

Medical Guidelines

31 July 2026

Copyright notice of the Guardianship Board

© Copyright of the Guardianship Board. Reproduction of this Guide in whole or in part is permitted only with prior written permission from the Guardianship Board.

A. Introduction

1. The Mental Health Ordinance (“MHO”), Cap. 136 sets out the statutory framework for the care and supervision of mentally incapacitated persons.
2. The definition of a mentally incapacitated person (“MIP”) is found in section 2 of the MHO and involves several technical terms. A “*mentally incapacitated person*” means, for the purpose of guardianship to which paragraph (b) of that definition applies, a patient or a mentally handicapped person. A “*patient*” is defined in section 2 as a person suffering or appearing to be suffering from mental disorder. “*Mental disorder*” is broadly defined in section 2. “*Mental handicap*” is also defined. According to section 2, “*mental incapacity*” means mental disorder or mental handicap, and “*mentally incapacitated*” is construed accordingly. However not all MIPs require guardianship.
3. Part IVB of the MHO governs the appointment of guardians for MIPs who have attained the age of 18 years (adults). Part IVC deals with the medical and dental treatment of MIPs.
4. Part IVC of the MHO applies to treatment or special treatment where the MIP is incapable of giving consent to the carrying out of that treatment (section 59ZB(2)). It does not apply if the MIP is in a mental hospital or a Correctional Services Department Psychiatric Centre or is under a supervision and treatment order made under Part IIIB (section 59ZB(1)).
5. The provisions in Part IVC apply to all types of medical treatment and not just psychiatric treatment. As far as the applicable principles are concerned, there is no essential difference between medical treatment and dental treatment. Doctors and dentists are collectively described as “Medical Professionals”. This Guide serves as an introduction to Medical Professionals on the use of Part IVC and on other issues relating to guardianship applications. For a quick visual presentation, please refer to the Chart on the last page of this Guide.
6. For arrangements related to advance directives involving MIPs, please refer to Part I of this Guide.

B. Can Mentally Incapacitated Persons Consent to Treatment?

7. In many cases, the MIP concerned may retain some capacity to make decisions. Where decision-making about consent to treatment is concerned, the operative test under the MHO is whether the patient is capable of understanding the general nature and effect of the relevant treatment, the consequence of consenting to or refusing treatment and is task-specific. This standard should be familiar to Medical Professionals as a general test of consent to treatment.
8. If it appears to the Medical Professional that a patient has difficulty giving consent, then the provisions and mechanisms of the MHO should be referred to. The Medical Professional needs to consider whether the patient is already designated as an MIP under the guardianship framework of Part IVB. If there is no record of guardianship for the patient and his/her mental capacity remains in doubt, a formal assessment should be conducted by the Medical Professional or referred to an approved doctor (psychiatrist) where required. For further information about mental capacity assessment, please read Part J of this Guide.

9. If the MIP retains sufficient capacity to decide on his/her own treatment, the Medical Professional should respect the decision. If the treatment can be postponed to a time when the MIP may recover the competence to make a decision, that option should be considered. The provisions of Part IVC may be helpful if a decision is reached that the patient is incapable of giving consent, but that the treatment ought to proceed. The Medical Professional should decide on a case-by-case basis and clearly document the decision in the medical records.
10. When the matter involves forensic examination, such as adult sexual violence cases, the Medical Professional must proceed with caution. Please also refer to the Social Welfare Department's Procedural Guidelines for Handling Adult Sexual Violence Cases (Revised 2021).

