



Hospice Foundation of Taiwan

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Forever Love, Endless Care

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2023 Palliative Hospice and Spirituality Forum Series I

A Comprehensive Umbrella of Care for the Body, Mind, and Soul

Learning from Japan

Addressing the Challenges of Promoting Advance Care Planning in Taiwan

Differences in Advance Care Planning between Taiwan and Japan

Deepening the Person-Centered Conversation Process

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2023 Palliative Hospice and Spirituality Forum Series I

A Comprehensive Umbrella of Care for the Body, Mind, and Soul

Ying-Wei Wang, director of the Hospice Foundation of Taiwan, reflects on his initial thoughts about planning and promoting the Spirituality Forum Series. When he first delved into hospice and palliative care, he found himself busy understanding the physical and emotional conditions of patients and families. Addressing the abstract issue of spirituality, an area that initially intimidated him, proved challenging amid his hectic schedule. However, he soon realized the impossibility of separating the body, mind, and spirit when discussing palliative care. The optimal approach, he discovered, was to involve clergy from various religions. Yet, formal clergy members were so occupied that they couldn't attend to all the needs of patients and their families.

He also contemplated that spirituality and religion should not necessarily be synonymous; spirituality is a personal exploration that everyone should undertake. Therefore, hospice clinicians ought to possess the fundamental ability to engage with patients on a spiritual level. Consequently, he organized a series of spiritual forums for physicians, registered professional nurses, and long-term care staff. The aim was to assist in guiding patients to share their life stories during everyday interactions and encourage them to reflect on their relationships and connections to the past, life, and nature.

Forum 1

The European Association for Palliative Care's White Paper on Spiritual Care Education in Palliative Care

Guidelines for Spiritual Care to the Elderly in Australia

Ying-Wei Wang, Director of Hospice Foundation of Taiwan, Director of Palliative Care Center, Hualien Tzu Chi Hospital



In 2010, Taiwan ranked 14th in the Global Quality of End-of-Life Care, and first in Asia. By 2015, Taiwan ascended to the 6th position in the Global Quality of Death (GQOD) rankings, and in 2021, it achieved the 3rd position. What transformations occurred in the realm of end-of-life medical care in Taiwan from 2010 to 2021?

According to Ying-Wei Wang, starting in 2021, there has been a heightened focus on the quality of communication and care in end-of-life situations. This includes indicators related to physical, mental, and spiritual well-being, such as being treated kindly, fostering increased medical-patient communication, facilitating emotional adjustment, enabling dying in a preferred place, and addressing spiritual needs. These aspects are deemed crucial for the advancement of palliative care in the future.

Hospice and Spiritual Care

Ying-Wei Wang emphasized the significance of spiritual care as a crucial and necessary aspect of palliative hospice care. While it has been included in the definition for almost 15 years, it has remained one of the most overlooked components. In the pursuit of promoting hospice care, there is a need to reevaluate the issue of spiritual care.

He discussed the European Association for Palliative Care's (EAPC) Spiritual Care Task Force, which focused on research, education and training, the promotion of implementation, the transformation of the task force into a Reference Group in 2019, and the development of the EAPC White Paper on Spiritual Care Education in Palliative Care in 2020.

The EAPC White Paper on Spiritual Care Education in Palliative Care integrates research evidence on best practice models, considering the diverse developments in end-of-life care in the European region. It addresses spiritual education for all palliative hospice professionals. Recognizing the significant lack of spiritual care training for healthcare professionals in the development of palliative care in Europe, the White Paper specifically emphasizes core competencies in spiritual care education, dividing palliative care into three levels: palliative care approach, general



palliative care, and specialized palliative care.

According to Ying-Wei Wang, the EAPC White Paper on Spiritual Care Education in Palliative Care outlines 10 core competencies in hospice care. For the 5th point, "meeting the spiritual needs of the patient," hospice professionals are required to have the following competencies:

- The ability to reflect on the importance of spirituality and the existential dimension in one's own life.
- Integrate the spiritual, existential, and religious needs of the patient and family into the plan of care and respect their choices.
- Provide opportunities for patients and families to express their spiritual and/or existential dimensions in a supportive and respectful manner.
- Recognize boundaries that may need to be respected in terms of cultural taboos, values, and choices.

