Hospice Foundation of Taiwan

HFT Newsletter

Forever Love, Endless Care

August 2025

Spotlight on Team Taiwan:

Poster & Oral Presentation Highlights at APHC 2025

Policy and Legislation: Six Years of the Patient Right to Autonomy Act

The System in Place, But the Dialogue Just Beginning

Clinical Frontline: Turning Points and Perseverance

Gentle Practice: Let the Right to a Good Death Blossom Everywhere

Hospice Foundation of Taiwan
www.hospice.org.tw
No. 45, Minsheng Road ,Danshui District, New Taipei City 25160 Taiwan
Tel: +886-2-28081130 Fax: +886-2-28081137 Email: hospice@hospice.org.tw

Like us on Facebook Like us on Instagram

Spotlight on Team Taiwan:

Poster & Oral Presentation Highlights at APHC 2025

To encourage healthcare professionals from Taiwan to actively participate in the Asia Pacific Hospice Conference (APHC), the Hospice Foundation of Taiwan offers a reward scheme each year to recognize outstanding oral and poster presentations. We are honored to share the works of this year's awardees, whose efforts reflect Taiwan's continuous advancement in palliative care.

🖋 | Oral Presentation Highlights

Below are the oral presenters who have agreed to share their slides. Click to view the Files.

Name	Organization	Title(Clickable)
Wei-Min Chu	Taichung Veterans General Hospital	Early Palliative Care Can Reduce Aggressive Treatment Before Death Among Terminally Ill Cancer and Non-Cancer Patients in Taiwan: A Population-Based Study
Chia-Hsuan Chiang	Dept. of Nursing, College of Nursing, National Yang Ming Chiao Tung University	Exploring Motivations and Pathways for Engaging in Advance Care Planning: A Life Trajectory Perspective
Ying-Li Lin	Changhua Christian Hospital	Symptom Trajectory Analysis During the Final Week of Life: A Retrospective Study in a Taiwanese Palliative Care Unit
Wen-Yi Tu	Chi Mei Hospital, Liouying	Exploring the Effectiveness of Multimedia in Enhancing Self-Care Abilities Among Cancer
Hui-Chun Yeh	National Taiwan University Hospital	Pathways to Community Hospice Spiritual Care Volunteering: A Grounded Theory Study

📌 Poster Presentation Highlights

We sincerely thank the following contributors for sharing their posters. These reflect valuable insights and frontline experiences in hospice care.

Name	Organization	Title(Clickable)
TING YUNG TIEN	Taipei City Hospital, RenAi Branch	The Experience of Animal-Assisted Therapy in a Hospice Ward of a Regional Hospital in Northern Taiwan
Cheng-Fen Wang	Taipei Tzu Chi Hospital, Tzu Chi Medical Foundation	Education Through Movies: A Preliminary Study on the Development of Spiritual Awareness Curriculum for Nurse in Hospice Ward
Wei-Min Chu	Taichung Veterans General Hospital	Trend Analysis of Art Therapy Usage Among Terminally Ill Cancer and Non-Cancer Patients in Taiwan: A 4-Year Observational Study
Chiang, Ching-Chun	Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation	Applying the Empowerment Model to Develop Professional Capacity for Palliative Care Services in Long-Term Care Facilities
Huei-Li Wu	School of Medicine, Tzu Chi University	Enhancing Public Understanding of End-of-Life Care: A Cultural Analysis of Educational Videos
Yi- Ting Wu	Mackay Home Health care, MacKay Memorial Hospital	Nursing Experience of Helping a Patient Having Good Death at Home during the Terminal Phase of Duodenal Ampullary Cancer
Chao-Fen Lu	Taipei City Hospital	A Study on the Needs of Certified Nursing Aide for Life and Death Education Courses in Taiwan
Li, Yi-Jhen	Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation	Compassionate Touch Therapy as a Complementary Approach in Palliative Care