C. When to apply for Guardianship

11. There is no need to apply for guardianship in most cases.
12. If the MIP has the capacity to consent for the treatment concerned, he/she should make his/her own decision on medical treatment (see Part B of this Guide).
13. If the MIP is unable to consent, the Medical Professional can provide **urgent medical treatment**, which is necessary and in his/her best interests without his/her consent (section 59ZF(1)).
14. If the MIP is unable to consent, the Medical Professional can also provide **non-urgent medical treatment**, without obtaining the patient's consent if the treatment is necessary and is in the patient's best interests (section 59ZF(3)). However, the Medical Professional must first take practicable steps to ascertain whether the MIP has a guardian or there is, or appears to be, no guardian appointed (section 59ZF(2)(a)) or the guardian has no consent power (section 59ZF(2)(b)). In rare situations where a guardian exists but cannot be reached in time, the Medical Professional must decide on a case-by-case basis, whether the matter was urgent enough to proceed under subsection (1) after all or to apply for guardianship or a court order if the matter was controversial.
15. If a family member of the MIP has reservations or objects to medical treatment in situations not covered above, that family member or another family member, the relevant Medical Professional or a social worker may apply to the Guardianship Board ("Board") to have a guardian appointed to make the decision and give consent where it is considered that the treatment is in the best interests of the MIP. If the MIP personally refuses or resists treatment that is proposed in his best interests and reacts strongly against it, the Medical Professional may also find it appropriate to apply for guardianship or a court order (see Part I of this Guide).
16. There must be clear understanding of what constitutes "treatment" and "special treatment" under Part IVC. For "special treatment", namely those treatment of an irreversible or controversial nature specified by the subsidiary legislation of the MHO under section 59ZC, the Medical Professional cannot make use of section 59ZF and must seek court approval under section 59ZD and satisfy the test under section 59ZJ. The Mental Health (Specification of Special Treatment) Notice 1998 has included sterilization operations

(except for operations that are intended primarily to treat other diseases of the reproductive system but having the effect of sterilization) as a special treatment. Organ transplant from the MIP to another person is prohibited outright by section 59ZBA.

17. The Medical Professional should in all these cases provide sufficient information to the family member or social worker concerned about the benefits and risks of the treatment, why it was necessary, why it was in the best interests of the MIP and what factors the guardianship applicant or proposed guardian should reasonably consider in making the decision and giving consent on behalf of the MIP.
18. The internal guidelines of the cluster or hospitals of the Hospital Authority may provide further conditions which the Medical Professional working in the Hospital Authority should follow and comply with. In all cases, there should be good documentation of the decision-making process in the medical records.

D. Applying for Guardianship

19. If the Medical Professional wishes to apply for guardianship of a patient, he may do so under section 59N(1)(c). The Medical Professional may find it appropriate to recommend a family member of the patient or the Director of Social Welfare to act as guardian. It is uncommon for the Medical Professionals to act as guardian themselves.
20. When Medical Professionals intend to apply for guardianship, they should familiarize themselves with the general principles regarding guardianship, not only in respect of the procedures but also the ethical considerations involved. Please refer to the Board's website for more information about how to make guardianship applications.
21. Medical Professionals involved in an application to the Board, in whatever capacity (but especially if they are the treating doctors), may be requested by the social enquiry report writer, representing the Director of Social Welfare, to provide information about their patients, to attend hearings for considering guardianship applications or subsequent reviews. Part H of this Guide provides a sample of the types of questions that they may asked to assist the Board with regard to consent to treatment issues.
22. The common documents involved in the process of a guardianship applications are the *Approved Doctor's Medical Report for Guardianship Application* and the *Registered Medical Practitioner's Report for a Guardianship Application*. Both forms are available for downloading from our website. Medical Practitioners may also be requested to complete Medical Enquiry Forms addressed to them from a representative of the Director of Social Welfare, requesting certain information to be placed before the Board, either during the reporting stage or for upcoming hearings.
23. The Board will, in every application for guardianship, consider the recommendations of the Director of Social Welfare as set out in the social enquiry report made under the MHO and conduct a hearing to decide whether there is any alternative to guardianship and if not, who is the appropriate guardian of the MIP concerned. If there is no suitable candidate for private guardians, the Board will appoint the public guardian, namely the Director of Social Welfare.

E. Guardian's powers to Consent to Medical Treatment

24. Under section 59R(3), a guardian appointed by the Board may be given one or more of the following powers:
- (a) to require the MIP to reside at such place as may be specified by the guardian.
 - (b) to convey, or to arrange the conveyance of the MIP to the place so specified by the guardian, and such reasonable force may be used as is necessary for the purpose.
 - (c) to require the MIP to attend at places and times so specified by the guardian for the purpose of medical or dental treatment or occupation, education or training.
 - (d) to consent to medical or dental treatment on behalf of the MIP, but only to the extent that the MIP is incapable of understanding the general nature and effect of such treatment.
 - (e) to require access to the MIP to be given at any place where the MIP is residing, to any doctor, approved social worker or community nurse.
 - (f) to hold, receive or pay the monthly sum on behalf of the MIP for the maintenance or other benefit of the MIP as if the guardian were a trustee of that monthly sum. The maximum monthly financial limit of that sum is governed by the Quarterly Report on General Household Survey by the Census and Statistics Department.
25. Medical Professionals should always check what specific powers were given to the guardian in question and not assume that all guardians have been given the powers to give consent to medical treatment (section 59R(3)(d)).