The EAPC acknowledges that spiritual care is multidimensional, encompassing life meaning challenges, values and attitudes, and religious considerations. This recognition leads to four key recommendations: reflecting on the individual's spiritual dimension; providing opportunities for patients and families to express their spiritual, existential, and religious needs; incorporating the spiritual needs of the patient, family, and caregiver into the plan of care; and respecting limitations posed by different cultures, rituals, and traditions.

Ying-Wei Wang emphasized that the need for spiritual care is not limited to the end of life; spiritual changes occur throughout the course of an illness. Addressing these changes through intervention and providing spiritual care is essential to meeting the patient's needs during these transformations.

Spiritual Care Is Relevant to Everyone

In addressing spiritual care for the elderly, Ying-Wei Wang shared insights from the



Guidelines for Spiritual Care to the Elderly in Australia, which encompasses three major aspects: all caregivers, spiritual care practitioners, and representatives of religions. The interdisciplinary team caring for patients and family members includes doctors, spiritual care practitioners, social workers, grief care practitioners, home caregivers, professional therapists, nursing staff, and volunteers.

The guidelines are structured into three main sections: spiritual care, pastoral care, and religious care, collectively referred to as the *spiritual care umbrella*. They adhere to four principles: the involvement of the entire organization, relational care, the universality of spiritual care, and its focus on the growth and prosperity of the individual.

According to Ying-Wei Wang, the *Guidelines for Spiritual Care to the Elderly in Australia* emphasize the balanced development of spiritual work, integrating both art and science. The artistic dimension involves person-centeredness, communication, sensitivity, and self-awareness. In contrast, the scientific aspect covers results, indicators, evidence, and ongoing work. Finding a balance between these two facets is crucial to effectively assisting those in need.

Forum 2

Clinical Spiritual Care: Hospice Spiritual Training and Clinical Application

Huey-Wen Lim, Physician, Yishun Community Hospital, Singapore

What is spiritual care? Dr. Huey-Wen Lim explains that spirituality refers to human cognition in the inner search for existence and meaning. It involves the deep relationship between individuals, their environment, nature or divine forces, and even their own selves at any given moment.

What benefits does spiritual care offer? According to Dr. Lim, studies in the U.S. have shown that spiritual care can reduce the mortality rate of patients in hospitals and increase the rate of transferring patients to hospice.



Clinical spiritual assessment utilizes FICA as a tool, which encompasses four key components: (1) understanding and knowledge of the patient; (2) their life story, including the people and things that are important to them; (3) their interpretation of life; and (4) their interpretation of life's dilemmas. Dr. Lim emphasizes that, akin to obtaining a medical history, caregivers need to inquire about a history of spiritual encounters to comprehend the patient's needs.

Following the spiritual assessment, patients may undergo spiritual distress, exhibiting clinical symptoms such as depression, loss, inability to practice daily religious rituals, wavering trust in beliefs, a sense of purposelessness, spiritual emptiness, feelings of emotional isolation from oneself or others, and negative perceptions about life's meaning. Dr. Lim suggests that diagnosing spiritual disturbance can help patients regain self-confidence and adopt a positive mindset.

Spiritual Care History Spawns the FICA Assessment Tool

F (Faith): *What are the patient's spiritual or religious beliefs?*

I (Importance): *Are these beliefs important?*

C (Community): *Talk about the people the patient has contact with, including family, friends or religious groups.*

A (Assist): *What spiritual care does the patient want from the health care provider?*

Allow the Patient to Live His or Her Last Days with Dignity and Meaning

In terms of clinical application, spiritual care can be summarized into six major objectives, which are to help patients recover: (1) sense of love and belonging in life, (2) life meaning and purpose, (3) appreciation of the beauty of nature, (4) spiritual/religious guidance, (5) mindfulness, gratitude, and calmness of mind, and (6) management of issues during and after life.