Name	Organization	Title(Clickable)
I-hsuan Li	Mennonite Christian Hospital	Analysis of the Implementation Effectiveness of Taiwan's "Patient Autonomy Act" in Rural Areas - A Case Study of Hualien Mennonite Hospital from 2021 to 2024
Jheng-Ling Li	Taipei Medical University Hospital	Enhancing Long-Term Care Facility Caregivers' Abilities in Chronic Wound Care for Terminal Patients Using the Empowerment Concept: A Feasibility Study
TONG-YING, LIN	Department of Thanatology and Health Counseling, National Taipei University of Nursing and Health Sciences,	Spiritual Care for Patients of Palliative Home Care- Taking Taiwanese Folk Religion as an Example
CHIA YU LIN	Taipei Veterans General Hospital Yuanshan Branch	Enhancing Cognitive Function and Social Connections in Community-Dwelling Elderly through Instrumental Music Learning
Su-Chyn Lin	Pingtung Veterans General Hospital	Caring for Patients with Nasopharyngeal Carcinoma Invading the Left Meckel's Cave in the Palliative Ward of a Hospital in Southern Taiwan
Tzu-Ling Lin	Tamsui Mackay Memorial Hospital	Exploring the knowledge, attitudes, and practice of nurses in assisting advance care planning engagement and advance decision completion
Lin Chin-Yu	China Medical University Hospital	Using artificial intelligence to create music, composing the final symphony of life for terminally ill patients.
Jui-YU Lin	Pingtung Veterans General Hospital	Care Model for Fungating Wounds in the Palliative Ward of a Hospital in Southern Taiwan
Huei-Wen Lin	Taipei Medical University Hospital	The Warm Guardianship of Life's End: Creating a New Culture of Palliative Care in Long-Term Care Institutions

Name	Organization	Title(Clickable)
Hsiao-Wei Lin	Taipei Medical University Hospital	Improvement Project on hospice care for non-cancer terminal patients
Wu Chiu Hsiang Chiu	Saint. Mary's Hospital Taitung	Integrating Namaste Care and Massage Therapy in the Palliative Management of Atypical Parkinson's Disease
HU, LIEN-FEN	Tamsui Mackay Memorial Hospital	The Flow of Love Integrating Expressive Arts to Deliver Five Life Principles in Spiritual Care and Grief Support for Families of Terminal Patients
Tsai-Yu Weng	Kaohsiung Medical University Hospital, Kaohsiung Medical University	Experience in Palliative Care of a Dementia Patient with Pneumonia and Respiratory Failure
Kao, Pei-Ching	Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation	The Impact of Namaste Care Training on Caregivers' Role Transformation and Emotional Growth
Shu-Fang Chang	Changhua Christian Hospital	Farewell from The Other Side: The Achievement of Peace and Contentment during COVID-19 Pandemic by Using Video Calls
Hui-Min Mei	Changhua Christian Hospital	The Effectiveness of Palliative Care Education for Caring Service Technicians in Remote Rural Areas to Enhance The Ability to Face Death Positively
Miaoling Chen	Saint. Mary's Hospital Taitung	Aromatherapy as a Palliative Treatment for Oral Mucositis in End-of-Life Care: Applications and Clinical Impact
Yi-Lin Chen	Taipei Tzu Chi Hospital, Tzu Chi Medical Foundation	Use Palliative Prognostic Index to Assist in Achieving End-Of-Life Preparation
Tzu-Chi Chen	Taipei Municipal Gan-Dau Hospital	Improvement Plan for Satisfaction with Controlled Drug Management In Hospice Wards of Community Hospitals

Name	Organization	Title(Clickable)
Hsiao-Lan Yu	Tamsui Mackay Memorial Hospital	Development and Evaluation of a VR System for Death Education to Improve the Death Literacy and Health in Family Caregivers of The End-of-Life Patients
ChiaHui-Huang	Private Xiang Yun Long Term Care Institution	Developing Holistic, People-Centered Palliative Care: Practical Experiences from a Long-Term Care Institution in Eastern Taiwan
Yu-Fang Huang	Datong Changji Community-based Long-term Care, MacKay Memorial Hospital	A survey on death literacy among care worker in day care centers for the elderly in the Northern Region
Tsai-Yun Huang, RN	Chi Mei Hospital, Liouying	Using of Pastel Art in the spiritual care of family members of critically ill hospice cases: a case study
Chih-chiao Yang	Taipei Tzu Chi Hospital, Tzu Chi Medical Foundation	The palliative care social work treatment and legal consultation services for a terminal cancer patient with visual impairment
Yu Hsiu Hong	Taipei Tzu Chi Hospital, Tzu Chi Medical Foundation	Outcome of Palliative Share Care
Liao Mei-Chen	China Medical University Hospital	The Dilemma of Executing Advance Care Planning (ACP) in the Super-Aged Society of Taiwan
Mei-yu Chao	Mennonite Christian Hospital	The experience of spiritual caregivers in Taiwan assisting in the establishment of spiritual care institutionsâ€”taking the Fuzhou Agape Social Work Service Center in China as an example
You-Kuan Liu	Taipei Tzu Chi Hospital, Tzu Chi Medical Foundation	The Quality Enhancement of Dying and Death in Hospice Ward
HSIU-Lan Pan	Taipei Hospital, Ministry of Health and Welfare	When Palliative Care Meets Watson's Theory of Human Caring: A Spiritual Journey
Yen-Min,Tsai	Chi Mei Hospital, Chiali	Enhancing Palliative Care Coverage through Multiple

