File Ref: HHB CR 2/581/23

LEGISLATIVE COUNCIL BRIEF

Advance Decision on Life-sustaining Treatment Ordinance
(Chapter 651)

ADVANCE DECISION ON LIFE-SUSTAINING TREATMENT ORDINANCE (COMMENCEMENT) NOTICE

INTRODUCTION

Pursuant to section 1(2) of the Advance Decision on Life-sustaining Treatment Ordinance (the Ordinance), the Secretary for Health (S for H) has made the Advance Decision on Life-sustaining Treatment Ordinance (Commencement) Notice 2026 (Commencement Notice) (at
A **Annex A**) for appointing 31 July 2026 as the day on which the Ordinance comes into operation.

BACKGROUND AND JUSTIFICATIONS

2. The Health Bureau (HHB) commenced the legislative exercise for the Ordinance in 2023 to provide a legal framework for Advance Medical Directives (AMDs) and Do-not-attempt Cardiopulmonary Resuscitation orders (DNACPR orders), including provisions on their making, issuance, revocation, validity and applicability, as well as the model/statutory forms, etc. The Ordinance was passed by the Legislative Council on 20 November 2024 and gazetted in the same month. Following the passage of the Ordinance, the HHB has coordinated proactively with relevant government departments and stakeholders (including the Hospital Authority, private hospitals, relevant healthcare professional bodies, residential care homes, non-governmental organisations, as well as emergency service organisations) to take forward the corresponding preparatory work. At present, all the preparatory work has been completed. On 8 May 2026, the HHB reported to the Legislative Council Panel on Health Services on the preparatory work and detailed arrangements for implementing the Ordinance (the relevant discussion
B paper is at **Annex B**), and obtained the Panel's support.

3. Pursuant to section 1(2) of the Ordinance, the Ordinance will come into operation on a date to be appointed by the S for H by notice published in the Gazette. In this connection, the S for H has made the Commencement Notice and appointed 31 July 2026 as the date on which the Ordinance (except part 6[1] and section 73[2]) and the relevant legislative amendments, will come into operation.

4. Leading up to and following the commencement of the Ordinance, the HHB will continue to collaborate with relevant healthcare professional organisations to provide training on the Ordinance. Concurrently, through public education and promotional activities, the HHB will enhance understanding of the Ordinance among the elderly, patients, persons with disabilities, and their carers. As part of these efforts, the HHB and the "Jockey Club End-of-Life Community Care Project"[3] are currently organising a series of community seminars to explain the key provisions of and implementation arrangements for the Ordinance to the public.

LEGISLATIVE TIMETABLE

5. The legislative timetable is as follows—

Publication in the Gazette	22 May 2026

[1] The Government will implement paper AMDs and electronic AMDs in phases. On 31 July 2026, the paper route of AMDs and electronic storage of such paper AMDs will take effect, whereby the public can decide whether to store their paper AMDs electronically after making one. Part 6 of the Ordinance relates to the making of AMDs by electronic means. Its commencement will be aligned with the Government's arrangements for the digitalisation of AMDs and will be implemented once the relevant functionalities of Electronic Health System (eHealth), training and other preparatory work are in place so as to enable members of the public in need to make electronic AMDs directly on eHealth. The S for H will announce the commencement date separately by notice published in the Gazette in due course. For details, please refer to paragraphs 13–14 of Annex B.

[2] Section 1(3) of the Ordinance stipulates that section 73 concerning the addition of the definition of unprofessional conduct to section 2(1) of the Dentists Registration Ordinance (Cap. 156) shall take effect from the date on which the Dentists Registration (Amendment) Ordinance 2024 comes into operation. As the Dentists Registration (Amendment) Ordinance 2024 took effect on 1 January 2025, section 73 of the Ordinance also came into operation on that date (i.e., 1 January 2025), therefore this commencement notice of the Ordinance does not include section 73.

[3] The "Jockey Club End-of-Life Community Care Project (JCECC)" is an end-of-life (EoL) care initiative launched by The Hong Kong Jockey Club Charities Trust in 2016, aiming to enhance the quality of EoL care in the community and in residential care homes for the elderly through collaboration with universities and various NGOs. The project covers home- and institution-based EoL support, caregiver trainings and public education, etc. With effect from August 2024, the project has been extended to serve persons with disabilities suffering from advanced illnesses, and the "JCECC: Unison" has been launched to support residential care homes for persons with disabilities in implementing EoL care services.