Through the combination of nursing disposition, rehabilitation assessment, and spiritual care, registered professional nurse Bing-Zhen Gao admits, "We can't



change the outcome, but we can influence the journey." We are committed to enabling our patients to live their last days with dignity and meaning.

In addition, social worker Xiao-Yi Lim also shared the Bio-Psycho-Social-Spiritual Model, which is commonly used in spiritual care in Singapore:

Bio: diagnosis, prognosis, current and expected health conditions, and behavior.

Psycho: mental ability, mood, personality, and coping ability.

Social: nature of family relationships, family circumstances, resources in the family and community, financial situation.

Spiritual: The meaning of life experiences, personal values, beliefs, and religious rituals.

According to Xiao-Yi Lim, this model can effectively examine symptoms and illnesses, along with their impact on the patient's physical and psychological aspects.

Spiritual care practitioner Shu-Ling Teng pointed out that for clinical cases, in addition to the use of medication, the team--including doctors, social workers, physical therapists, nurses, and others--is also utilized to carry out comprehensive care and spiritual conversations. This allows the patients to share their feelings, life stories, and discuss their beliefs. The patients can even explore and face their strengths, as well as physical regrets and hopes. Shu-Ling Teng said that through the spiritual care journey, medical staffs were able to see positive changes in the patients' lives, even though sadness continued to surround the patients.

Forum 3

Long-term Care Organizations: Hospice Spiritual Care for the Elderly

Fang Liu, Associate Professor and Director, School of Gerontology and Long-Term Care, Taipei Medical University



An individual's spirituality can exist independently of religious beliefs, affiliations, or practices. Spiritual care constitutes a crucial aspect of holistic and compassionate healthcare. Empirical studies have demonstrated that acknowledging and supporting an individual's spirituality can alleviate the suffering experienced by many during illness or at the end of life.

The reason for the consistent emphasis on spirituality lies in its significance as a vital component of long-term care units. It promotes meaningful aging and facilitates the elderly in becoming the best version of themselves in their current circumstances. With an increasing number of long-term care units globally and actively promoting palliative and spiritual care, Fang Liu noted that one of the goals of hospice care is to enable patients to depart peacefully from their homes. Long-term care organizations are often considered by many residents as their home and the final residence in their lives. Therefore, it is imperative for long-term care staff to possess the skills of spiritual care to enhance the quality of life for residents, fostering a sense of belonging and connection.

Spirituality and Quality of Life Are Intertwined

Maintaining and enhancing the quality of life is a primary objective for reputable long-term care facilities. According to the World Health Organization (WHO), spirituality is intricately connected to the quality of life, asserting, "Whether we realize it or not, we all have spiritual needs."

Regarding the relationship between long-term care residents and staff, Fang Liu highlighted that, unlike acute care in hospitals, the bond between residents and staff is notably close. This closeness stems from frontline staff providing 80% of direct care to long-term care residents, maintaining daily or weekly contact with residents' family members and friends. Even without a blood relationship, numerous studies indicate that long-term care residents and caregivers establish a familial connection, forming a close-knit relationship.



What are the benefits of offering spiritual care to the elderly? Fang Liu stated that studies reveal positive impacts of spirituality and religion on elderly individuals with dementia. Beyond sustaining social activities, the comfort derived from prayer and familiar rituals establishes a more regular life rhythm, stimulating neural pathways. Fang Liu emphasizes that meaningful activities in long-term care facilities assist seniors in accepting a dementia diagnosis, slowing the progression of the disease and cognitive decline, and preparing seniors for the end of life.

Five Elements Meeting the Spiritual Needs of the Elderly for Peace of Mind

As long-term care organizations are considered home by many residents, spirituality holds even more significance for this group of elderly individuals and the long-term care units. According to the *Guidelines for Spiritual Care to the Elderly* in Australia, hospice and spiritual care for the elderly should focus on five key elements:

1. Organizational leadership and alignment: Embedding and practicing spiritual care at all levels throughout the organization.
2. Relationship and connectedness: Providing care within the context of mutual, respectful, and genuine relationships.
3. Identifying and meeting spiritual needs: Recognizing choices, preferences, and needs of older people, identified, documented, and shared by the care team.
4. Ethical context of spiritual care: Establishing an ethical framework to ensure spiritual care respects and upholds the rights of older people.
5. Enabling spiritual expression: Implementing individualized activities and interventions to encourage finding meaning, purpose, connectedness, and hope.