F. Standard Conditions of Guardianship

26. Section 59S requires the guardian to bear in mind the interests and welfare of the MIP. The requirements are included in the Guardianship Order as standard conditions. The general term "Subject" is used to refer to an MIP who is the subject of guardianship cases. The Standard Conditions are:
- (a) that the interests of the subject are promoted by the guardian, including overriding the views and wishes of the subject, where the guardian considers that such actions are in the subject's interests; despite that, that the views and wishes of the subject are, in so far as they may be ascertained, respected;
 - (b) that a private guardian shall comply with the Mental Health (Guardianship) Regulations (Cap. 136 sub. leg. D);
 - (c) the guardian, when considering whether or not to give consent to the carrying out of medical or dental treatment, shall observe and apply the following principles, namely to:
 - (i) ensure that the subject is not deprived of the treatment merely because the subject lacks the capacity to consent to the carrying out of that treatment; and
 - (ii) ensure that any treatment that is proposed to be carried out on the subject is carried out in the subject's best interests.

- (d) the guardian is under a legal duty to act as if the guardian were a trustee of the monthly sum. The duties of a guardian include: -
- (i) the guardian must keep proper records and accounts (in case of private guardian) in the Board's standard Monthly Statement form; and submit the records with relevant receipts to the caseworker for checking monthly;
 - (ii) keeping the money of the subject in the guardian account, separate from the guardian's own money; and
 - (iii) not to enter any financial transaction in which the guardian would have a conflict of interest with the subject.

G. Determining Best Interests

27. If the Medical Professional and the guardian can agree on what approach and treatment would be in the best interests of the MIP, then they may proceed accordingly. If they are unable to agree, the Medical Professional working in the Hospital Authority can refer the case to the clinical ethics committee of the hospital/cluster concerned for consultation and guidance. The Medical Professional in the private sector may refer the case to the ethics committee or advisory committee of the hospital, if available, for consultation and guidance.
28. If the matter cannot be resolved by consensus or involves important ethical issues that merit serious consideration, the parties may find it necessary to seek a court order. Section 59ZA defined "in the best interests" of the person concerned to include to (a) save the life of the person, (b) prevent damage or deterioration to the physical or mental health and well-being of that person or (c) bring about an improvement in the physical or mental health and well-being of that person. In applying the principles stipulated in the Ordinance, the Board will be guided by applicable case law in Hong Kong. The court said that the term "well-being" used in the definition was a broad inclusive term which concurred with the meaning given in the common law to the "best interests" of a patient. According to case law, the best interests of a patient in common law are not limited solely to best medical interests, nor are best interests limited solely to what is necessary. The broader nature of "best interests" also involved, if not required, the doctor applying the best practice of consulting relatives and others who are concerned with the care of the patient, sometimes with other specialists, or even an inter-disciplinary team. The best interests involved were not limited simply to what was necessary to keep the patient clinically alive but embraced a broader range of factors, especially what the patient would have wished. In other words, best interests of a patient were not limited to medical issues and may include relevant information about the patient's circumstances and background. If available, such information could assist the Board to assess what would be material for that patient concerned.¹ The court also clarified that in deciding whether a certain treatment would be in the best interests of the patient, the doctor can apply the same test as in making other decisions, namely to act reasonably in accordance with a responsible and competent body of relevant professional opinion.

¹ Case references: *F v West Berkshire Hospital Authority* [1989] 2 AC 1, *The Hospital Authority v C* (HCMP 479/2003), *Re MB* [1997] EWCA Civ 3093.

29. It is understood that this approach is in line with the approach of the Hospital Authority. These principles will be the starting point of any discussions on the determination of relevant issues relating to “best interests”, subject to arguments that may be brought by any party, before the Board.