Name	Organization	Title(Clickable)
		Approaches: A Case Study of a Hospital in Tainan
Yu-Li Tsai	School of Medicine, Tzu Chi University	Health-Literate Promotional Materials in Palliative Care: A Cross-Cultural Study
Wei-Chun Cheng	Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation	Deepening Empathy in Hospice Care: Insights from Fifth-Year Medical Students on Experience in Clinical Education
Lu Su Hong	Mackay Memorial Hospital	Capturing Memories, Healing Hearts: Phototherapy's Impact in Palliative Care
Yu-Hua,Lai	Tung’s Taichung MetroHarbor Hospital	Creating Meaningful Memories Through Art Therapy: A Case Study in Hospice ward
Wan-Chin Hsieh	Taipei Hospital, Ministry of Health and Welfare	Complementary Therapy - Sharing Experiences on the Use of Gold Ointment and Far-Infrared Treatment to Improve Chronic Non-Healing Wounds in Palliative Elderly Patient of Non-Cancer
Su, Wei-Cheng	Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation	Palliative care for cancer patients with schizophrenia: a case series study
Chen Yoon LEE (Shi Xian Seng)	Taipei Hospital, Ministry of Health and Welfare	Exploration of Spiritual Growth in Terminally Ill Patients

Our Gratitude

We thank all contributors to APHC 2025. Whether or not your work is featured here, your dedication continues to shape the future of hospice care in Taiwan.

Notes

- All materials are shared with permission from the authors. Please do not alter or reuse without authorization.

Policy and Legislation: Six Years of the Patient Right to Autonomy Act

The System Is in Place, but the Dialogue Is Just Beginning

In 2019, the Patient Right to Autonomy Act came into effect, making Taiwan the first country in Asia to pass a dedicated law protecting patients' rights to make their own medical decisions. The policy enables people, while still of sound mind, to decide in advance what kinds of medical treatment they would want if they were to lose consciousness with no chance of recovery or face end-of-life decisions. It reflects the principle of personal autonomy in choosing "the kind of medical care I wish to receive." However, as ideals meet reality, gaps in the system and obstacles to implementation have gradually surfaced.

At the age of 73, Mrs. Lin did something that deeply impressed her daughter: she arranged for an Advance Care Planning (ACP) consultation. After two in-depth sessions, she signed an Advance Directive (AD), stating that if she were to fall into an irreversible coma or a permanent vegetative state, she would decline intubation, resuscitation, and artificial nutrition. She even wrote by hand: "Please let me go peacefully."

This personal choice was made possible by Taiwan's Patient Right to Autonomy Act, which came into effect in 2019. As Asia's first dedicated law explicitly protecting a patient's right to decide one's own medical treatments, it allows individuals--while still mentally competent--to make decisions about medical care under five specific clinical situations: terminal illness, irreversible coma, permanent vegetative state, severe dementia, and other unbearable and untreatable conditions formally declared by authorities. These conditions are defined in the law and require a formal consultation process involving a team of healthcare professionals, including doctors, nurses, and social workers, before the directive can be acted upon.

What sets this law apart is that it does not require a prior diagnosis, nor does it depend on family decisions. Instead, it establishes a professional process through which individuals make their own choices, clearly stating, “When the time comes, these are the medical treatments I wish to receive, and these are the ones I refuse.”

Starting from Ethics
An Institutional Experiment

“The Patient Right to Autonomy Act isn’t about giving up—it’s about making a choice," says Dr. Daniel Fu-Chang Tsai, Director of the Center for Biomedical Ethics at National Taiwan University Hospital. As one of the law’s key advocates, Dr. Tsai has spent years focusing on medical ethics and quality end-of-life care, taking part in numerous public briefings and playing a role in shaping the system’s framework. In his view, the law’s essence isn’t “how to end life,” but rather “how to live with dignity and leave this world with autonomy.” Some people wish to exhaust every possible medical option to extend life, while others prefer to let nature take its course. This legislation exists to safeguard both choices equally.