Tabling at Legislative Council for negative vetting	27 May 2026
Commencement Date of the Ordinance	31 July 2026

PUBLIC CONSULTATION

6. The government briefed the Legislative Council Panel on Health Services on 8 May 2026 on the implementation arrangements of the Ordinance, and indicated that the HHB would appoint 31 July 2026 as the commencement date of the Ordinance. The Panel expressed its support.

PUBLICITY

7. A press release will be issued following the gazettal of the Commencement Notice. A spokesperson will also be available to handle media and public enquiries.

ENQUIRIES

8. Enquires on this brief can be addressed to Mr. Leo LI, Principal Assistant Secretary for Health, at 3509 8913.

Health Bureau
May 2026

Advance Decision on Life-sustaining Treatment Ordinance (Commencement) Notice 2026

Under section 1(2) of the Advance Decision on Life-sustaining Treatment Ordinance (Cap. 651), I appoint 31 July 2026 as the day on which the Ordinance (except Part 6 and section 73) comes into operation.

Acting Secretary for Health

19 May 2026

For discussion
on 8 May 2026

Legislative Council Panel on Health Services

Implementation Arrangements for the Advance Decision on Life-sustaining Treatment Ordinance

Introduction

This paper briefs Members on the detailed implementation arrangements for the Advance Decision on Life-sustaining Treatment Ordinance (the Ordinance) and proposes to appoint 31 July 2026 as the commencement date of the Ordinance.

Background

2. The policy objective of the Government is to ensure that terminally ill patients and their families receive appropriate end-of-life (EoL) care services. The purpose of introducing Advance Decision Instruments (ADIs), namely Advance Medical Directives (AMDs) and Do-not-attempt Cardiopulmonary Resuscitation Orders (DNACPR orders), is to respect the wishes expressed by terminally ill patients in relation to life-sustaining treatments.

3. Since 2010, the Hospital Authority (HA) has, pursuant to common law, facilitated terminally ill patients who meet the appropriate clinical conditions to make Advance Directives (ADs) and DNACPR orders. With the increasing public awareness and acceptance of EoL care and ADIs, the numbers of ADs and DNACPR orders made within the HA have continued to rise.[1]

4. After extensive consultation, the Government commenced the legislative exercise for the Ordinance in 2023 to provide a legal framework

[1] From 2012 onwards, the number of ADs made in the HA increased from 325 in 2013 to 2 070 in 2025. Whereas the number of DNACPR orders made in the HA increased from 325 in 2013 to 5 084 in 2025.

for AMDs and DNACPR orders, encompassing requirements related to the making, issuing, revocation, validity, applicability, the use of model/ prescribed forms for AMDs and DNACPR orders, etc. The Ordinance was passed by the Legislative Council on 20 November 2024 and gazetted. The relevant provisions have yet to come into operation pending the designation of a commencement date by the Secretary for Health by notice in the Gazette.

Advance Care Planning and ADIs

5. AMDs and DNACPR orders specified under the Ordinance form part of advance care planning (ACP). ACP is intended for patients suffering from advanced illnesses. Its purpose is to facilitate communication among healthcare professionals, patients, family members and caregivers and, having regard to the prognosis of the disease, treatment options and their pros and cons, as well as the patient's values and wishes, to discuss the patient's future medical and personal care plans in the event of a critical condition. Discussions on ACP generally cover both personal care and treatment aspects. Personal care may include preferred places for receiving care and personal goals that the patient wishes to achieve. The treatment aspect mainly refers to the scope of treatment. Mentally capable adult patients may consider making AMDs at an appropriate time, and doctors may also issue DNACPR orders for patients in need.

6. The appropriate timing for discussing ACP depends on the disease trajectory and the patient's wishes. Discussions on ACP (including AMDs) should neither be too early nor too late. If the discussion commences too early, the patient and family members may lack sufficient understanding of the illness and cannot engage in a thorough and meaningful discussion on ACP; if the discussion commences too late, the patient's understanding and psychological state at the time may no longer allow him or her to participate in the discussion. Therefore, initiating discussions at appropriate clinical trigger points[2] can allow patients, while understanding the disease prognosis, to express their wishes with full mental capacity, and at the same time obviate the need for family members

[2] Common clinical situations include a marked decline in physical function or mobility (such as the need for prolonged admission to residential care homes), the disease clearly entering its late stage, or a shift in treatment from curative to palliative care.

to make treatment decisions hastily when the patient's condition becomes critical.

