



# Advance Care Planning in Palliative Care in Asia: Barriers and Implications

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Advance care planning (ACP) in palliative care is essential for patient autonomy and quality of dying. This review explores ACP practices in South Korea, Japan, and Taiwan, highlighting how legislation and cultural values shape those practices. In these three sectors, which are influenced by Confucian values, family involvement plays a significant role in decision-making. In South Korea, the Life-Sustaining Treatment Decisions Act made ACP processes mandatory at all healthcare institutions and rapidly created advance directive registration agencies nationwide, with a national web-based system for legal documentation. The Act's narrow focus on terminal illness and dying phase may inadvertently delay end-of-life discussions. A broader social consensus is needed to allocate end-of-life care resources in a way that reflects patients' and families' wishes. Japan's family-based approach highlights relational autonomy, with ACP timing varying and no formal legal frameworks for advance directives. Expanded palliative care, ACP guidelines, systemic support, and public awareness drive progress in Japan. Taiwan's two relevant legislative frameworks—the Hospice Palliative Care Act and Patient Right to Autonomy Act—expand palliative care services for terminal illnesses and non-cancer diseases such as severe dementia, irreversible coma, and a persistent vegetative state. Misunderstandings of ACP and family-led decision-making may hinder ACP uptake. ACP referral based on patient care needs rather than terminal diagnoses is suggested. Overcoming common barriers in Asia necessitates open dialogues about death and public education. A standardized legal framework and comprehensive training for healthcare providers are equally important. Further international collaboration will suggest culturally sensitive ACP conversations across Asia.

**Key Words:** Advance care planning, Palliative care, Relational autonomy, Asia

Received October 14, 2024  
Revised November 3, 2024  
Accepted November 4, 2024

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## INTRODUCTION

Advance care planning (ACP) is essential for ensuring patient autonomy and improving the quality of dying. ACP involves individuals defining their goals and preferences for future medical treatment and care, discussing these with family and healthcare providers, and documenting and reviewing these goals and preferences when appropriate [1]. It is integral to palliative care, facilitating the initiation of end-of-life (EOL) communication. By combining ACP with effective palliative care, such as symptom management, the quality of dying for patients and their families is enhanced, and aggressive medical interventions in the final weeks of life are reduced [2]. Research indicates that ACP improves the quality of communication between patients and physicians, particularly in conveying treatment preferences. It also reduces decisional conflict, enhances agreement on preferences between patients and caregivers, and increases the documentation of these preferences. However, the process of ACP is complex and influenced by cultural, societal, and legal factors. In Asia, traditional values place a strong emphasis on family involvement and medical paternalism [3]. Confucianism, which promotes the concept of 'filial piety,' views it as a virtue and duty for children to protect their parents from bad news, especially regarding death. Therefore, family members often override individual preferences in EOL discussions across Asia [4].

Advances in legislation and growing societal awareness have led to progress in ACP in Asia. It is crucial to acknowledge the concept of "relational autonomy" in this region, where patient autonomy is often defined within the framework of family values [5]. A recent international Delphi study conducted in five Asian sectors identified a key domain not previously emphasized in Western counterparts: a "person-centered and family-based approach." This approach emphasizes the vital role of family involvement in supporting an individual's participation in ACP and ensuring that decisions reflect the person's best interests through shared decision-making. In many Asian contexts, treatment preferences are deeply intertwined with familial relationships and responsibilities, with family members and healthcare providers playing a pivotal role in fostering meaningful engagement in ACP.

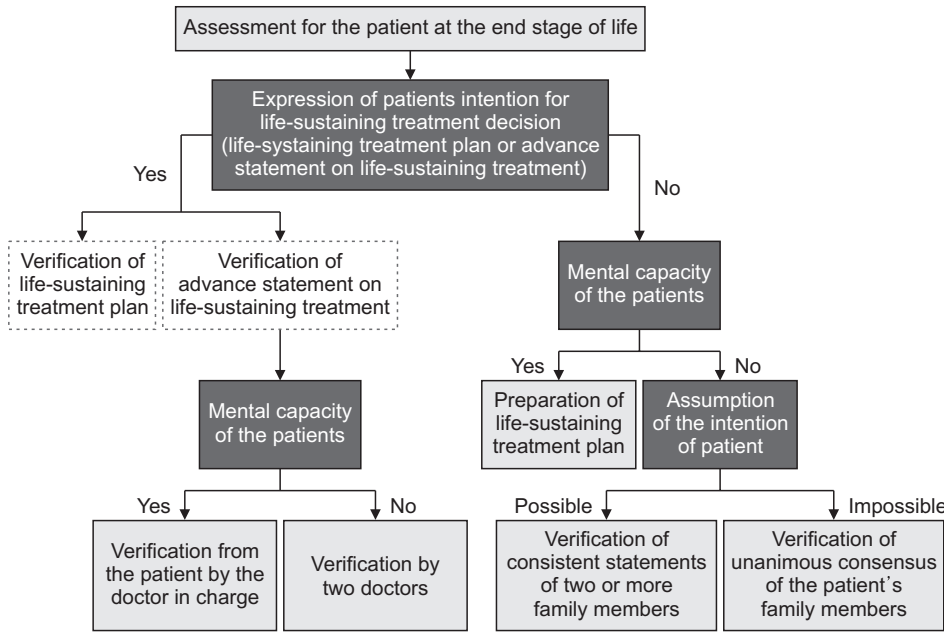
Under the influence of Confucianism, South Korea, Japan,