The Spiritual Needs Model for Long-term Care Facilities

Evaluation of elderly-centered care services is approached from four perspectives:

1. Meaningfulness: Whether the elderly can reestablish a new balance in their lives and cope with illnesses and functional deterioration in old age.
2. Transcendence: Whether the elderly can find the foundation of their existence, beliefs, faith, and aesthetics.
3. Values: Whether the elderly can be understood, affirmed, respected, and maintain their autonomy.
4. Psychosocial Identity: Whether the elderly feel loved and cared for, possess positive thoughts about themselves, and have the feeling and ability to forgive others.

So then, *how can spiritual care be implemented in long-term care facilities?* Fang Liu pointed out five important driving forces: (1) active participation of the organization's senior management, (2) close alignment of values embraced and practiced by staff, (3) staff education and training, (4) integration of spirituality with related philosophies/models, and (5) cultivation of a culture that recognizes and responds to the needs of spirituality.

Lastly, Fang Liu emphasized that all members of the geriatric or palliative care team can provide spiritual care through activities such as sensitive and respectful interactions, empathic communication, reminiscence, mindfulness and meditation, and therapeutic life review. Spiritual care is optimized when a holistic organizational approach is taken, building trusting relationships and providing the elderly with opportunities to connect with family, friends, and nature, ensuring they feel safe and can engage in meaningful activities or give back to others.

~ to be continued~



Learning from Japan Addressing the Challenges of Promoting Advance Care Planning in Taiwan

The healthcare environments in Taiwan and Japan differ, and there are also disparities in the implementation and promotion of Advance Care Planning (ACP). In April of this year, the Taiwan Academy of Hospice Palliative Medicine, in collaboration with the Rotary Club of Taipei Tienmou, invited relevant experts and scholars from Japan to Taiwan for exchanges and conversations, aiming to share the similarities and differences in the promotion, research, advocacy, development, and implementation of ACP.

In the era of the approaching super-aged society, the issue of care for the elderly has been increasingly emphasized by various countries. Taiwan's concept of hospice and palliative care predates that of other Asian countries. Following the enactment of the Hospice and Palliative Care Act, the Patient Right to Autonomy Act was formally launched in early 2019. Although it has been in effect for four years, there is still room for improvement. With Taiwan entering a super-aged society in 2025, the issue of health care is urgent, and the implementation of the concept of hospice also needs new discussions.

Among Asian countries, Japan still lacks a specific legal framework for Advance Care Planning (ACP), but the development of hospice and palliative care is thriving. In order to encourage a different perspective among domestic healthcare professionals in promoting ACP, following the 2020 field trip to Japan organized by the Hospice Foundation of Taiwan, this year, in collaboration between the Rotary Club of Osaka Umeda, Japan, and the Rotary Club of Taipei Tienmou, Taiwan, with the Taiwan Academy of Hospice Palliative Medicine as a facilitator, the Japan



Association for Clinical Ethics, Japanese Society for Palliative Medicine, and related experts and scholars were invited to Taiwan. Two seminars were held in Taipei and Kaohsiung, respectively, aiming to explore additional solutions for promoting ACP in Taiwan by drawing on Japan's implementation practices and perspectives on ACP.



Differences in ACP Implementation Between Taiwan and Japan

The promotion of ACP and the Patient Right to Autonomy Act in both Taiwan and Japan is notably similar to that of home medical care. Japan developed a local healthcare system integrated with long-term care in the 1980s, and the timeline for promoting ACP aligns closely with that of Taiwan. Both countries have exerted efforts to progress in terms of culture, law, and ethics, yet there remains a significant disparity in the actual implementation of ACP.