Principle of "Cautious Making, Easy Revoking"

7. The main purpose of an AMD is to allow adult patients suffering from advanced and irreversible diseases, while they are mentally capable of deciding on a life-sustaining treatment[3], to indicate in advance the life-sustaining treatments that they wish to refuse when they subsequently lose mental capacity and the specified preconditions[4]are met. When the patient's condition reaches the specified preconditions in the AMD, healthcare professionals will follow the patient's wishes and withhold or withdraw the pertinent life-sustaining treatments, and will not incur legal liabilities (see paragraph 12 below). Healthcare professionals will continue to provide basic care and palliative care for the patient, so as to preserve the patient's dignity and comfort at the end of life.

8. Since an AMD is a medical decision made by patients of their own volition, the Ordinance upholds the principle of "cautious making, easy revoking". "Cautious making" is intended to ensure that a maker makes an informed decision after having fully understood and carefully weighed the implications of each instruction, namely, the non-performance of specified life-sustaining treatment when the specified preconditions are met. The Ordinance therefore sets out a number of statutory requirements[5] which must be complied with in the making process. An

[3] Life-sustaining treatments refer to a variety of medical treatments that may potentially postpone a patient's death and include, for example, cardiopulmonary resuscitation (CPR), artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for potentially life-threatening infection, and artificial nutrition and hydration (i.e. the feeding of food and water to a person through a tube). Through an AMD, makers may refuse one or multiple life-sustaining treatments.

[4] The Ordinance provides three specified clinical conditions in the model AMD forms for makers to choose from, specifying the circumstances in which the AMD applies, namely: (i) being terminally ill (i.e. the patient suffers from an advanced, progressive and irreversible medical condition with a short life expectancy in terms of days, weeks or months, where any form of LST would only serve to postpone the person's death); (ii) being in a persistent vegetative state or a state of irreversible coma; or (iii) being in another end-stage, irreversible, life-limiting condition (distinct from the above two categories, referring to a progressive and irreversible condition which has reached its end stage and limits the person's survival).

[5]Legal requirements include: the maker is an adult who is mentally capable of deciding on a life sustaining treatment; all instructions in the AMD are presented in a clear way; the maker of the AMD signs the directive in the presence of not less than 2 witnesses; both witnesses, to the best of their knowledge, are not interested persons of the maker; one of the witnesses is a registered medical practitioner who explains to the maker the nature of the AMD and the effect of following each of the

AMD will only apply under specific circumstances (i.e. where the maker is mentally incapable of deciding on a life-sustaining treatment and the specified preconditions are met), so as to ensure that the decision not to provide or to withdraw life-sustaining treatments is one which the maker had anticipated and understood when making the AMD. To facilitate members of the public with clinical needs in making AMDs, the Ordinance provides model forms to ensure that all instructions are clearly presented and comply with statutory requirements. As regards "easy revoking", this is manifested in the provision of convenient and flexible revocation arrangements. As long as the maker is mentally capable of deciding on a life sustaining treatment, he or she may revoke the AMD at any time orally, in writing or by destroying the document, in order to cater for situations where the maker may need to change the decision in future.

9. AMDs primarily regulate the duties and legal liabilities of treatment providers (i.e. the four categories of healthcare professionals[6] specified in the Ordinance) in administering or withdrawing life-sustaining treatments when the patient has reached the specified preconditions. Regardless of whether the patient is in a hospital or a non-hospital setting, healthcare professionals must comply with an AMD provided that they have notice of it and are satisfied that the AMD is valid and applicable.