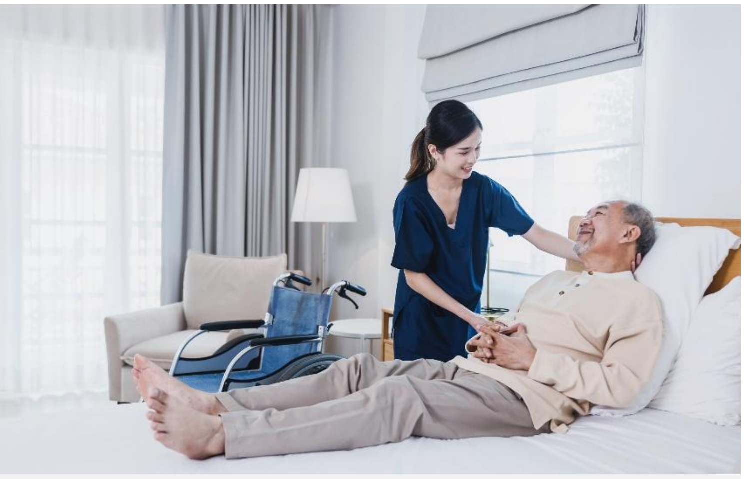
In many countries, Advance Care Planning (ACP) and Advance Directives (AD) are introduced gradually through administrative guidelines or clinical practice, building consensus over time. Taiwan, however, took the legislative-first route. While this gave the policy stronger visibility and legal weight, it also meant the public and the healthcare system had to catch up simultaneously—effectively turning it into a real-time institutional experiment with few precedents to follow.

As of early 2025, more than 93,000 people have signed an Advance Directive, representing less than 1% of Taiwan’s adult population. Despite having a well-defined legal framework and a careful procedural design, the number of people who actually complete the process remains limited.

Another major hurdle is accessibility. To sign an AD, a person must be at least 18 years old, possess full legal capacity, and go through the full ACP consultation process. While these requirements are intended to protect the integrity of personal choice, they can become roadblocks in practice. Elderly individuals with mobility issues, residents in remote regions with poor transportation, or people with limited access to accurate information often find themselves unable to even begin—a situation that leaves a well-meaning system stalled at the first step.

Ideal vs. Reality
Gaps in the System Emerging

“The Patient Right to Autonomy Act emphasizes information, understanding, voluntariness, and choice,” says Dr. Daniel Fu-Chang Tsai. “But in practice, it often becomes reduced to just explanation and consent.” While the procedures may be followed correctly, he warns, the deeper ethical reflection and meaningful family conversations envisioned by the law can be lost when the process becomes merely a checklist of options.



Current regulations require that individuals signing an AD must have full legal capacity. This requirement may limit the ability of those without full legal capacity to express their own wishes.

There are also legal limitations in the current system. Sam-Rong Hwang, Senior Partner at Formosa Transnational Attorneys at

Law, notes that the law does not adequately address the needs of individuals with conditions such as dementia or those lacking full legal capacity. Under current regulations, only adults with full legal competence may sign an Advance Directive. This excludes many people who may be mentally clear, but because they are under guardianship, cannot participate in the process even if they can still express their preferences clearly.

For example, a man in his seventies diagnosed with mild dementia may be fully capable of stating that he does not want invasive treatment and wishes to pass away naturally. However, because he has been placed under guardianship, he is legally deemed to lack full capacity and is excluded from signing an Advance Directive.

“He can still express himself clearly, but because of a diagnosis and a legal ruling, the system no longer listens,” says Hwang. This design flaw, he argues, limits the very people the law was intended to protect. When legal thresholds are set too high, they risk contradicting the core principle of patient autonomy.

“This is a learning process for our entire society,” says Dr. Yue-Ping Liu, Director of the Department of Medical Affairs at the Ministry of Health and Welfare. “We are not just implementing a policy; we are fostering a new way of understanding life.” From her perspective, the challenges encountered along the way are part of the system’s gradual process of taking root in society.

Beyond the Medical Sphere

Bringing the Policy into Everyday Life

"If we rely solely on the medical system, we can’t reach a truly diverse range of communities," says Dr. Yue-Ping Liu. At the heart of the Patient Right to Autonomy

> “This is a learning process for our entire society.
> We're not just implementing a policy; we're fostering a new way of understanding life."
>
> **—Dr. Yue-Ping Liu, Director, Department of Medical Affairs, Ministry of Health and Welfare**

Act is the idea of advance conversations, but if those conversations remain confined to hospitals, their reach is quickly limited. That’s why the Ministry began expanding outreach into long-term care centers, community health clinics, libraries, and community colleges—connecting the policy to daily life and local culture.

One example is the podcast series Encounter and Foresee, which invites doctors and families to share personal experiences. The Ministry has also published a set of illustrated children’s books—The Little Red Robot, Second-Oldest Brother Pig’s Happiness Party, and Grandpa Sloth’s Wish—which tour libraries and schools. It has even partnered with a theater troupe to stage plays explaining the concept of a good death in language children can understand.

In addition, the Ministry has integrated the three major end-of-life laws—the Human Organ Transplant Act, the Hospice and Palliative Care Act, and the Patient Right to Autonomy Act—under the Taiwan Organ Sharing Registry and Patient Autonomy Promotion Center. While each law has its own scope, they share a common principle: “When facing death, we all have the right to choose how we leave, and how we remain.”