H. Questions to be considered at the Hearing when Consent to Treatment is involved

30. Medical Professionals may be requested to attend hearings of the Board. This could happen when they are applicants or expert witnesses. Where the case involves the topic of consent to perform operations or other invasive treatment, the Medical Professionals may find it useful to get prepared on the following issues which the Board would usually be interested about:
- (a) the nature of the treatment, how long the treatment would take and the period required for rehabilitation or recovery;
 - (b) what are the benefits, risks and side effects of the treatment?
 - (c) whether there are additional risks in view of the patient’s age and health condition?
 - (d) what are the viable alternative management option(s) apart from the current/proposed treatment?
 - (e) the process of seeking consent from the patient directly, if any, and the details of any assessment showing that the patient was not capable of understanding the nature and effect of the treatment;
 - (f) whether there has been any difference of opinion within the team or division of Medical Professionals as to whether to proceed with the treatment;
 - (g) an assessment of whether the Medical Professional could proceed under Part IVC of the Ordinance and if not, the rationale;
 - (h) what would be the approach taken if the MIP refuses treatment?
 - (i) what the Medical Professional considered to be in the MIP’s best interests;
 - (j) any precedent cases for the Board’s consideration?

The list is not exhaustive and other questions may be asked to address the needs of specific cases.

I. Special considerations

31. Part IVC provides a mechanism for applications to the Court of First Instance under section 59ZG as may be required, for instance, if special treatment for an MIP is required, when guardians are unable or unwilling to give consent without good reasons concerning a request under section 59ZE, or when guardians have failed to properly observe applicable principles and refused treatment.
32. To give some examples, a direct application to the Court of First Instance may be appropriate and more efficient in complicated cases where Medical Professionals believe that a private or public guardian, even appointed, might not be able to perform their role properly due to, say, insurmountable resistance by certain family members or other special circumstances e.g. existence of a dubious advance directive, strong religious beliefs or convictions, or important ethical issues or controversies such as where life-sustaining treatment are involved. Consultations with the clinical ethics committees and internal legal

advice from the organization where the treating doctor is based at should be sought as soon as possible in these circumstances.

33. As from 31 July 2026, the new provisions of the Advance Decision on Life-sustaining Treatment Ordinance, Cap. 651 (《維持生命治療的預作決定條例》) (“ADLSTO”) will apply, creating a statutory basis for advance medical directives (AMD) and do-not-attempt cardiopulmonary resuscitation (DNACPR) orders. Section 72 of the ADLSTO disapplied sections 59ZD(1), 59ZE and 59ZF of the MHO concerning life-sustaining treatment (LST) for (*for AMD and other valid directives*) and CPR (*for DNACPR orders*). Medical Professionals should note the scope of the new provisions and areas in which a guardian’s power of consent remain unaffected. The Chart shown in this Guide is premised on there being no issue relating to LST and CPR.
34. When there is no valid AMD or DNACPR order made by the MIP prior to loss of mental capacity, the ADLSTO permits the MIP’s attending doctors to make a DNACPR order in the prescribed form in respect of an adult who is mentally incapable of deciding on a life-sustaining treatment in certain specified conditions. Under section 47 of the ADLSTO, a guardian appointed under Part IVB of the MHO, together with other responsible persons, may be invited to co-sign the DNACPR in the specified circumstances to indicate consensus. This power provided by the ADLSTO is in addition to the guardians’ powers under the MHO. It should be noted that the applicable scope of section 47 is narrower than the definition of an MIP and it would be up to the attending doctors, not a guardian, to initiate the process. A DNACPR order is understood, according to the prescribed form, to be made on the basis that performing CPR in such circumstances would not be in the subject person’s best interests.
35. For an DNACPR order to be effective, it is not mandatory for the guardian to be the selected responsible person to co-sign the Order. The Board adopts a neutral view as to the role a guardian wishes to play in the process.
36. Should the attending doctors consider that the guardian of an MIP would be the most suitable person to co-sign a DNACPR order, they may wish to check whether the guardian’s appointment is effective on the day in question and would not shortly expire according to the terms and effect of the relevant guardianship order.
37. Where end-of-life issues are involved, the Board expects guardians and Medical Professionals to accord dignity to persons under guardianship and to act with reverence and caution when performing their respective roles. The Board will comply with the ADLSTO and refer to the Hong Kong Academy of Medicine’s Best Practice Guidelines on Advance Medical Directives (2025) and any promulgations made from time to time from the Hospital Authority and the Government in the first instance, when being required to determine any question affecting guardians. Medical Professionals may wish to first seek to resolve any problems involving a guardian or an MIP with their own governing bodies or seek appropriate advice as envisaged in paragraph 32.

