

Advance Care Planning (ACP)?
Advance Medical Directives (AMD)?
Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)?

LET'S GET TO KNOW MORE!

Foreword

As medical technology advances, many diseases may be under better control or even having a chance of cure. However, there is an end to everyone's life. Some diseases will progress to a point when all treatments become futile. Application of life sustaining treatment (LST) to a dying patient with end-stage irreversible disease may be of no overall benefit to the patient and even aggravate his/her suffering and prolong the dying process. In anticipation of the progressive decline of an irreversible condition, the health care workers shall invite the patient and his/her family members to decide on the future care, including the use of LST, which may be futile as patient is dying.

The Hospital Authority agrees that it is ethically and legally acceptable to withhold or withdraw LST when:

- A mentally capable adult has decided to refuse the LST if being adequately informed; or
- The treatment is futile and has no overall benefit.

If the patient is mentally incapable, a decision to withhold or withdraw futile treatment is made by the doctors based on the best interests of the patient and consensus building with family members. If the patient has not previously expressed his/her values and treatment preferences, which are important in the consideration of his/her best interests, then the medical team may have difficulty reaching a consensus with the family. Therefore, it is useful if the patient has expressed prior wishes on the preferred care, or even signed an AMD when he/she is mentally capable.

Indeed, it is not easy for healthcare workers to discuss death and dying with the patient and family. When the timing is appropriate, healthcare workers can discuss with the patient and family via an ACP process, to enable them to understand the issues and options before a decision is made. The aim of this education booklet / website is to provide relevant information for better understanding of the subject by the patient, the family members, and the public.

醫院管理局
HOSPITAL AUTHORITY

Hospital Authority Clinical Ethics Committee
(Updated in September 2026)

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1 What is "Life-Sustaining Treatment" (LST) and what kinds of Treatment are included?

Life sustaining treatment refers to any treatment which may prolong the patient's survival or postpone dying. But as LSTs are invasive, they may cause suffering and burden to the patient. Without the life-sustaining treatment, the patient will eventually die from the underlying irreversible disease.



LST often includes

- Cardiopulmonary resuscitation
- Artificial ventilation (ventilator)
- Blood products (transfusion, blood platelet, blood plasma)
- Pacemakers and vasopressors
- Chemotherapy
- Dialysis (renal replacement therapy)
- Antibiotics
- Artificial nutrition and hydration (e.g., via nasogastric tube)

What is Cardiopulmonary Resuscitation (CPR)?

CPR is an emergency procedure for a person near or in cardiac arrest. The steps may involve (1) chest compression to restore blood flow temporarily; (2) ensure an unobstructed airway; (3) defibrillation. This is to buy time when more advanced treatments are available, e.g. use of artificial ventilation, drugs, intravenous fluid support, and cardiac pacing.



Why Would LST Become Futile?

LST such as CPR is an invasive emergency intervention, the outcome of which depends on various factors. In a terminally-ill patient, as the underlying disease such as advanced cancer or organ failure causing cardiac arrest has not changed, the success rate of CPR resulting in effective rescue is very low. On the other hand, CPR may cause complications, e.g. rib fracture. Performing futile CPR on a dying patient can only prolong the dying process while causing unnecessary pain and suffering.



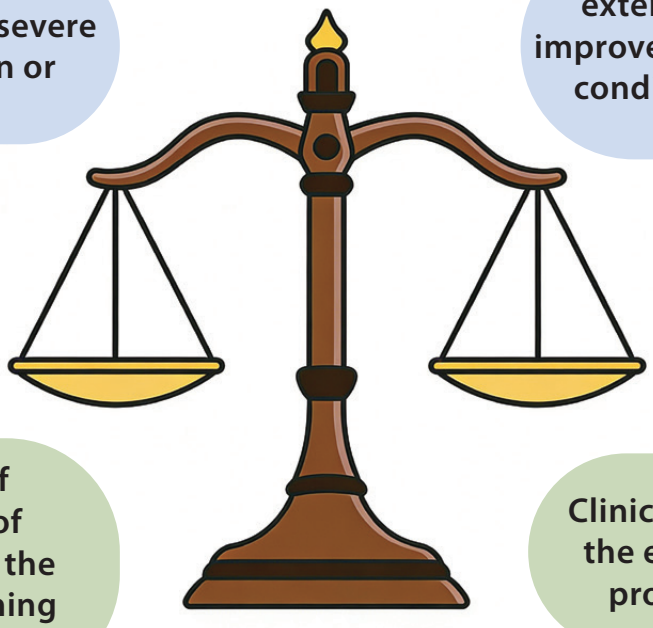
The same is also true for other LSTs. While in some situations, the LSTs can temporarily sustain life, the underlying disease condition remains irreversible. These interventions only serve to prolong the dying process, which may be of little meaning to the patient, or even aggravate his/her suffering and thus are not in the best interests of the patient. Overall speaking, these treatments are futile. In such cases, adopting the palliative care approach is more appropriate.