Shao-Yi Cheng, the President of the Taiwan Academy of Hospice Palliative Medicine, pointed out that both Taiwan and Japan are grappling with the challenges of an aging population and actively promoting ACP. However, the most significant disparity in the viewpoints and practices regarding ACP implementation between Taiwan and Japan lies in the approach. "Taiwan places significant importance on legislation to confer legal validity to the patient's signature on the Advance Decision



(AD), thus emphasizing modifications to laws and regulations to safeguard the rights and interests of the signatory. In contrast, Japan does not primarily focus on legal perspectives but rather approaches ACP from philosophical and ethical concepts to contemplate life issues. Japan also encourages local governments to integrate ACP with the home medical care system."

"Japan's emphasis on the popularity rate, allowing individuals to learn about ACP and sign it through a doctor they know well, is linked to Japan's active promotion of home medical care," Shao-Yi Cheng explained. She further noted that Japan lacks specific legislation or legal protection for ACP. "In fact, clinical guidelines developed by local governments and medical associations vary, and there is no standardized AD form as seen in Taiwan. Instead, the focus is on collaboration with local medical care and implementation in the home medical care sector."

Still Room for Progress in Promoting ACP in Taiwan

Currently, there are about 4 million elderly people in Taiwan, with over 200,000 deaths each year. Four years after the promotion of the Patient Right to Autonomy Act, only fewer than 50,000 people have signed the AD, which is less than 2% of the total population. Hence, there is indeed room for progress.

According to Shao-Yi Cheng's research, she stated, "Taiwan's population actually has a high level of acceptance of patient autonomy." A few years ago, the Department of Family Medicine at National Taiwan University Hospital (NTUH) collaborated with Kyoto University in Japan on a study comparing the acceptance of ACP in Taiwan and Japan. The study aimed to investigate at which stage of the disease it is most appropriate for ACP to intervene and be discussed. The results revealed that both in Taiwan and Japan, patients preferred their doctors to initiate discussions as early as possible.

"The results of this study have overturned our expectations. We used to think that people would prefer ACP to intervene only as a last resort, but the fact is that people



in Taiwan are even more inclined than in Japan to want ACP to intervene as early as possible." Shao-Yi Cheng sees significant potential in Taiwan, where the concept of hospice and palliative care has been consciously embraced both legally and by the public. However, the reasons for the lack of success are likely to be multifaceted.

"The high cost of counseling is a significant deterrent," she pointed out. While Taiwan's healthcare system is robust and medical costs are low, asking the public to spend thousands of dollars on ACP consultation is challenging. "It now appears that only individuals from specific classes, such as those with financial means and knowledge, are willing to invest the time and money to go to the hospital for consultation and signing. Encouraging the public to visit hospitals to sign the AD is even more challenging, and the recent outbreak of the COVID pandemic has further hindered patients' willingness to go to the hospital for AD signing."

Certainly, insufficient publicity and accessibility are also contributing factors. Shao-Yi Cheng shared her experience abroad: In Europe and the United States, some hospitals include health education leaflets in the information provided to patients upon admission. This allows patients and their families to have time to learn about it. "In fact, Taipei City Hospital has done an excellent job by organizing large-scale lectures, enabling the public to sign the leaflet immediately after the event." She suggested that in the future, the health education leaflet could be transformed into a simplified version of an app. This way, patients or their families can quickly receive relevant information while waiting for appointments, making them more willing to consult with a doctor for further understanding.

For example, in Japan, the process of promoting ACP does not have restrictions limiting its implementation to hospitals, and there is no specific consultation and document signing process. Instead, it emphasizes the establishment of a strong doctor-patient relationship between healthcare workers and patients through repeated communication during the treatment process. This approach aims to help the public understand the significance of a good death. "Japan believes that ACP is a process of assisting patients in moving towards a good death. It requires a long



period of delicate participation and care to slowly build up a good doctor-patient relationship and then discuss the matter step by step." This is a valuable aspect worth learning from.