10. DNACPR orders under the Ordinance are to ensure that, in environments outside hospitals and even when no healthcare professionals are present, rescuers will act in accordance with the relevant DNACPR orders and will not perform cardiopulmonary resuscitation (CPR) on the patients. The "cautious making" principle is similarly manifested in the issuing of DNACPR orders. A DNACPR order must be signed by two registered medical practitioners (RMPs), one of whom must be a specialist, certifying that the patient has already met the specified preconditions. DNACPR orders fall into two main categories: AMD-based DNACPR orders and non-AMD-based DNACPR orders. RMPs may issue AMD-based DNACPR orders for makers whose AMDs specify refusal of CPR, so as to ensure that rescuers in non-hospital settings can act on the

instructions in the AMD (i.e. not performing specified life sustaining treatments under the specified preconditions) on the maker; the other witness has attained 18 years of age, etc.

[6] The four categories of healthcare professionals are registered dentists, registered medical practitioners or housemen, registered nurses or enrolled nurses, and registered Chinese medicine practitioners or listed Chinese medicine practitioners.

patients' instructions in the AMDs to refuse CPR. Given that minors and adults who are mentally incapable of deciding on a life-sustaining treatment cannot make AMDs, RMPs may make non-AMD-based DNACPR orders for them if a consensus is reached among the patient's practitioner-in-charge and family members that CPR would not be in the patient's best interests. A responsible person (e.g. a family member) has to agree with the decision and co-sign the non-AMD-based DNACPR order. Since a DNACPR order will only be issued at the last stage of the patient's life, its validity period is limited to a maximum of one year and may be extended by a doctor as clinically necessary.

11. Supplementary information on AMDs and DNACPR orders is set out at **Annex**.

Principle of "If in Doubt, Save Lives First"

12. Healthcare professionals and rescuers will act in accordance with the principle of "if in doubt, save lives first". They will only comply with the instructions of an AMD or a DNACPR order to withhold or withdraw the relevant life-sustaining treatments when they have notice that the patient holds a valid and applicable AMD or DNACPR order. Given that healthcare professionals and rescuers often need to make split-second decisions during rescue operations, the Ordinance stipulates that they are not required to search the patient or his/her personal belongings to ascertain whether the person carries a valid AMD or has been issued with a valid DNACPR order. Meanwhile, the Ordinance also provides legal protection for healthcare professionals and first-aiders (regardless of whether they are professionally trained or not). Under specified conditions, including where healthcare professionals and rescuers do not have notice that the patient holds a valid and applicable AMD or DNACPR order and hence administer life-sustaining treatments, or where healthcare professionals and rescuers honestly and reasonably believe that the patient holds a valid and applicable AMD or DNACPR order and hence do not administer life-sustaining treatments, healthcare professionals and rescuers will be exempted from the relevant legal liabilities[7].

[7] Legal liabilities refer to civil or criminal liability, or liability in respect of professional misconduct.

13. To facilitate the presentation of AMDs by family members of the makers to healthcare professionals, the Ordinance accepts any of the following as a valid proof of an AMD: the original, a certified true copy, a paper directive stored electronically in the Electronic Health System (eHealth), and a directive made and stored electronically in eHealth. The Government will implement paper AMDs and electronic AMDs (eAMDs) in phases. In the first phase, the paper route of AMDs and the electronic storage of such paper AMDs will take effect, whereby the public can decide whether to store their paper AMDs electronically after making one. Once the relevant functions of the designated electronic system are in place, the Government will enable the electronic making of eAMDs directly in the system. Citizens as well as public and private healthcare institutions may access AMDs stored or made electronically through eHealth.

14. The implementation of eAMDs aims to provide additional convenience to members of the public by relieving makers and family members from the inconvenience of having to carry the paper copies and enabling healthcare professionals to access their AMDs even in emergency situations. Whether to store or make AMDs electronically is purely a voluntary choice by members of the public. They may continue to make and keep AMDs solely in paper form, and the legal effect thereof is the same as their electronic counterparts.

15. As for DNACPR orders, because they may need to be complied with in emergencies outside hospitals, and healthcare professionals and rescuers must make immediate decisions, such orders must be issued in writing using the prescribed forms provided in the Ordinance and no electronic version is available. This arrangement enables healthcare professionals and rescuers to immediately determine, from the appearance of the forms, their authenticity and scope of application without the need to check against electronic systems or other documents, thus ensuring that DNACPR orders can be followed immediately in time-critical rescue operations.

