if he is to die soon. He wants to make an advance medical directive (AMD) for refusal of cancer treatment and cardiopulmonary resuscitation.

An adult patient is mentally capable of making an AMD to refuse life-sustaining treatment if he is able to understand the nature and consequences of his decision based on adequate and accurate information given to him.

The doctor should consider if the patient's decision is in line with his values and past behaviours and whether he can express his views coherently. The doctor should also identify and modify factors that may affect the patient's choice, e.g. misconceptions about cancer treatment, misunderstanding of his prognosis, or lack of social support. A valid and applicable AMD has to be respected even if the refusal seems unwise or not in the patient's best interests. If serious doubts about the patient's mental capacity still remain, the doctor may consider referral to a psychiatrist for assessment.

Scenario 2

An 80-year-old man is diagnosed to have bronchogenic carcinoma with secondaries to the bone and the brain. He has signed an advance medical directive (AMD) for refusal of cardiopulmonary resuscitation, witnessed by a registered medical practitioner and another non-interested person in the presence of his wife and daughter. His pain is well controlled with syrup morphine 8 mg Q4H. After a few months, his condition deteriorates with cognitive impairment. His son, who returns from overseas, is in shock when knowing the poor state of his father. He also has queries about the AMD's validity as the patient is on strong opioid and has brain metastases.

A patient's mental capability for deciding on life-sustaining treatment is time- and task-specific. If the patient was mentally capable when making the AMD, the AMD is valid and has to be respected. Proper documentation of the process of the making of the AMD in the presence of witnesses and involvement of family members in the discussion are important in reducing conflicts later on.

The doctor may explain to the patient's son that use of morphine or other strong opioids (if properly prescribed with side effects monitored). and the presence of brain secondaries may not necessarily affect the patient's mental capacity. The doctor should also encourage discussion between the patient's wife, daughter and son to facilitate the son's understanding of the patient's preferences when the AMD was made.

Scenario 3

A 32-year-old pilot, who was previously healthy, became comatose after a car crash 7 months ago. Despite intensive treatment and supportive measures, the patient's prognosis is guarded and his doctor proclaims that he is in persistent vegetative state (PVS). Five years ago, the patient had made an advance medical directive (AMD) for refusal of artificial nutrition and hydration (ANH) should he suffer from irreversible coma or PVS in the future. His mother, who visits him daily, claims that her son can interact with her by eye blinking and even waving of hands. She cannot accept the diagnosis of PVS and the removal of ANH. She thinks her son would not prefer to die in his current state.

When the patient becomes mentally incapable and the specified precondition under the AMD is met (i.e. irreversible coma or PVS), the AMD is applicable. The doctor should acknowledge the feelings of the patient's mother and her interpretation that the patient can still have purposeful interactions with her. Though the patient is awake with circadian rhythm, he is not aware of his surroundings. As the PVS is not an easy diagnosis, seeking another opinion will help to build more convincing evidence. When facing unresolved conflicts in a complex situation, it is advisable to seek opinion from local ethics committee, hospital management and / or legal advisers, who may decide whether to submit an application to the court to determine the validity and / or applicability of the AMD.

Scenario 4

A 79-year-old lady who suffers from recurrent stroke, is also diagnosed to have Alzheimer's disease. The old lady used to enjoy eating, and after some difficulty in oral feeding, she decides to make an advance medical directive (AMD) to refuse Ryle's tube feeding. Her decision is supported by her daughter, who is also the main caregiver in careful hand feeding. With time, the patient has deteriorated further in cognition and function. She has repeated admissions into hospital for suspected aspiration. Patient's daughter becomes perplexed and asked the doctor-in-charge if she should revoke the AMD.

The AMD for refusal of tube feeding has to be respected as long as the patient was mentally capable and understood the implications at the time of making the AMD. The daughter has no power to revoke the AMD made by the patient. The doctor should acknowledge the tension experienced by the daughter and reaffirm the respect for patient's autonomy. Measures to prevent aspiration by oral feeding should be discussed and reinforced, and the doctor should explain to the daughter that tube feeding does not preclude aspiration. Artificial hydration such as subcutaneous fluid may be discussed with the daughter as an option to address dehydration.