2 What is "In the Patient's best interests"?

Something that is "in the patient's best interests" refers to the balance of potential benefits over potential harm, distress, and suffering resulting from the pursuit of a given treatment.

When deciding whether a treatment is in the patient's best interests, the following should be contemplated in balancing burdens over benefits:

- whether the invasiveness of the treatment is justified in the circumstances
- the likelihood of the patient experiencing severe unmanageable pain or suffering
- the likelihood and extent of any degree of improvement in the patient's condition if treatment is provided



- the likelihood of irreversible loss of consciousness and the likelihood of regaining mental capacity
- Clinical judgement about the effectiveness of the proposed treatment
- patient's preferences, views, and beliefs

When considering what is in the patient's best interests, it is more than a medical issue. One has to take into consideration the patient's wish, values, and beliefs. If the patient is unable to express himself/herself, views of family members concerning the patient's values, preferences, cultural and religious beliefs should be solicited to determine what is in the best interests of the patient.

3 Is withholding or withdrawing futile life-sustaining treatment (LST) the same as euthanasia?

Euthanasia is defined as the "direct intentional killing of a person as part of the medical care being offered". It involves the deliberate act of a doctor to administer drugs or substances to end the patient's life. In Hong Kong, euthanasia is illegal and ethically unacceptable.



Withholding / withdrawing futile LST

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Euthanasia



The patient has the right to refuse unwanted treatment, including LST. A healthcare professional who provides treatment against the patient's will may be liable to legal action for battery or assault. Withholding such treatment in this case is an act of respecting the patient's wish and allowing patient to die eventually from the underlying natural illness. This is not tantamount to performing euthanasia.

Withholding or withdrawing futile treatment for a patient is not performing euthanasia as the treatment is not in the best interests of the patient. Administering futile LST on a dying patient would only inflict more suffering. What the patient needs in the final days is not futile treatment, but end-of-life care and a peaceful death.

4 What is advance care planning (ACP)?



For a patient who has a serious illness, planning on future medical and personal care at the end of life can be made via an ACP process among the patient, the family members, and healthcare workers, taking into consideration factors such as disease prognosis, benefits and burdens of treatment, values and preferences of the patient, etc.

Usually, ACP is a process of communication intended for mentally capable patients. Participation of family members/responsible or eligible persons is highly encouraged. The patient can express preferences for future medical or personal care, or make an advance medical directive (AMD) refusing life-sustaining treatment (LST).





In the Hospital Authority, the term ACP extends beyond communication with mentally capable adult patients to include that with family members of mentally incapable and minor patients. Decision-making regarding the patient's future medical or personal care should be by consensus building among members of the healthcare team and with the patient's family/responsible or eligible persons, based on the best interests of the patient.

Parties involved in the ACP process and their roles

Clinicians



- In the communication process, clinicians often assume a facilitating and guiding role, and:
  - ➢ Provide information on disease prognosis, treatment options available, benefits and risks, as well as related medical evidence, including end-of-life scenarios;
  - ➢ Facilitate the patient to express his/her values and preferences for treatment with good communication skills using a patient-centered approach and empower patient autonomy
  - ➢ Encourage the family to listen to the patient's concerns and elicit views from family members; and
  - ➢ Resolve disagreement and deal with emotional responses as necessary and work towards a consensus for an agreed care plan.

Patient



- The patient takes a central role in the discussion. He/she can express his/her views, values, and needs to the medical team and the family. Healthcare workers will assist if difficulties arise.
- Scope of views expressed can include expectation for medical and personal care, expected roles of healthcare workers and the family. The patient can also refuse specified LST when he/she becomes mentally incapable and in the end stage, including cardiopulmonary resuscitation.
- As for paediatric patients, they are encouraged to participate in the discussion. However, the extent of participation depends on their mental maturity as assessed by the doctor. A minor cannot sign an AMD.