Preparation before the Implementation of the Ordinance

16. To tie in with the commencement of the Ordinance, the Government has, after passage of the Ordinance, coordinated relevant

government departments and stakeholders (including the HA, private hospitals, relevant healthcare professional bodies, residential care homes (RCHs) and non-governmental organisations (NGOs), as well as emergency service organisations) to take forward corresponding preparatory work in light of the implementation of the Ordinance, including:

(a) providing guidelines and trainings for relevant personnel;
(b) updating relevant systems to support the implementation of eAMDs;
(c) enhancing the understanding of the Ordinance among terminally ill patients and their carers;
(d) strengthening EoL care services; and
(e) promoting life-and-death education continuously.

Providing Guidelines and Trainings for Relevant Personnel

17. For the four categories of healthcare professionals specified under the Ordinance, relevant healthcare professional bodies have, in light of the legal framework of the Ordinance, formulated or updated codes of practice and guidelines and provided trainings to healthcare professionals, so as to ensure that they understand the relevant implementation requirements of AMDs and DNACPR orders. Among them, the Hong Kong Academy of Medicine (HKAM) published the Best Practice Guidelines on Advance Medical Directives (Best Practice Guidelines) in April 2025, covering the legal framework of AMDs and DNACPR orders, ethical considerations for EoL clinical decisions, the application of model forms and prescribed forms for AMDs and DNACPR orders, and protection for treatment providers, while setting out frequently asked questions and clinical scenarios to elaborate in detail on the application of the Ordinance and practical arrangements. After passage of the Ordinance, the Health Bureau (HHB) has, in collaboration with relevant healthcare professional bodies (including the HKAM and HA) and social service organisations, organised training seminars to explain to healthcare professionals the background and main provisions of the Ordinance. The HHB will, together with relevant healthcare professional bodies, organise an online briefing for healthcare professionals at the end of this month to introduce the main provisions of the Ordinance, in particular the legal obligations

and protection in relation to the administration of AMDs and DNACPR orders under the Ordinance. The HKAM will also provide trainings for healthcare professionals through seminars and online courses. Relevant reference materials, including the Best Practice Guidelines, will be disseminated through information platforms (such as HHB's thematic website) and relevant professional organisations for professionals' reference.

18. The HA has, in light of the legal framework of the Ordinance, issued clinical guidelines in October 2025 to provide reference for its healthcare professionals. To enable relevant healthcare professionals to grasp the basic principles and procedures for handling AMDs and DNACPR orders, the HA has organised a total of 14 forums in 2025, with more than 10 000 healthcare professionals participating. These forums covered the statutory requirements, clinical judgment and key implementation arrangements in respect of AMDs and DNACPR orders, with online training courses available. The HA will continue to provide trainings for relevant professionals before and after the Ordinance commences.

19. As regards rescuers, the HHB has organised seven training seminars for government departments and organisations involved in emergency rescue (including the Fire Services Department, the Hong Kong Police Force, the Auxiliary Medical Service, St. John Ambulance and the Government Flying Service) to explain the statutory requirements of DNACPR orders under the Ordinance. The seminars focused on the "if in doubt, save lives first" principle, procedures to identify valid and applicable DNACPR orders, and the legal protection for rescuers, with more than 800 frontline rescuers and management personnel participating. The HHB has also contacted major organisations providing first-aid trainings and certification courses, reminding them to update their training materials so as to ensure that they cover the implementation arrangements for DNACPR orders and related legal protection under the Ordinance.

AMDs made electronically and stored in a designated electronic system

20. To tie in with the first-phase implementation of eAMDs, the HHB has enhanced the relevant functions under eHealth. To support the

implementation of eAMDs in HA facilities, the HA has updated its clinical management system and electronic health record sharing system to ensure that their relevant systems can interface with eHealth. Besides, the HHB briefed private healthcare institutions (including private hospitals, RCHs and social service organisations) and professional organisations of healthcare professionals in June and December 2025 respectively on the operational arrangements for eAMDs, and coordinated relevant healthcare institutions and organisations to update their electronic systems, so as to tie in with and support the implementation of eAMDs after the Ordinance commences. Before the Ordinance comes into effect and the system functions are officially launched, the HHB will conduct online briefings for relevant professional institutions and organisations to elaborate on the practical operation of eAMDs, ensuring that both healthcare professionals and electronic systems are operationally ready. The HHB will also disseminate reference materials on eAMDs to members of the public and healthcare professionals through existing publicity channels of the eHealth.