Scenario 5

A 72-year-old patient with progressive renal failure has signed an advance medical directive (AMD) to refuse dialysis. He is escorted by his wife to the hospital in a stuporous state with acidotic breathing. According to his wife, the couple travelled with their children to Phuket for holiday 4 weeks ago, during which the patient felt unwell. He underwent temporary dialysis in a local hospital before he was well enough to travel back to Hong Kong. The family presented the AMD to the doctor and sought the doctor's advice on what to do.

The doctor should try to ascertain from the family the reason for temporary dialysis. It may serve as a prerequisite for travelling back to Hong Kong, but may also be an act that is inconsistent with his AMD to refuse dialysis. If there are doubts about the patient's latest intent, the doctor may propose to provide temporary dialysis again and discuss with the patient further when he regains mental capacity.

Scenario 6

A 66-year-old retired teacher who is a diabetic is recently diagnosed to have Alzheimer's disease after being referred to a specialist clinic for forgetfulness and a decline in problem-solving. His father also died of severe dementia years ago, and he witnessed in pain when cardiopulmonary resuscitation (CPR) was performed on his dying father, who was already debilitated and demented. He discussed with his doctor to make an advance medical directive (AMD) for refusal of CPR, with the understanding that the AMD will only be applicable when he is in severe dementia and mentally incapable. A week later, he is sent to the public hospital in a critical condition and near cardiac arrest. The electronic clinical management system indicates that the patient has dementia and has signed an AMD for refusal of CPR 2 weeks ago. There is no indication that a do-not-attempt cardiopulmonary resuscitation (DNACPR) order exists.

In the absence of an AMD-based DNACPR order, the attending registered medical practitioner (RMP) has to assess the validity and applicability of the patient's AMD. In particular, the attending RMP must be satisfied that the specified precondition under the AMD has been met (i.e. severe dementia and mentally incapable). If the attending RMP determines that the patient's critical condition is due to causes other than severe dementia, the AMD is not applicable and CPR should be performed based on the best interests of the patient.

Scenario 7

An 85-year-old lady with disseminated carcinoma of the pancreas is escorted to the Accident and Emergency Department by her daughter in a cachexic and terminal state. Her daughter presents the advance medical directive (AMD) and the do-not-attempt cardiopulmonary resuscitation (DNACPR) order to the doctor. However, the DNACPR order has expired as the patient did not come back for follow up as scheduled 2 weeks ago because of the COVID pandemic. The daughter confirms that her mother has not revoked her AMD and pleading the doctor to respect her mother's wish.

Since the DNACPR order has expired, it becomes invalid. The doctor shall act in accordance with what he/she reasonably believes to be a valid and applicable AMD in the absence of foul play. If the doctor has doubt, the doctor can decide on further action based on the patient's best interests.

Scenario 8

A 70-year-old lady with incurable lung cancer sustains a fall at home, resulting in fracture neck of right femur. She lives alone and is supported by community services. The patient tells her doctor that she has signed an advance medical directive (AMD) to refuse cardiopulmonary resuscitation (CPR). She has no anxiety about death, but she is worried that she cannot manage at home after the fracture.

The AMD is not applicable here as patient is still mentally capable. The doctor should not presume that a patient who refuses CPR in advance, will refuse all invasive treatments, or will deprive the patient's right to receive other treatments. Appropriate information on treatment options should be provided, taking into consideration of risks and benefits, the likely outcome and the projected survival. A patient may choose to perform surgery if he / she may be able to return to the community with a reasonable quality of life after corrective surgery. If surgery under general anaesthesia is indicated, suspension of AMD and do-not-attempt cardiopulmonary resuscitation (DNACPR) order should be discussed with the patient. A unilateral or uninformed suspension of the DNACPR order is not acceptable by contemporary ethical standards. The doctor should also discuss the period of suspension with the patient before the operation, i.e. whether to resume the AMD in the post operative period. This is important to cater for the unfortunate case that the patient becomes mentally incapable after the operation.