Family members /responsible or eligible persons



- In traditional Chinese culture, family factors and views of family members are important considerations.
- Depending on circumstances, family members may assume the following roles:
  - ➢ Understand the wish of the mentally capable adult patient, and take up the expected role in the future care plan;
  - ➢ Provide input on the prior wish or preference of a mentally incapable adult patient so that the medical team can work out a care plan with the family by consensus building based on the best interests of the patient; and
  - ➢ Parents of a minor can communicate with the medical team and arrive at a consensus, taking into consideration all the aspects stated above.
- Family support is important to the patient. We understand that the family may be under stress. Should they need assistance, healthcare workers are ready to help.

However, in situations when the immediate family members of the patient are not available, other responsible persons including the legal guardian or the cohabitant should be invited to join the discussion. In circumstances when the family members or the responsible persons are not available, the doctor may invite other eligible persons who are close to the patient and care about the best interests of the patient concerned.

Scope of ACP Discussion

Disease	Disease anticipated progression and prognosis
Treatment	Treatment options available, benefits and risks
Patient's preferences and values	• Patient's expectation from treatments. • Preference for treatment limits • Preference for personal care • Personal goals to accomplish
Family members / responsible or eligible Persons	• Family values and concerns • Views and preferences of parents for minors • Prior wish or preference of incapable patients
Other	May include arrangements after death, e.g. funeral process, organ donation, etc.

What is the appropriate timing for ACP discussion?

Regarding the appropriate timing for ACP discussion, first we need to understand the progression of the severe chronic diseases. The state and functional status of these patients would worsen with time, with some experiencing acute deterioration at some point. The length of progression depends on the disease and patient's condition, ranging from a few months to several years. In the later stages, the disease may follow a more rapid and obvious downhill course.

Therefore, if ACP is conducted too late, the mental state of the patient may not allow him/her to participate in the discussion.

On the contrary, if ACP is initiated too early, the patient and family may not have sufficient understanding of the disease and thus psychologically not be ready for the discussion.



The following are some suggestions for the initiation of ACP:

- Significant decline in functional status and level of physical activity, or need to be institutionalized;
- Considerable discomfort in terms of physical and psychological symptoms, and social anxiety;
- Obvious commencement of the final stage, e.g. following multiple hospital admissions, recurrent acute episodes, having experienced an acute severe episode when death is imminent; and
- Futility of disease targeted treatments established and transition from curative treatment to palliative care.

The above may occur in the later stages of the disease. But in some diseases, ACP may be necessary shortly after diagnosis for:

- Patients with dementia when they are still mentally capable in the early stage;
- Patients with cancer diagnosed at a late stage; and
- Some severe diseases such as motor neuron disease that may have a more rapid downhill course after diagnosis.

What follow-up is needed after the ACP?



✦ The discussion is not one-off

The ACP is an ongoing process. Consensus may not be reached via one single discussion, and review may be required as the patient's condition or preference changes.

✦ Details of the ACP discussion should be documented to facilitate continuity of care

Healthcare workers will document the details of the ACP discussion, including the patient's preference and choice. The results of discussion may be documented in the ACP form. When the patient is critically ill and has lost capacity, clinicians can make reference to these records and provide appropriate care respecting the patient's wish.

✦ A mentally capable adult patient may choose to make an AMD as necessary

5 What is an advance medical directive (AMD)?

A mentally capable and properly informed adult patient aged 18 and above can make an AMD, explicitly expressing his/her wish to refuse specified life-sustaining treatment (LST) in pre-specified conditions when he/she is in an end-stage condition and mentally incapable of making health care decisions. 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 comes into effect on 31 July 2026.

Use of AMD in Hospital Authority (HA)

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) as follows. While the use of model AMD forms is not compulsory under the Ordinance, it is strongly preferred and should be encouraged. The model AMD form covers the following preconditions (a), (b), and (c). HA does not provide non-model AMD forms for conditions beyond the scope of the model AMD form. The Ordinance also provides a statutory DNACPR form with continuing basis, applicable to the same scope of 3 preconditions as in the model AMD form.

a. Terminally Ill

"Terminally ill" means suffering from an advanced, progressive, and irreversible disease, and failing to respond to curative therapy, having a short life expectancy in terms of days, weeks, or a few months; and the application of LST would only serve to postpone the moment of death.

b. Persistent Vegetative State (PVS) or irreversible coma

c. Other End-Stage Irreversible Life-Limiting Conditions:

"Other end-stage irreversible life-limiting condition" which means suffering from an advanced, progressive, and irreversible condition not belonging to the above (a) or (b), but has reached the end stage of the condition, limiting the survival of the patient. Examples include: (i) patients with end-stage renal failure, end-stage motor neuron disease, or end-stage chronic obstructive pulmonary disease who may not fall into the definition of terminal illness in precondition (a) because their survival may be prolonged by dialysis or assisted ventilation, and (ii) patients with irreversible loss of major cerebral function and extremely poor functional status who do not fall into precondition (b).