The Ministry of Health and Welfare collaborated with a theater troupe to launch a stage play that introduces the concept of a good death using language that children can easily understand.

These efforts may appear small on their own, but together they create a path for the Patient Right to Autonomy Act to be seen and understood in everyday life. The aim is not simply to persuade people to sign an Advance Directive, but to plant a broader idea: that choices about life and death can—and should—be considered well in advance.

"Patient autonomy doesn't begin at the moment of signing a document; it begins the moment someone realizes they have the right to choose," says Dr. Daniel Tsai. He notes that the medical field has long avoided conversations about death, but through this policy’s outreach, such discussions between professionals, patients, and families are becoming less difficult. And this kind of education, he emphasizes, must be carried out by society as a whole.

Patching the Gaps Without Amending the Law

Rethinking Systems and Roles

Although the framework of the Patient Right to Autonomy Act is already in place, confusion persists—particularly around the law’s three core elements: Advance Care Planning (ACP), Advance Directives (AD), and the Healthcare Agent (HCA). Many healthcare workers and members of the public remain unclear about their distinct purposes and the correct order in which they should be completed.

For example, some assume that simply listing a healthcare agent on their National Health Insurance card means all formalities are done. Others believe that undergoing ACP automatically produces a signed AD—only to later discover that no legal directive was ever finalized. If a patient loses consciousness, these gaps can leave doctors unable to carry out requests such as declining intubation or resuscitation, forcing them instead to follow standard emergency protocols.

Sam-Rong Hwang notes that such mismatches between legal intent and clinical reality are common. The problem, he argues, is not only the complexity of the terminology but also the lack of early, clear public explanation about how the three components connect, and the correct sequence for completing them. In a medical crisis, an incomplete form or unclear agent designation can prevent a patient’s wishes from being honored—and place loved ones in emotionally wrenching dilemmas.

"Didn’t you say it was already signed?" is a question often heard outside intensive care units. But signed what? At which stage? Was the agent legally authorized? These details can make the difference between a choice being honored or not.

The System Is Only the Start
The Conversation Is Just Beginning

Hwang also points out that the current framework remains heavily led by medical teams, with little room for other voices. Allowing broader participation—from lawyers, social workers, or spiritual leaders—could expand the scope of these conversations beyond medical choices to include personal values, beliefs, and family dynamics. Some signers wish to confirm the process with a trusted lawyer; others prefer to first discuss it with a religious advisor. Yet the system still struggles to offer this flexibility.

Over the past six years, the Patient Right to Autonomy Act has moved the idea of “a good death” from being solely a clinical concern to becoming a shared social learning process. It is not a single form or one-time signature—it is a continuing dialogue about how we wish to live and how we wish to go. The law, the system, and the culture are still taking shape, but the conversation has already begun.

Clinical Frontline: Turning Points and Perseverance

Gentle Practice: Let the Right to a Good Death Blossom Everywhere

Six years have passed since the implementation of the Patient Right to Autonomy Act. On the clinical frontlines, healthcare professionals have proceeded with caution and dedication—starting from understanding the law, to overcoming challenges such as limited counseling staff, difficulties with Advance Directive signing, and obstacles in implementation. Every step has been a leap into uncharted territory. Yet, they have chosen to shoulder the profound responsibility of honoring patients' wishes for a good death with dedication and compassion.

The Patient Right to Autonomy Act (commonly referred to as the PRAA) is not only Taiwan's first piece of medical legislation centered on the patient, but also the first comprehensive law in all of Asia to protect a patient's right to make autonomous medical decisions. Through Advance Care Planning (ACP), individuals can sign an Advance Directive (AD) to ensure their medical choices are respected.

But as with all pioneering efforts, the journey has not been without headwinds. Frontline professionals have faced ongoing challenges yet continued to press forward, enabling the PRAA to take root and flourish across Taiwan over the past six years—blossoming into a visible and lasting cultural change.

The First Year

A Journey from Nothing to Something

In the early stages of promoting the PRAA, Taipei City Hospital actively collaborated with social groups and private organizations to help the public understand the law, while also offering on-site Advance Directive (AD) signings during these sessions.

"Although the Patient Right to Autonomy Act (PRAA) officially took effect on January 6, 2019, it had already been passed in late 2015 and announced on January 6, 2016," said Dr. Wen-Jung Sun, then Director of the Community Medicine Department & Family Medicine Division at Taipei City Hospital (now practicing in Family Medicine at Tainan Municipal Hospital). In those early days, the clinical field was completely lost. In his own words: "This was an entirely new law. What exactly did it say? How were we supposed to implement it? We simply had no idea."