Scenario 9

A 70-year-old lady, suffering from advanced breast cancer, has decided to make an advance medical directive (AMD) for refusal of cardiopulmonary resuscitation. Because of her physical decline, she moves to a residential care home for the elderly (RCHE) where she prefers to stay for care and die. To facilitate her wish, the Geriatrician has been visiting her for medical support. One day, the Geriatrician receives a call from the staff, telling him that the patient may be dying. On examination of the patient upon arrival, the family doctor finds no signs of life, but notices bruises on the patient's left face and an open wound on her forehead, which are not present in his last visit a week ago. The staff would like to know if they could proceed with the logistics without reporting the death to the Coroner.

With the amendment of the Coroners Ordinance, patients who die in RCHE or residential care homes for persons with disabilities are exempted from reporting to the Coroner, provided that the following conditions are fulfilled:

1. The patient, before death, was diagnosed by a registered medical practitioner (RMP) as having a terminal illness. The term 'terminal illness' is not defined in the Coroner's Ordinance and whether a patient has 'terminal illness' is a matter of clinical judgement of the doctor; it is not limited to advanced cancer and may cover other medical conditions that have deteriorated to the extent that death is anticipated;
2. The patient was attended by an RMP during his / her last illness within 14 days before his / her death; and
3. The cause of death stated by the RMP in the patient's certificate of the cause of death is a natural cause.

The making of AMD or expression of wish to die at RCHE does not automatically preclude reporting to the Coroner. The above conditions have to be satisfied, i.e. (1) and (2) and (3) as confirmed by an RMP. If the RMP is unable to accurately state the medical cause of the death in the death certificate, the death will have to be reported to the Coroner.

Scenario 10

A 68-year-old man has made an advance medical directive (AMD) for refusal of cardiopulmonary resuscitation after being diagnosed to have lung cancer. Today, he suffers from major trauma due to a traffic accident and is brought to the Accident and Emergency Department. His wife mentions the presence of AMD in the electronic system. The medical team decides to provide emergency resuscitative measures immediately. Are the treatment providers liable for performing life-sustaining treatment on this patient?

In this situation, the critical condition of the patient is due to the trauma and not the underlining lung cancer. The treatment providers are not obliged to ascertain whether a validating copy of an AMD is stored in the system if their clinical judgement that the relevant instruction in the AMD would not be valid or applicable. The treatment providers are therefore not liable.

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Appendix 1: Model AMD forms and prescribed DNACPR order forms

The standard advance medical directive (AMD) forms can be found in Schedule 2 of the Advance Decision on Life-sustaining Treatment Ordinance. The Government recommends that the public use these model forms when creating AMDs to ensure clarity and compliance with legal requirements. Similarly, the prescribed do-not-attempt cardiopulmonary resuscitation (DNACPR) order forms and continuation sheets for extending the effective period are outlined in Schedule 3 of the Ordinance. These documents are currently accessible for download on the Health Bureau website for public use and are listed below for readers' reference.

	English	Chinese
Model AMD forms		
AMD	pdf	pdf
AMD (for refusal of cardiopulmonary resuscitation only)	pdf	pdf
Prescribed DNACPR order forms		
DNACPR order (AMD-based)	pdf	pdf
DNACPR order (not AMD-based) (for mentally incapable adult)	pdf	pdf
DNACPR order (not AMD-based) (for minor)	pdf	pdf
Continuation Sheet for DNACPR order (for adult) (applicable for statutory form 1 & 2)	pdf	pdf
Continuation Sheet for DNACPR order (for minor) (applicable for statutory form 3 only)	pdf	pdf

Appendix 2: Questions and answers

Q1 Is withholding or withdrawing LST equivalent to euthanasia?