Enhancing Public Awareness of the Ordinance and EoL Care

21. The HHB proactively promotes public awareness of the Ordinance through cross-departmental and cross-sectoral public education and promotional initiatives. Apart from introducing the Ordinance to the public through channels such as promotional pamphlets, mobile van publicity campaigns and a designated website, the HA and other relevant government departments have taken forward a series of public education activities targeting specific groups including elderly persons, patients and their carers. Such initiatives cover the requirements of making AMDs and DNACPR orders under the Ordinance, ACP, EoL care and related topics. Also, the HHB has established collaborative networks with relevant government departments and social service organisations to elucidate to the public the content of the Ordinance via various avenues such as seminars and talks, etc. After passage of the Ordinance, the HHB, Jockey Club End-of-Life Community Care Project (JCECC)[8] and social

[8] The "Jockey Club End-of-Life Community Care Project (JCECC)" is an EoL care initiative launched by The Hong Kong Jockey Club Charities Trust in 2016, aiming to enhance the quality of EoL care in the community and in residential care homes for the elderly (RCHEs) through collaboration with universities and various NGOs. The project covers home- and institution-based EoL support, caregiver trainings and public education, etc. With effect from August 2024, the project has been extended to serve persons with disabilities suffering from advanced illnesses, and the "JCECC: Unison" has been

service organisations co-organised eight community talks to introduce the Ordinance. Starting from April this year, the HHB has, together with JCECC, launched a new round of talks and expanded the target audience to persons with disabilities and their carers as well as professionals from the social welfare sector. In addition, the HHB will prepare information materials and, through relevant government departments and social service organisations, distribute them to specific target groups such as the elderly, patients and their carers, etc., so as to enhance their understanding of AMDs and DNACPR orders.

Strengthening EoL Care Services

22. At present, the HA provides palliative care services for terminally ill patients, including inpatient, consultative, outpatient, palliative day-care, home-care and bereavement services, etc. Since 2015-16, the HA has also gradually strengthened the services of community geriatric assessment teams (CGATs) and implemented EoL care services in residential care homes for the elderly (RCHEs) to support residents with terminal illnesses in RCHEs. To tie in with the implementation of the Ordinance, the HA will further strengthen palliative care services at hospital and community levels, including expanding the service capacity of palliative care consultative services and CGATs' palliative care services in both RCHEs and home settings, so as to provide patients with holistic physical, psychological, social and spiritual care. Meanwhile, the HA will continue to strengthen medical-social collaboration with community partners, for example the JCECC, to provide continuous support for terminally ill patients in the community.

23. Separately, the Social Welfare Department (SWD) has all along been supporting RCHDs and RCHEs that are not nursing homes (specified RCHs) in adopting various models to provide EoL care services, formulating operational guidelines, and providing relevant trainings and educational activities for residents, caregivers and staff on a regular basis. In preparation for the implementation of the Ordinance, the SWD provided EoL care reference guideline to 816 RCHEs and 267 subvented RCHDs in May 2024. Furthermore, additional resources have been allocated for

launched to support residential care homes for persons with disabilities (RCHDs) in implementing EoL care services.

contract homes to recruit additional healthcare and relevant professionals. Through multidisciplinary teams, care plans are formulated and nursing care is provided for residents suffering from critical and terminal illnesses, while spiritual care and social or family support are also offered to their families. From September 2017 onwards, all newly planned contract RCHEs have been equipped with EoL care rooms, so that residents can spend their final days with dignity and peace in familiar surroundings. The SWD will continue to encourage existing RCHDs and RCHEs to exercise flexibility in using or converting areas or rooms within their premises to provide EoL care services for their residents.