At the time, Dr. Sheng-Jean Huang, Superintendent of Taipei City Hospital and a member of the expert panel for the PRAA, decisively committed the hospital to serving as a demonstration site. The day after the law passed, he convened a meeting with relevant departments, determined to transform the black-and-white legal text into lived reality through internal consensus and dedicated education programs.

Dr. Sun, who joined these efforts from the start, candidly shared that even with promotional videos, public understanding of the law remained vague. Although the hospital offered a regular ACP clinic every Tuesday, few people actually summoned the courage to register for a consultation. Most were hesitant and remained on the sidelines.

Seeing the public's uncertainty, Dr. Sun and his team decided to take the message beyond the hospital walls. They began engaging with community groups, institutions, and even small reading clubs. In these venues, they set up projectors, distributed informational booklets, and helped clarify concepts and stimulate reflection. "As long as they showed interest," he said, "we would make the time to go to people. We also provided on-site AD signing and uploaded the documents immediately via scanning."

To encourage participation, Taipei City Hospital set the ACP consultation fee at the lowest possible rate. Family members who accompanied patients were offered a discounted price of NT$800, and elderly individuals, low-income households, and other underprivileged groups were eligible for additional subsidies. "Many people searched online, saw that we were the most affordable option, and that's what brought many of them to us," Dr. Sun added.

Growing Through Learning

Frontline Challenges and Testimonies

As public outreach began to ripple outward, the challenges facing the clinical frontlines also began to emerge.

Dr. Chun-Yi Yang, Director of the Department of Social Work at Taipei City Hospital, shared that although her department was designated as the lead unit for promoting the PRAA, the law's provisions were extensive and complex, so that even after undergoing intensive training, the team still struggled to fully grasp the Act's legal clauses, implementation procedures, and underlying philosophy.

To strengthen outreach, the hospital decided to produce a promotional video. Before the filming began, Yang recalled that she was filled with anxiety, saying:

“I kept asking myself—if even I don’t fully understand the law myself, how could I explain it to others?”

Her concerns reflected the dilemma shared by many frontline healthcare workers during the early stages of the PRAA’s implementation. With no precedent to follow, they relied solely on their training and cautiously navigated each case in clinical practice. Even now, six years after the law took effect, patient questions often prompt the team to pause, clarify, research, and discuss before offering a thoughtful reply.

“Even today, we’re still constantly learning,” Dr. Yang reflected, recalling two ALS (Amyotrophic Lateral Sclerosis) patients her team had guided through end-of-life planning. The first patient arrived at the hospital having already lost all mobility and met the criteria to activate the PRAA. “During our discussions, he asked how the PRAA differed from the Hospice Palliative Care Act. Even now, that’s still a question many people can’t clearly answer—nor could we at the time,” Dr. Yang said.

The team delved into research, comparing the two laws in detail before finally offering a response. The process not only helped the patient, but also deepened the team’s own understanding of the PRAA’s essence.

The second ALS patient also met the activation criteria. He was mentally alert and expressed clearly, “I want to activate the law now, while I’m still aware, and not after I’ve already lost that awareness.” In his case, activation meant removing the ventilator. While this was legally compliant, Yang did not immediately give her approval. She remembered the first ALS patient telling her how, during a brief power outage the ventilator had stopped momentarily, and even that short interruption had caused such unbearable agony that he never wanted to experience it again.

"This very patient had never experienced that. We had to have further conversations to ensure he was truly ready to face death," Dr. Yang said. Their team took great care with every detail, and before removing the ventilator, they let him drink his favorite whiskey. Even after the activation, they monitored him closely. "We watched to see if he was in pain, and checked in regularly, asking him: 'How are you feeling now? Do you need more comfort?'"

Today, Dr. Yang has accumulated extensive experience with actual execution of the PRAA—far more than many teams who have only been involved in handling Advance Directives. In that regard, she is considered a veteran. Yet, she remains humble, saying: "There is no standard operating procedure for implementing the PRAA. Only through constant communication and dialogue can we truly fulfill the law's noble intention, which is to protect patients' medical autonomy and their right to a good death."

Dedicated Services
Opening a Window for Those Facing Barriers

Unlike Taipei City Hospital, which participated in the pilot program's early stages, Chi-Mei Medical Center in Tainan entered the implementation of the PRAA at a later stage. However, before diving in, the team at Chi-Mei held extensive discussions aimed to reduce barriers once the law came into full effect.

At the start of implementing the PRAA, Chi-Mei Medical Center established a dedicated service unit to provide consultations rather than assigning the responsibility to existing staff as an additional duty.