A1 No. Euthanasia is defined as direct intentional killing of the patient as part of the medical care provided. It is illegal in Hong Kong. Withholding and withdrawing LSTs is to allow natural death from the underlying disease to occur and not be prolonged and is ethically and legally acceptable in Hong Kong.

Q2 How to assess whether someone is eligible to co-sign on a non-AMD-based DNACPR order if no family member or guardian is available?

A2 In assessing whether someone is eligible to co-sign on a non-AMD-based DNACPR, the RMP must consider various factors including the relationship between the person and the patient, their frequency of contact, perceived level of closeness, the degree of perceived significance of the person to the patient, and any prior wish expressed by the patient as to whether the person would act in his/her best interests. For example, the RMP may consider the involvement of the person in the daily care of the patient, including daily activities and personal hygiene, or in medical care of the patient including escort and medical decision making.

For minors with adequate mental maturity, their views on who will act in their best interests should also be taken into account.

Q3 Can a houseman sign the AMD or DNACPR order?

A3 Housemen are under provisional registration under the Medical Council of Hong Kong. A houseman thus cannot sign on the AMD or the DNACPR order (including an extension) as RMP. However, he / she may sign as the second witness of the AMD, provided he / she is not an interested person.

Q4 Would signing the AMD affect the insurance policy of the patient?

A4 No, it would not and should not. Under the Ordinance, the making of an AMD does not affect the sale, procurement or issuance of an insurance policy, nor does it invalidate the policy if LST is withheld.

Q5 What would you do when a distant relative of the patient suddenly appears and wants to apply to the Court for declaration of the validity and applicability of the AMD?

A5
a. A relevant person (not being an immediate family member or cohabitee of the patient) is eligible to apply to Court for declaration if he / she is an adult and reasonably assessed by the RMP to have sufficiently close connection with the maker to be concerned about the well-being of the maker. If the maker is mentally capable: the RMP should seek the views of the maker as to whether the person qualifies as a relevant person and should discuss with the maker as to whether he/she may wish to continue or revoke the AMD. Reasons for continuation or revocation of the AMD should be documented.
b. If the maker is mentally incapable but clinically stable: the RMP has to assess the validity and applicability of the AMD, and has the duty to respect a valid and applicable AMD. If the RMP is satisfied that an AMD is valid and applicable, explanation should be given to the family member that he / she cannot revoke the AMD.
c. If the maker is mentally incapable and in cardiac arrest: the RMP may not have time to explore the details or wait for the results of Court application. In case of doubt, LST shall be given as clinically indicated based on the patient's best interest until the status of the AMD is clear.
d. Seek advice from the local clinical ethics committee and / or legal advisers if required.
e. Inform hospital management of the case.

Q6 In the operation of a non-AMD-based DNACPR order, who may disregard the order in exceptional circumstances as in Section N-3?

A6 Only the RMP attending the patient (and not any other treatment provider) can disregard a non-AMD-based DNACPR order if he / she considers that (i) there is any exceptional circumstance that warrants disregarding the order, and (ii) disregarding the order is in the subject person's best interests. Such situations are expected to be rare and the attending RMP's power to disregard a non-AMD-based DNACPR order should not be exercised lightly, for example when the attending RMP has serious doubts about the assessment of the 2 RMPs signing the non-AMD-based DNACPR order. The rationale and reasons for disregarding a non-AMD-based DNACPR order should also be clearly documented.

Q7 In facing a patient in cardiac arrest who had made an AMD for refusal of CPR 6 months ago, what to do if the family members claim that the patient has clearly expressed his / her decision to revoke the AMD yesterday and has torn the paper AMD in front of them? The family members further explain that they do not have time to inform the doctor-in-charge about the revocation so as to remove the e-PDF copy.