J. Quick Guide to Mental Capacity Assessment

38. The Board follows certain general principles applied in the medical field in respect of mental capacity assessment, for instance:

- (a) all adult patients are presumed to have mental capacity to make treatment decisions, unless there is evidence suggesting a lack of such capacity;
 - (b) a formal assessment of an adult patient's capacity is only necessary where there is concern that he is incapacitated; and
 - (c) before such an assessment is undertaken, reasonably practicable steps that will enhance a patient's capacity, competence or communication should be taken in advance. Communication difficulty due to language barrier, hearing loss, for example, or other extraneous factors should be overcome and not taken from granted as symptoms of incapacity.
39. Medical Professionals should bear in mind that different levels of mental capacity are required for different tasks. The risks and benefits of the treatment and also the consequences if the patient refused treatment are relevant. A higher level of mental capacity is required when making decisions with serious consequences (e.g. refusal of heart surgery) than decisions with far less serious consequences (e.g. refusal of a cough medicine).
 40. A valid informed consent is based on the presence of task-specific mental capacity and voluntariness (absence of undue influence). In this context, mental capacity refers to a person's ability to make valid decisions regarding the proposed medical or dental treatment.
 41. A person is deemed mentally capable if he/she can understand, appreciate and weigh the respective benefits and risks of available treatment options (including no treatment) as proposed by the treating Medical Professionals, and be able to clearly indicate his/her own choice with the rationale behind.
 42. The Medical Professionals giving medical reports or opinions to the Board may be required to address claims by the MIPs or their family members that the MIP was no longer mentally incapacitated. In such cases, the Board will usually require parties and their experts to produce further assessment reports and/or attend hearings if the issue is contentious. While most cases are straightforward, Medical Professionals should be aware of the importance of their reports/opinions and be always equipped to meet possible challenges made to their professional opinions. Written reports, opinions or responses may be disclosed to relevant third parties in this context.
 43. Formal medical capacity assessment is a highly complex area. Medical Professionals should consult with colleagues with relevant specialist qualifications and expertise as may be required for each case.

K. Where to look for Guardians under Part IVB

44. The Guardian of a Subject has a duty to inform Medical Professionals who treat or operate on the Subject that the latter is under a Guardianship Order. However Medical Professionals should not rely totally on this, and should double check themselves when there are needs to treat or operate on a mentally incapacitated patient and the circumstances suggest that the patient might possibly be under guardianship.

45. For public sector patients, the Board has, with the Hospital Authority and the relevant dental establishments, respective long-standing arrangements for checking the patients' guardianship status. Medical Professionals in the public sector should follow their internal checking processes.
46. For private sector patients, Medical Professionals should specifically ask the family members of the Subject and if in doubt, contact the Board for enquiries.
47. The Board only reveals information of Subjects and Guardians on a need-to-know basis in the interest of protecting the privacy of Subjects. All other persons including Medical Professionals who wish to obtain such information must provide a written request to the Secretariat with succinct reasons for the enquiry and proof of relationship with the Subject.

.....

For more information, please contact the Guardianship Board:

Address : Unit 807, 8/F	Tel : 2369 1999
Hong Kong Pacific Centre	Fax : 2739 7171
28 Hankow Road, Tsimshatsui	E mail : gbenquiry@adultguardianship.org.hk
Kowloon, Hong Kong	Website : www.adultguardianship.org.hk

.....

IMPORTANT NOTE:

The information in this leaflet is for general guidance only and does not purport to be legal advice given by the Guardianship Board.

GUARDIANSHIP BOARD

Chart on Part IVC, Mental Health Ordinance (“MHO”)