Points to Note for Making an AMD

- The HA AMD form* must be signed by the patient and two witnesses, one of whom must be a registered medical practitioner in Hong Kong. Both witnesses should be adults with no interest in the estate of the maker.

- A completed AMD is the property of the patient. The patient and family have the primary responsibility of keeping it, and presenting the original copy to the clinicians on the patient's admission. The patient's directive will be in effect if the AMD is valid and applicable. A standard pouch would be provided to keep these forms. Patients may also choose to upload a digital copy of the AMD to the designated electronic system when it is ready (Electronic Health Record Sharing System, eHRSS). This is encouraged as the electronic copy of the AMD shall serve as a validating copy when the patient or family members forgot to bring the paper copy. The patient and family members should be advised to take proper steps in storage and presentation of the forms to healthcare workers as needed, and to inform other family members or carers about where the forms are kept.

- If the patient changes his/her mind after making an AMD, the medical team should be informed as soon as possible with the AMD document amended or revoked. In case there are different versions and discrepancies, the latest dated copy of the AMD, be it in paper or in digital form, shall be assessed by the doctors as the validating copy.

- An AMD is in effect only when the patient is no longer mentally capable of making decisions and confirmed by the doctors as suffering from the pre-specified conditions stated in the AMD. If the clinicians think the applicability of the AMD (e.g. the coma is caused by other factors) or the validity of the document (e.g. being damaged) is in question, the doctors shall provide emergency treatment as clinically indicated.

- If an AMD is applicable and valid, clinicians have the responsibility to follow the directive. No one can revoke the AMD made by the patient.

- The Ordinance also makes provisions for making, revocation and operation of DNACPR orders on a continuing basis and has provided statutory or prescribed DNACPR forms for mandatory use. The DNACPR orders with continuing effect include 2 categories, firstly, the AMD-based DNACPR order for a mentally capable adult who makes an Advance Medical Directive (AMD) for refusal of CPR and secondly, the non-AMD-based DNACPR orders for mentally incapable adults and minors who are unable to make AMD. The Ordinance does not cover hospitalised DNACPR orders on an episodic basis.

* Advance Medical Directive Form:

6 Overcome Barriers to Advance Care Planning (ACP)

It is understandable people are often reluctant to discuss topics about illness, loss of mental capacity and death. Discussing death is considered a social taboo and people think this would bring bad luck. However, birth, aging, sickness and death are in fact the inescapable realities of life. Now with a rapidly aging population, there is even a greater need to know more about ACP.

It is not good to discuss this... or talk about it later.

The patient and family may be concerned about the subject, or lack the necessary skills, or worried about possible emotional outbursts resulting from the discussion of this serious topic. Healthcare workers can assume a coordinating role in the communication process and deal with emotions. Traditional Chinese people are often more subtle and hope the others can understand their meaning behind. However, healthcare decision-making is a complicated process. It is advisable to make use of the appropriate time when the patient can make autonomous decisions before his/her illness progresses to an advanced stage.

The healthcare workers are too busy!

In a busy clinical environment, it is not easy to initiate ACP discussions. Special arrangements may be needed for such a purpose, and the discussion is not a one-off. The patient, family, and healthcare workers may need to find time and conduct ACP through concerted, ongoing efforts.

Will the patient become down-hearted and depressed?

The patient's family may worry such discussions would inflict negative emotions on the patient. However, a lot of literature reveals that patients generally hope their "right to know" is respected. Telling lies and withholding facts will make the patient feel uneasy and cannot help them face up to the illness or make the necessary arrangements for his/her life thereafter. Healthcare workers will conduct the discussion sensitively with skills, avoiding a rigid or forcing approach.

Will the doctor give up on me because I refuse life-sustaining treatment (LST)?

Healthcare workers will never give up on patients. Such anxiety is unnecessary. Even if LST is withheld, effective relief from pain and other distressing symptoms would be continued. For incurable end-stage diseases when dying is unavoidable, the care approach would change from curative to palliative, ensuring the patient a peaceful and respectful death.

What are the advantages of ACP?