A7 An AMD can be revoked by a mentally capable patient voluntarily. Where an AMD is revoked verbally or by any means other than written or verbal communications, it must be done in the presence of at least one adult witness. If the attending doctor is satisfied, upon information provided by the family members, that the existing AMD has been revoked (including being satisfied that the patient is mentally capable at the time of revocation), the doctor may perform CPR on the basis that there is no valid and applicable AMD. In such circumstances, the attending doctor will not be held liable for performing CPR on the patient.

Q8 A 70-year-old man has signed an AMD for refusal of CPR after he is diagnosed to have metastatic cancer. While having lunch with his family, he develops severe shortness of breath. On presentation to the hospital, he is in a very poor state. He keeps on yelling in distress, telling the doctor repeatedly: "Please save me, I am not ready to die!" Does it mean the patient wants to revoke his AMD?

A8 A mentally capable adult can voluntarily revoke his / her AMD at any time. He / she may adopt one of the ways to revoke the AMD as described in Section J-2.1-2.8. Verbal revocation shall include a formal statement of "I now revoke my AMD". However, the patient may give expressions that he / she may want LST instead of a clear revocation as such. Some examples of such expressions are "Please do something to save my life" or "I don't want to die yet". To the best extent possible, the treatment provider should clarify with the patient or the family members whether he / she intends to revoke the AMD.

Other expressions such as "Please help me" or "Please relieve my sufferings" often may indicate that patient has distressing symptoms that need palliation, instead of an intention to revoke the AMD. The context must be considered in determining whether such expressions amount to an intention to revoke the AMD.

Q9 For patients who choose to die in place, e.g. in a residential care home, is the making of an AMD a necessary and sufficient condition for classifying the patient's death as a non-reportable case to the Coroner?

A9 No. The existence or absence of an AMD or DNACPR order does not affect whether a death is reportable under the Coroners Ordinance.

In ACP, the patient or his / her family members may express their wish for the preferred place of care and death. To facilitate dying in place, the amended Coroners Ordinance allows deaths in residential care home for the elderly or residential care homes for persons with disabilities to be exempted from being reported to the Coroner, provided that all three of the following conditions are satisfied:

1. The patient, before death, was diagnosed by an RMP as having a terminal illness. The term 'terminal illness' is not defined in the Coroner's Ordinance and whether a patient has 'terminal illness' is a matter of clinical judgement; it is not limited to advanced cancer and may cover other medical conditions that have deteriorated to the extent that death is anticipated;
2. The patient was attended by an RMP during his / her last illness within 14 days prior to his / her death; and
3. The cause of death stated by the RMP in the patient's certificate of the case of death is a natural cause.

For patients who wish to die at home, conditions (1) and either (2) or (3) have to be fulfilled for exemption from referral to Coroner:

1. An RMP confirms that patient dies from a natural cause.
2. The patient is diagnosed to have a terminal illness by an RMP.
3. The patient is visited by an RMP within 2 weeks before death.

Q10 What will happen to the existing AMD and DNACPR order made before the Ordinance commences? Would they be recognised when the Ordinance comes into operation in a future date?

A10 The 18-month window period allows time for transitioning existing DNACPR order forms and AMDs to the new format as needed.

The Ordinance only covers DNACPR orders with continuing effect, and not those used for care episodes in an inpatient setting. When the Ordinance comes into operation, only the prescribed DNACPR order forms would be recognised. As there would be a time interval between the enactment of the Ordinance and when the Ordinance comes into effect, doctors should adopt the prescribed DNACPR order forms upon expiry of the existing DNACPR orders and when new DNACPR orders are required to be made. During this transition period, it is expected that vast majority if not all existing DNACPR orders will be gradually replaced by the prescribed DNACPR order forms. This mechanism shall avoid the hassles of abrupt transition of forms. However, the prescribed DNACPR order forms would only be recognised by ambulance crew as and when the Ordinance comes into effect.

Q11 A mentally capable patient would like to refuse CPR in case he becomes mentally incapable due to incurable cancer. However, he prefers not to make an AMD and requests the doctor to sign the DNACPR order form. Should the doctor comply with his request?