"From the start, we realized that the PRAA is already challenging enough for healthcare professionals to grasp, let alone for the general public," said Dr. Wan-Ting Hsieh, Director of Palliative Medicine Department at Chi-Mei Medical Center. Acknowledging the law's complexity—both in legal wording and procedural requirements—the hospital decided not to stretch existing staff working part-time; but instead, to establish a dedicated service unit and hire full-time case managers specifically to provide consultation and support.

"We understand from an operation management perspective, implementing ACP (Advance Care Planning) doesn't generate revenue for the hospital. However, without dedicated staff, there's no way we could properly help people make decisions that truly reflect their wishes," Dr. Hsieh explained, and emphasized that both PRAA and palliative care are difficult to promote and execute. Whether the law can truly fulfill its promise depends heavily on frontline personnel. Drawing from her years of experience in hospice care, she added: "ACP involves a lot of preparatory work. We can't expect already overwhelmed physicians, nurses, social workers, and psychologists to take on all these extra responsibilities. Even if they are willing, they may not have the capacity."

Reflecting on the early days, full of uncertainty and doubt, Dr. Hsieh now smiles, "We originally thought that since ACP consultations require an out-of-pocket cost, acceptance would be low. But in reality, people are very willing to spend a little time and money to have a say in how their final journey in life will unfold."

Today, Chi-Mei's ACP consultations are booked out six months in advance. But the team knows that behind these numbers are many others who need the PRAA even more, like people with urgent needs but find it difficult to access services. "For example, patients with rare diseases, strokes, or major illnesses may be fully conscious but have difficulty speaking or moving. This adds significant complexity to the consultation process," Dr. Hsieh noted. That's why she and her team are committed to reaching those often left behind. "In addition to offering in-hospital ACP clinics, we proactively enter the community. Even when communication is challenging and consultations take much more time and effort, we feel it's incredibly meaningful to serve these individuals."

On the other hand, Dr. Hsieh finds during consultations that people's understanding of the PRAA often differs significantly from the law's actual stipulations—a gap she chooses to see as an opportunity.

"One of the most important goals of ACP is to close the gap between expectations and reality." She shared the story of a 100-year-old woman who embraced the PRAA and came to reject all forms of medical intervention at the end of life, including tubes and medications. "On the surface, it looked like the whole process should have taken just five minutes. But the reality was not that simple."

While the PRAA is centered on patient autonomy, Dr. Hsieh stressed that every decision must still meet specific legal and clinical criteria. "Many people come with misconceptions about the PRAA. If they ever need to activate it and it doesn't align with what they imagined, they may feel disappointed. That's why the consultation process is so important. We need to guide them to fully understand the law and help them make decisions that genuinely reflect their needs."

Two-Stage Consultation
Integrating ACP into Routine Healthcare

Before an Advance Directive (AD) can be signed, it must be preceded by an Advance Care Planning (ACP) consultation to clear up questions and ensure understanding. And when it comes time to execute the AD, it must be done in a way that is both medically sound and compassionate.

According to Dr. Ying-Wei Wang, Director of the Center for Palliative Care at Hualien Tzu Chi Hospital, the PRAA is already quite comprehensive. The law requires that ACP consultations be carried out with the involvement of not only the patient and their family but also a multidisciplinary team of medical, social work, and psychological professionals. Yet challenges persist, especially in the execution of ADs.


Launched by the Hualien County Health Bureau, this pilot program brings ACP consultations into primary care. When doctors notice changes in a patient's condition during a routine visit, they can immediately begin a conversation about advance medical planning.