"The lack of personalization in ACP is also a problem," said Shao-Yi Cheng. She added that standardized forms may not be suitable for patients at all stages of their illnesses. "As their conditions change, they should be able to make choices at different stages." Therefore, she suggested that if there is an opportunity to launch ACP version 2.0, consideration could be given to providing multiple options. Government subsidies for the elderly or care recipients in long-term care organizations could be implemented, allowing people with urgent needs to sign the form as a matter of priority.

Japan Emphasizes and Promotes Dying Well at Home

In 2019, Shao-Yi Cheng proposed the *Taipei Declaration on Advance Care Planning*, which was published in the *Journal of Palliative Medicine* and recognized as one of the earliest advance care guidelines in the Asia-Pacific region.

The declaration emphasizes that advance care is a process involving patients and their families in understanding the meaning of a good death. It involves discussing potential challenges with the healthcare team when the disease becomes incurable, covering physical, mental, spiritual, and social dimensions. The consideration of individual needs is highlighted, ensuring that the process meets the current needs of patients and families at any stage. The declaration suggests approaching this from multiple perspectives, including the patient, family members, healthcare professionals, trainers, researchers, and policymakers. It emphasizes an ethical foundation for execution to achieve its goals.

She believes that Japan's focus on promoting a good death at home is a crucial aspect for the future healthcare promotion in Taiwan. The promotion of community hospice care represents the final step in enabling patients to return home with peace of mind.



It is essential to enhance and promote the capability of community doctors to care for patients returning home from the hospital. This ensures that patients and their family members can feel at ease. Additionally, establishing daycare centers in the community provides a space for communication and rehabilitation for patients returning home.

"In Taiwan, the fast-paced nature of medical care leaves healthcare workers with little time to engage in detailed discussions with patients about their end-of-life thoughts," she stated. She emphasized that learning from Japan's concept of integrating ACP into daily life is valuable. Establishing a gradual and strong doctor-patient relationship, gaining the trust of patients and their families, and bridging the aging and end-of-life processes are crucial. This approach ensures that end-of-life care becomes intimately connected with people's hearts, allowing life to reach its fullest potential.



Differences in Advance Care Planning between Taiwan and Japan

Deepening the Person-Centered Conversation Process

With the enactment of the Patient Right to Autonomy Act in 2019, Advance Care Planning became a legal procedure for validating Advance Decision. However, in comparison to Taiwan, where the consultation tends to focus on achieving a good death, Japan, having long entered a super-aging society, places more emphasis on the conversational process.

How do you decide to navigate the final stretch of your life when faced with physical incapacity or even unconsciousness? Would you choose to be intubated, relying on life-sustaining equipment to sustain your incapacitated body, proceeding towards the end of life in an awkward manner? Alternatively, do you opt to preserve your last shreds of dignity, disconnect life-sustaining equipment, and maintain the integrity of your body for a dignified death?

With the enactment of the Patient Right to Autonomy Act (PRAA) in 2019, a person now has the ability to make this decision in advance by signing an Advance Decision (AD). However, the AD only takes effect after you have undergone an Advance Care Planning (ACP) session with your healthcare provider, giving ACP a unique legal status and making it a prominent topic in hospice care.

Advance Care Planning: A Willingness to End Well

Attorney Sam-Rong Hwang, holding a master's degree in law from Nagoya University in Japan, has been actively involved in researching the PRAA. In early 2018, he initiated participation in the Rotary International Global Grants Program, fostering a connection between Rotary Club Taipei-Tienmu and the Taiwan Society



of Home Health Care. He organized a team comprising medical doctors, nurse practitioners, psychologists, and other professionals to visit Japan for a seminar, exchanging experiences with the Japan Home Health Care Alliance. Upon returning to Taiwan, he recognized the necessity to further delve into related healthcare issues. Following the same pattern in 2020, he revisited Japan with a team of healthcare professionals from the Hospice Foundation of Taiwan for additional exchanges on ACP and hospice and palliative care.