Continuously Promoting Life-and-death Education

24. All along, the Government and public institutions have been enhancing public understanding of topics such as ACP, ADIs and EoL care through diversified life-and-death education promotion activities. For example, the Visiting Health Teams of the Elderly Health Service of the Department of Health provide health education on ageing, life-and-death education, grief management and spiritual care for frail residents. These programmes are tailored for the elderly and their carers at RCHEs, elderly community centres and elderly health centres. To enhance support for patients and their carers on EoL care, the HA has set up the "Smart Patient" online platform to provide diversified information on palliative care, and has launched the "Smart Patient" talk series to introduce concepts such as ACP and AMDs to patient groups and the public. As regards school education, life and death education is part of life education and constitutes an important component of values education. Learning elements related to life education have already been embedded in the primary and secondary curricula. The *Values Education Curriculum Framework (2026)* continues to identify "strengthening life education" as one of the major focuses of continuous enhancement for schools, and sets out such notions as "understanding the course of human life: birth, aging, illness and death, etc., and cherishing all we have", "taking care of the elderly and needy family members, and learning to cope with the death of relatives", and "being grateful for everything we have, learning to accept loss with equanimity, and actively seeking the meaning of life" as suggested expected learning outcomes for students. The Education Bureau has been providing ongoing support for schools to implement life education both within and beyond the classroom through updating curriculum guides,

developing learning and teaching resources, providing professional development programmes for teachers (including commissioning universities to organise specialised programmes) and organising student activities, etc., with a view to helping students understand, appreciate, respect and explore life.

25. The Government will continue to promote life-and-death education through cross-departmental and cross-sector collaboration, and enhance the community's understanding of EoL care and life planning.

Commencement Date of the Ordinance and Implementation Arrangements

26. Preparatory work has now been largely completed. The Government will appoint 31 July 2026 as the commencement date of the Ordinance by notice in the Gazette.

Implementation arrangements for AMDs

27. AMDs made before the commencement of the Ordinance will remain valid as long as they comply with the requirements set out in the Ordinance and all relevant instructions are presented in a clear way. For example, a pre-existing directive made before the commencement of the Ordinance using the HA's original form should have met the requirements under the Ordinance and will continue to be valid. To ensure a smooth transition, the HA has been gradually adopting the model forms set out in the Schedule to the Ordinance to make AMDs for their patients since December 2025, ensuring that newly made AMDs remain valid after the Ordinance comes into operation. We recommend that members of the public who have made AMDs should regularly review the instructions therein with their RMPs and, if changes are necessary, update or modify the instructions using the model forms specified in the Ordinance.

28. If members of the public who have already made a paper AMD wish to store it electronically in eHealth, the Ordinance stipulates that the uploading must be assisted by an RMP, mainly for the RMP to first review whether the AMD has been properly completed and is valid before uploading, so as to ensure that all AMDs stored in eHealth comply with the

requirements stipulated in the Ordinance. To tie in with the implementation of paper AMDs and eAMDs, HA doctors will arrange uploading for patients who wish to upload their paper AMDs. On the other hand, doctors in private healthcare institutions may also upload AMDs for their patients as part of their healthcare service process.

29. As aforementioned, the making of AMDs forms part of the ACP and the appropriate timing for discussion is when the patient suffers an advanced or irreversible disease and is able to make informed choices after fully understanding the disease prognosis. During the ACP discussion process, patients may, according to their personal wishes, or healthcare professionals may, according to the clinical conditions of the patients, make suggestions on making AMDs. Healthcare professionals will, in accordance with relevant clinical guidelines (such as the Best Practice Guidelines) and having regard to patients' clinical conditions, initiate appropriate discussions. At present, ACP is primarily implemented in palliative care, oncology and geriatrics in the HA. In the course of ACP discussions, the HA will assist its patients in making AMDs.

30. Regarding community support, HA's CGATs, led by geriatric specialists, regularly visit RCHEs to provide multi-disciplinary healthcare treatment for the residents suffering from more serious or complicated conditions who are unable to attend appointments at Specialist Out-patient Clinics due to difficulties in mobility. CGATs also implement EoL Care Programme in collaboration with palliative care teams and RCHEs. Services involve discussing factors, such as disease prognosis, pros and cons of treatment, patients' values and wishes, etc., with terminally ill residents and their families to formulate an advance care plan.

31. The Government is also concurrently strengthening preparations at the community and primary healthcare levels. Through relevant professional bodies, the Primary Healthcare Commission (PHCC) organised medical seminars on AMDs for over 350 family doctors in March this year, covering the legal framework of the Ordinance, clinical communication skills for ACP, the application of model forms, and the legal protection for healthcare professionals and rescuers under the Ordinance. The objective is to enable patients, based on their current health status and prognosis, to initiate ACP discussions in a community

setting with assistance from family doctors who are familiar with their conditions and personal wishes at an appropriate time. In addition, the PHCC will further organise continuing education programmes on EoL care to strengthen the clinical knowledge of relevant primary healthcare service providers in this field.