A11 No. For a mentally capable adult patient, any DNACPR order must be AMD-based. Non-AMD-based DNACPR order are only available for mentally incapable adult patients or minors, which are signed by 2 RMPs based on their assessment of the patient's best interests.

Q12 You are the doctor-in-charge of a 72-year-old patient with hypertension who is mentally capable and physically fit for his age. He would like to make an AMD now for refusal of CPR when he reaches the age of 80, irrespective of his health condition by then. Would you consider his request?

A12 In principle, the specified precondition as selected by the patient in his / her AMD should be a medical diagnosis that can be ascertained by the RMP to be life limiting and progressive.

In this case, the doctor-in-charge is facing the following difficulties:

1. The prespecified age is not linked to any medical condition, and patient could still be in good physical condition at that time.
2. The conditions that could lead to cardiac arrest requiring CPR in this patient can range from accidents to medical diseases, and from reversible to irreversible situations. The scope of information to be provided could be difficult to cover.
3. The specified condition does not fit into the model AMD form. If a non-model AMD form is signed in this case, an AMD-based DNACPR cannot be made until the patient reaches age 80 (as the specified precondition has not yet satisfied); even if patient has reached age 80, an AMD-based DNACPR cannot be made as the prescribed DNACPR forms under the Ordinance do not cater for such a specified precondition (and all DNACPR orders must be made using the prescribed forms).
4. There is also a possibility that the treatment provider who attends the patient in future may doubt the validity and applicability of the AMD, especially in situations when the cardiac arrest is due to a likely reversible cause.

The doctor-in-charge should explain to the patient the limitations in making the AMD at present. A practical approach is to review the wish of the patient as he ages further or when his medical conditions change in due course.

Q13 A patient from Korea is planning to stay in Hong Kong for treatment of his cancer. He has made an AMD in Korean in his homeland for refusal of CPR in case his cancer does not respond to treatment and he becomes mentally incapable. He is asking if the doctors in Hong Kong will respect his AMD. How would you advise the patient?

A13 An AMD, regardless of whether made within or outside Hong Kong, must be signed by an RMP registered in Hong Kong in order for it to be valid. Hence, if it is not signed by an RMP in Hong Kong (e.g. by a doctor in Korea), it is not valid and treatment providers in Hong Kong are not obliged to comply with the same, even if a translation is provided.

Further, if the AMD is not written in Chinese or English, RMPs are not obliged to review it unless it has been translated into Chinese or English. In Hong Kong, if it is certified by a translator and the translator is certified to be competent by:

a. A notary public practising in Hong Kong;
b. A solicitor practising in Hong Kong; or
c. A consular officer in Hong Kong.

Outside Hong Kong, if it is certified by a translator approved by a court of law of the place and the translator is certified to be competent by:

a. A notary public practising in the place;
b. A professional legal practitioner practising in the place;
c. An officer of court of law duly authorised by the law of the place to certify documents for any judicial or other legal purpose; or
d. A consular officer in the place.

When the AMD is not signed by an RMP in Hong Kong, the patient should be advised that the certified translated copy may not comply with the Ordinance. However, it will serve to indicate the expressed wish of the patient, which the local doctors will take into consideration.

The doctor may suggest the patient to sign a new AMD using the local model AMD form, where its operation will be protected by the Ordinance.

Q14 A patient with advanced cancer would like to make an AMD for refusal of LST. She is an ethnic minority and not able to read Chinese or English. What should the doctor do?

A14 The Ordinance provides model AMD forms and prescribed DNACPR forms in Chinese and English. If the patient cannot read Chinese or English, the doctor should read the contents of the AMD form, and DNACPR form as indicated, to the patient (with an interpreter as needed), and explain that the AMD has to be in Chinese or English for recognition by local treatment providers. The patient can sign on the AMD form provided she understands the implication and nature of the AMD and the refusal.