After returning home, the participants of the seminar believed that they could further enhance exchanges by inviting Japanese experts and scholars to Taiwan. However, their plans were hindered by the COVID-19 pandemic, and it was not until May 2023 that they finally succeeded in inviting several Japanese doctors, professors, and other professionals to Taiwan for in-person and online exchanges. These three seminar exchanges sparked different insights and practices in ACP between Taiwan and Japan.

According to Article 3, Paragraph 6 of the PRAA, ACP is defined as the process of communication between a patient and healthcare providers, relatives, or other relevant individuals. This communication aims to discuss the appropriate care that should be provided to the patient in specific clinical conditions, when the patient is in a coma, or is unable to clearly express their wishes. It also involves addressing



decisions about life-sustaining treatments, artificial nutrition, and fluid feeding, which the patient is allowed to accept or refuse.

Under this provision, individuals seeking consultation must engage with healthcare providers (i.e., doctors, nursing staff, social workers), at least one relative within the second degree of consanguinity, and the appointed medical surrogate agent (if applicable). The purpose of the consultation is to make advance decisions regarding the acceptance or refusal of life-sustaining treatment, artificial nutrition, and fluid feeding. This is particularly relevant when the individual is at the end of life, in an irreversible coma, in a permanent vegetative state, experiencing profound dementia, or in any other case of a serious illness designated by the government.

The consultation results are documented after the individual signs an AD. The hospital assists in scanning and uploading these results to the Ministry of Health and Welfare's database. Furthermore, the information is recorded on the individual's health insurance card.

The AD, similar to the *Advance Hospice Palliative Care & Life-Sustaining Treatment Choices of Intent (or DNR – Do Not Resuscitate)* under the Hospice Palliative Care Act, provides a means to proactively reject excessive medical treatment, ensuring that patients can experience a good death. However, the scope of the AD is broader, encompassing a wider range of diseases and offering more options for refusing or accepting various medical treatments.

Person-Centered Approach Toward the End of Life

According to Sam-Rong Hwang, Japan does not have a specific law like the PRAA, and there is no mandatory requirement for ACP. Japan places a stronger emphasis on the conversation process, aiming to improve family relationships and doctor-patient relationships through dialogue.

For instance, Elder A may have initially opted to decline life-sustaining treatments, but upon learning that A's grandchild is about to be born, A decides to undergo life-



sustaining treatments to witness A's grandson's arrival for the first and last time.

On the other hand, Elder B may have initially chosen to receive life-sustaining treatments to prolong life, but towards the end of life, B embraced certain religious beliefs, leading to a change of heart, and decides to decline life-sustaining treatments in the hope of maintaining an intact body while aspiring to achieve a good death.

In Taiwan, under the PRAA, the content of an AD can be altered even after signing. However, the primary emphasis of the promotion is to educate the public on choosing what is known as a *good death*. Due to the existence of this dedicated law, healthcare professionals involved often lean towards strict adherence to legal requirements, guiding the public to opt for the so-called *good death*. This, in turn, indirectly influences public thought processes, imposing values on them, and suggesting that a *good death* is the outcome of both ACP and AD.

Sam-Rong Hwang holds a different perspective. Comparing the varying mindsets of the governments and people in the two countries, he believes that, despite Japan lacking a specialized law like the PRAA and only having administrative guidelines for the *Life Meeting* formulated by the Ministry of Health, Labour and Welfare, there is an expectation that the Japanese people might be less constrained by legal frameworks, placing greater emphasis on the conversational process. According to Sam-Rong Hwang, the Japanese system may prioritize person-centered practices to a greater extent.

Upon further exploration, what constitutes a *good death*? For the Taiwanese, it appears that a good death entails a peaceful and dignified passing, preserving the integrity of the body—a concept of leaving the body intact. Therefore, encountering life-sustaining medical treatments that inevitably lead to intubation, tracheotomy, or electrocution, causing more or less damage to the body, is not considered a good death. Consequently, in pursuit of a good death, Taiwanese individuals opt to refuse life-sustaining medical treatments during the ACP process. To a certain extent, this



aligns with the government's expectations to avoid wasting medical resources and to shield healthcare workers from potential legal disputes.