Patients' right to know	The patient needs healthcare workers to provide sufficient information, such as disease prognosis, the benefits and burdens of LST, as well as clarifications on the meaning of "withholding LST," before he/she can make an informed choice. ACP is a good chance for the patient and family to gain an in-depth understanding of the illness.
Respect patient autonomy	Modern healthcare puts emphasis on patient engagement. Mentally capable adult patients have the legal right to autonomous decisions, including refusing or accepting specified treatment and care. ACP provides an opportunity for a terminally-ill patient to exercise autonomous decision-making, by expressing in advance wishes about his/her values and preferences and refusal of LST. In the future when the patient is no longer capable of making decisions, his/her directive would be respected by the medical team and family members.
Of best interests to the patient	When considering what is in the patient's best interests, it is more than a healthcare issue. In balancing benefits and burdens, one has to take into consideration the patient's wish, values and beliefs. If the patient is unable to express himself/herself, views of family members concerning the patient's values, preferences, cultural and religious beliefs should be solicited to determine what is in the best interests of the patient.
Avoid future disputes	Healthcare workers, the patient, family and carers may have different views on life as well as LST. If they can deal with any disagreement and conflicts through open communication as early as possible and acknowledge the patient's wish, this can avoid disagreement and conflicts between the healthcare workers and the family over decision making in the patient's terminal phase. In this way, the patient's right to a peaceful death is ensured.
Promote family relationships	In the course of discussion, healthcare workers will encourage and guide the patient to express his intrinsic values and preferences which may rarely be or not facilitated to be discussed at home. If the family knows more about the patient and his/her wish, this would in turn shape the care for the patient.
Reduce suffering at the end of life	If the patient has decided to refuse futile LST and opts for a natural and respectful death, this can reduce unnecessary suffering of the patient and relieve the grief of the family.

7 Besides patients with advanced illnesses, should healthy people also initiate advance care planning (ACP) or make an advance medical directive (AMD)?

- In the Hospital Authority setting, ACP and AMD are mainly for patients with advanced irreversible illnesses. For the relatively healthy patients in HA with such request, the doctor may encourage the patient to have discussion among the family and responsible or eligible persons, or suggest the patient to obtain more information on ACP from HA websites or even seek for services in the community. This does not preclude the doctor from offering advice or assistance as his/her work arrangement permits.

- A sudden stroke or brain injury may cause a person to fall into a persistent vegetative state or an irreversible coma. It is thus reasonable that a healthy person would make prior treatment decisions for such conditions. But for a person without illness, it is debatable whether he/she should make treatment plans for a terminal illness:

  - As many diseases can progress to a terminal stage and the symptoms and treatment outcomes of various diseases are different, a person needs a vast amount of complex medical information before he/she can make a meaningful directive;

  - For most terminal diseases, the patient is still conscious at the time of diagnosis. As the patient knows by then what kind of disease he/she is facing with, it is easier to make decisions; and

  - The patient's acceptance of disease symptoms and disability may change with his/her bodily condition. Therefore, it may not be appropriate to make decisions too early.

- While noting the challenges in making an AMD by a healthy adult, getting to know early what are life sustaining treatment, ACP and AMD can facilitate a person's discussion with clinicians once unfortunately falling ill. Discussing with the family the practical arrangements and expressing one's values regarding the dying process at an appropriate time is also helpful.

8 Enable Rescuers to Find the DNACPR Orders

After the Advance Decision and Life-sustaining Treatment Ordinance is in act, rescuers such as fire services personnel and ambulance crew will follow the DNACPR order NOT TO perform CPR as long as the DNACPR order presented is valid and applicable. As the rescuers are not obliged to search patient belongings, patients/families and carers should put the DNACPR order inside the standard pouch provided by HA. The pouch should be kept in a safe, visible and reachable location for easy identification and quick access by families, carers and rescuers.

9 Special Circumstances

If the patient is under the age of 18, what can the parents do?

Same as adult patients mentioned above, people under the age of 18 may also suffer from terminal diseases. Parents of these minors should discuss in advance with healthcare workers the most appropriate care plan for the patient. This is to avoid making hasty decisions by the parents when the patient falls into a critical condition, thus generating anxiety, confusion, guilt and conflicts. As the patient has not reached the legal age to sign an advance medical directive (AMD), healthcare workers would discuss with the patient and parents via an advance care planning (ACP) process. Details of the ACP discussion will be documented in the patient's medical record. The clinical team would provide the most appropriate care in accordance with the consensus reached. When the patient's condition deteriorates, the information can serve as important reference.