Implementation arrangements for DNACPR Orders

32. For existing DNACPR orders issued before the commencement of the Ordinance to remain valid thereafter, they must be replaced by the prescribed forms provided in the Ordinance prior to its commencement. To ensure a smooth transition, the HA has been using the prescribed forms provided in the Ordinance since December 2025 to issue new orders or re-issue existing ones for their patients. The replacement process for all existing orders will be completed before the Ordinance comes into effect. To facilitate patients in carrying DNACPR orders, the HA will provide patients with prominently designed document pouches, clearly marked as containing DNACPR orders and authorising rescuers to search for the orders inside, so that they can quickly identify and inspect the orders when necessary. The Government has also reminded doctors in the private healthcare sector of the aforementioned transitional requirements through relevant professional bodies and the Best Practice Guidelines issued by the HKAM.

Advice Sought

33. Members are invited to note the contents of this paper and offer their comments.

Health Bureau
Labour and Welfare Bureau
Education Bureau
Security Bureau
May 2026

Annex

Supplementary Information on
Advance Medical Directives and Do-not-attempt Cardiopulmonary Resuscitation Orders

	Advance Medical Directives (AMDs)	Do-not-attempt Cardiopulmonary Resuscitation Orders (DNACPR orders)
Nature and Legal Status	・ Legally binding ・ Enjoy the legal status established under the Advance Decision on Life-sustaining Treatment Ordinance	・ Legally binding ・ Enjoy the legal status established under the Advance Decision on Life-sustaining Treatment Ordinance
Scope	・ Refuse one or multiple life-sustaining treatments (which may include cardiopulmonary resuscitation (CPR)) under specified circumstances	・ Cover only CPR and exclude other life-sustaining treatments
The maker and the triggering conditions	・ Made by an adult patient who is mentally capable of deciding on a life-sustaining treatment, in the presence of not less than two witnesses (one of whom must be a registered medical practitioner (RMP)), in a prudent manner and in compliance with the requirements of the Ordinance ・ An AMD takes effect when the patient becomes mentally incapable of deciding on a life-sustaining treatment and satisfies the specified precondition(s) in the AMD (e.g., being terminally ill, being in a	・ Issued by two RMPs (one of whom must be a specialist) (based on clinical judgment that the patient meets the specified preconditions and following communication with the patient/family) ・ Applicable when the patient suffers cardiopulmonary arrest

	persistent vegetative state or a state of irreversible coma, or being in other end-stage, irreversible, life-limiting conditions).	
Who is obligated to comply / to be bound	· Treatment providers (i.e. the four categories of healthcare professionals specified under the Ordinance) are obliged to comply with an AMD, as long as they have notice of a validating copy of the patient's AMD and honestly and reasonably believe that it is valid and applicable · No one (other than the patient) has the authority to override a valid and applicable AMD	· Rescuers (including ambulance crews and non-professional first-aiders) are obliged to comply with a DNACPR order as long as they understand what the order means and honestly and reasonably believe that it is valid and applicable
Whether amendments or revocation are permitted	· A patient may revoke its AMD at any time in accordance with the methods stipulated in the Ordinance, provided that the patient is mentally capable of deciding on a life-sustaining treatment	· Doctors may re-assess and re-issue a DNACPR order based on changes in the patient's clinical conditions and wishes
Implementation arrangements	· An AMD should be made using the model forms provided in the Ordinance; a non-model form may also be used, but the maker must ensure that the AMD complies with the requirements stipulated in the Ordinance · Members of the public who have already made a paper AMD may choose to upload	· A DNACPR order must be issued using the prescribed forms provided in the Ordinance · No electronic version will be available · DNACPR orders not issued using the prescribed forms provided in the Ordinance, including those issued by the HA, must be re-issued using the prescribed

	a scanned copy or electronic image of their paper AMDs to eHealth for storage and retrieval • AMDs made using the HA's original form before the Ordinance comes into operation comply with the requirements under the Ordinance and will remain valid after the Ordinance takes effect	forms in order to remain valid after the Ordinance takes effect