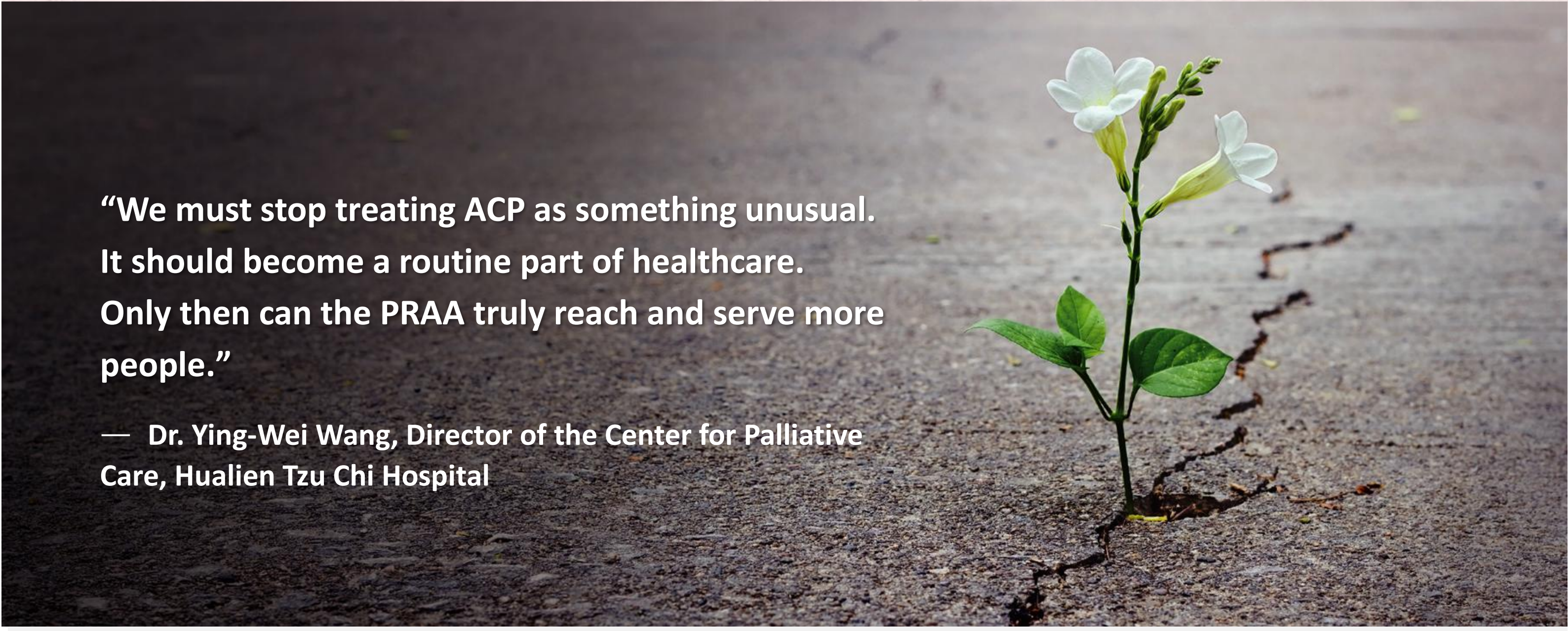
"Many times, we find that the PRAA still leaves certain scenarios unresolved," Dr. Wang explained. "For instance, during AD signing, patients are asked to decide how long they’d want IV drips, or which life-prolonging treatments they would accept. But life is unpredictable, and so is illness; thus, there remain many grey areas in medicine.”

He offered an example: nasogastric (NG) tubes. Many believe there’s no value in placing one for a terminally ill patient. “But sometimes we insert an NG tube not to prolong life, but to administer medications that ease discomfort for the patient,” he noted.

Reflecting on years of experience, Dr. Wang shared an important insight: for ADs to be truly effective, ACP should occur in two distinct stages. “Stage one focuses on understanding the PRAA and making initial decisions about future medical preferences. Stage two happens after the patient becomes ill. At this point, decisions are made in close consultation with the medical team, based on the patient’s actual condition. For example: When should a patient with end-stage kidney disease stop dialysis? Or, at what point should a heart failure patient stop using mechanical support?”

Only by making decisions in real time, he argues, can patients’ wishes for a good death truly be honored. “Otherwise, ADs risk becoming idealized on paper but impossible to carry out when the moment arrives.”

To that end, Dr. Wang suggests shifting from centralized “ACP clinics” to a more flexible model he calls “ACP in outpatient care.” Putting his philosophy into action, Dr. Wang has worked with the Hualien County Public Health Bureau to launch a pilot program that brings ACP into primary care settings. “When a family doctor who knows the patient well notices a change in his condition, that’s the ideal time to bring up advance medical planning. That’s what outpatient ACP is all about.”



> **“We must stop treating ACP as something unusual.**
> **It should become a routine part of healthcare.**
> **Only then can the PRAA truly reach and serve more people.”**
>
> — **Dr. Ying-Wei Wang, Director of the Center for Palliative Care, Hualien Tzu Chi Hospital**

Now that the PRAA has gained traction across Taiwan and the public is increasingly aware of Advance Medical Planning, Dr. Wang believes it’s time for the next step. “We must stop treating ACP as something unusual. It should become a routine part of healthcare. Only then can the PRAA truly reach and serve more people.”

As a new law, the PRAA placed enormous pressure on frontline medical staff, but they did not shy away. Over the past six years, healthcare professionals across Taiwan have endeavored to transform the law’s ideals into practical processes. With each challenge, they adapted and grew, sowing seeds of awareness and empowerment in communities everywhere. And now, those seeds have quietly taken root, blooming into flowers across the entire nation.