- Children are encouraged to take part in the discussion. However, the extent of participation depends on the patient's mental maturity as assessed by the doctor.



Dementia

Background

Dementia is a broad category of brain diseases that cause a severe decline in mental ability. This is not a normal process of aging. The death of brain cells leads to mental deterioration and gradual cognitive decline that can affect daily life. Dementia is common in people aged over 65, but also seen in middle-aged people. The most common type of dementia is Alzheimer's disease, which makes up 50% to 75% of cases. Other types include vascular dementia, Lewy body dementia and frontotemporal dementia. Patients confirmed with dementia would gradually experience in the following several years short-term memory loss, weakened self-care ability, difficulty in expressing and understanding language, decreased ability in thinking and judgement, and disorientation to person, time and space.

As the disease progresses, the patient would gradually lose the ability to make decisions. Appropriate care planning enables the patient to enjoy better quality of life, ensuring his/her wish being respected and followed.

Diagnosis of early stage dementia

At the moment dementia is diagnosed, the patient and the family begin to face a big challenge. The patient usually experiences complex emotions such as disbelief, shock, anger and grief which are all natural reactions. Thereafter, the patient should take advantage of the early phase when his/her mind is still sound to discuss ACP with the family and medical team, or even make an AMD if considered appropriate, ensuring he/she can have the preferred choice of care. If ACP is conducted too late, the patient may not be able to participate in the discussion due to cognitive impairment and thus his/her preferred option of care cannot take effect.

Advanced dementia

As elderly patients with dementia enter the advanced stage, many of them would lose the ability to make decisions. If they have not conducted ACP or made an AMD, the medical team can only discuss "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) with the family with regard to the patient's end-of-life care. Family members/responsible or eligible persons may have to express their views on DNACPR as the patient has not expressed prior wishes about his/her care preferences. Having to do so, family members may feel anxious, guilty and stressed. Therefore, conducting ACP in the early stage of dementia can reduce unnecessary stress on the family, with the choice of the elderly patient being understood and respected.

10 Patient Stories



A Patient with Cancer

Oi-ming was an optimistic and cheerful woman aged 70. She was married and lived happily with her husband and two daughters. She had always been healthy until two years ago she was diagnosed with colon cancer. She underwent surgical resection but half a year later the cancer spread to the lungs. She refused chemotherapy and radiotherapy and chose traditional Chinese medicine for treatment. A palliative care team helped her to manage her discomfort. She had not been admitted to hospital for over a year. She attended outpatient palliative care and day rehabilitation program regularly and established good relationships with the palliative care team. Three months ago, Oi-ming's functional course went downhill, presented with shortness of breath, decreased appetite, fatigue and pleural effusion.

She had made it clear to the medical team her refusal of any invasive treatment and did not want futile treatment just to prolong her survival. She was not afraid of death. She told the doctor her family would miss her and they hoped she could live longer. But she had a different view and worried her family might put her on unnecessary life-sustaining treatment. To facilitate Oi-ming in making a properly informed healthcare choice and enable her family to understand her decision, the doctor met Oi-ming and three of her family members to discuss advance care planning (ACP). This was to ensure they knew Oi-ming's values, preferences and rationale for her choice which would be respected by healthcare workers. During the ACP process, Oi-ming made an advance medical directive specifying what treatment she did not want.

Oi-ming also made preparations for the arrangement after death. She let her family know that she had not given up on her life, and had lived a contented life. She hoped her family could accede to her wish for a respectful death. Oi-ming did not change her mind thereafter, and opted to receive palliative care only. Her family understood and respected her choice. Eventually she died peacefully in the presence of her family members.

A Patient with Dementia



Ms Lee, aged 70, had been diagnosed with early signs of Lewy body dementia. According to the doctor, her disease might progress with a faster course of deterioration than that of Alzheimer's disease (a more common form of dementia), likely to present with serious Parkinson's disease symptoms and hallucination, loss of the ability of decision-making and feeding problems in the advanced stage. Many similar late-stage patients need to rely on nasogastric tube feeding and become bed-ridden, with the quality of life seriously affected. Discussions on ACP were then conducted between the doctor and Ms Lee with her family. Since Ms Lee did not want to receive invasive treatment in the final stage, she had decided not to accept nasogastric tube feeding and cardiopulmonary resuscitation (CPR), and her wishes regarding her future treatment plan were documented in the ACP.