However, this perspective may not be universal among the Japanese people. Approximately 10 years ago, there were voices in Japanese society to legislate for a dignified death, but it quickly faced a wave of opposition. Various groups, including those representing mentally and physically challenged individuals, rare disease groups, lawyer groups, and even doctor groups, distanced themselves from legislation on dignified death. This might be because Japanese people believe that life is not a simple decision and that more thorough discussions should take place before determining whether or not to embrace a dignified death. This reflects the cautious approach of the Japanese people in exploring the nuanced nature of human existence on this issue, rather than making a hasty and simplistic decision on the concept of a *good death*.

Three Exchanges Nurturing Growth

In 2018, 2020, and 2023, Sam-Rong Hwang participated in three exchanges between Taiwan and Japan focused on home medical care, ACP, and hospice and palliative care. Each exchange had a distinct impact. He noted that during the first exchange, discussions were primarily between Taiwan and Japan's residential healthcare professionals, with limited emphasis on ACP and hospice and palliative care—topics only briefly touched upon. However, the last two exchanges delved more profoundly into these subjects.

In 2020, a team of 24 physicians, nurse practitioners, and psychologists from the Hospice Foundation of Taiwan, including Director Chun-Kai Fang, CEO Yi-Yin Lin, and Attorney Sam-Rong Hwang, embarked on a fruitful academic exchange in Japan. Following the team's return to Taiwan, two ACP seminars were conducted in July and August at Tamsui MacKay Memorial Hospital. These seminars compared the legal systems, ethical concepts, and practical healthcare issues between Taiwan and Japan. The seminars provided Taiwan's healthcare professionals with an



opportunity to reevaluate the status of ACP and related matters.

In 2023, through collaboration with the Taiwan Academy of Hospice Palliative Medicine, Japanese experts and scholars were invited to Taiwan for a combined online and in-person seminar. The event featured eight Japanese doctors and professors participating either in person or online. This seminar took place after the fourth anniversary of the implementation of Taiwan's PRAA, providing a wealth of clinical cases for discussion in Taiwan. The cultural differences between Taiwan and Japan provided ample opportunities for Taiwanese healthcare professionals to engage in thoughtful discussions on ACP and hospice and palliative care.

Sam-Rong Hwang is pleased to witness healthcare professionals in Taiwan contemplating the system from different perspectives. He sees these considerations as seeds that will sprout and grow in the future. In the ongoing promotion of ACP and AD signing, he hopes to contribute diverse opinions and foster discussions on this topic within society. This way, healthcare professionals and others can reflect more on person-centered practices.

Sam-Rong Hwang couldn't speak on behalf of the Japanese experts, but he observed their surprise upon learning about the completion of Taiwan's PRAA legislation. The surprise could stem from various aspects, such as amazement at Taiwan's society reaching a consensus on values and successfully legislating. They might be astonished that Taiwan achieved legislation where the state guides people's values. Another possibility is that they found it surprising that the people of Taiwan completed legislation quickly without thoroughly contemplating this aspect of the issue beforehand.

Living a Good Life Is All About People

Sam-Rong Hwang envisions the future direction of ACP with a focus on two key perspectives. Firstly, *From Act to Person-centered*, highlighting the shift from



merely emphasizing legal frameworks to placing a greater emphasis on person-centered approaches. Secondly, *From AD to ACP*, emphasizing the transition from concentrating solely on the signing of the AD to prioritizing the implementation of ACP.

Additionally, *From Outcome to Process* emphasizes not only the result of the decision but also the importance of dialogue and discussion, in which the system should refocus on the individual. And *From Hospital to Home* involves not only an institution-based approach but also underscores the role of home healthcare and home-based healthcare in advancing ACP.

Moreover, it is important to adopt a broader perspective. *From Healthcare to Total Domains* involves not only focusing on healthcare but also considering life comprehensively, including financial and life planning, referred to as Advance Total Planning (ATP). Lastly, returning to the core of the ACP system, *From Good Death to Good Life* means not only prioritizing the pursuit of a good death but also placing importance on *living fully* and *living well*, providing an opportunity for a good death.