and Taiwan exemplify successful ACP implementation in Asia. Herein, we provide an overview of ACP practices in these three sectors more specifically, drawing on the scientific literature and legal documents. Our goal is to explore the barriers and effective strategies for implementing ACP in palliative care across Asia, with an emphasis on cultural considerations.

## OVERVIEW OF ACP

**South Korea:** South Korea is an aging society, with older adults making up 19% of its total population of approximately 51.3 million in 2024 [A1]. Koreans have had legislation related to ACP, "the Life-Sustaining Treatment (LST) Decisions Act, originally titled "Act on Hospice and Palliative Care and Decisions on LST for Patients at the End of Life" through social consensus from 2018 [A2]. This legislation was prompted by two high-profile legal disputes concerning LST decisions in hospitals [6]. The LST Decisions Act is designed to uphold patient autonomy and minimize suffering caused by unnecessary LST. Under the Act, if patients are unable to express their wishes due to a lack of mental capacity, immediate family members are empowered to make decisions regarding LST. Furthermore, in instances of ethical conflicts among stakeholders [7], the Act requires medical institutions to establish institutional ethics committees. These committees are tasked with deliberating on the discontinuation of LST and addressing related issues.

The law recognizes two legal forms of ACP: the advance directive (AD) and physician orders for life-sustaining treatment (POLST or LST plan). ADs are available to individuals over 19 years of age at any stage of life: they can voluntarily complete an AD at national registry agencies with the assistance of counselors. Meanwhile, patients in the end stage of illness or dying phase can work with their healthcare providers, specifically doctors, to establish an LST plan [A3]. The decision-making process for LST begins during two main periods as defined by law: the "end stage of disease" and the "dying process." The former typically refers to a life expectancy of a few months, while the latter indicates that death is expected within days [A4]. The process involves necessary steps and requirements for executing LST plans (Figure 1). Both AD and LST plans must be registered by uploading them to the



**Figure 1.** Diagram of the procedure for withholding or withdrawing life-sustaining treatment (LST) in South Korea [SL2]. When the patient is mentally competent, a doctor should check the patient’s own intent with an advance statement regarding LST. If a patient lacks decision-making capacity, two or more family members must provide concordant statements about the patient’s intent on LST. When it is impossible to identify a patient’s intent, all first-degree members of the patient’s family (including spouse) should reach a consensus.

Source: National Agency for Management for Life-Sustaining Treatment. Procedure diagram [Internet]. Seoul: Korea National Institute for Bioethics Policy; 2024 [cited 2024 Sep 21]. Available from: <https://www.lst.go.kr/eng/half/procedure.do>.

online LST Information Processing System [A5]. This national system stores all legal ACP documents and is managed by the National Agency for Management of LST. Access to this system is restricted to authorized institutions and healthcare providers to ensure confidentiality. National registry agencies for ADs are widely distributed and easily accessible across the country. These include branches of the National Health Insurance Cooperation, public health centers, medical institutions, non-profit organizations, and senior welfare centers (designated in 2021). The eligibility for LST plans has recently been broadened to include all diseases. Additionally, the range of immediate family members authorized to give legal consent to POLST has been narrowed to first-degree relatives, making the process more practical following a legal amendment in 2019. The National Agency for Management of LST offers official education through online platforms [A6]. E-learning courses are tailored for healthcare professionals, counselors at registry agencies, and the general public.

The legislation significantly increased public awareness [A4]. As of October 2024, there are 730 AD registry agencies with counselors and 454 medical institutions that offer AD and LST plans. Approximately 2.5 million people (2,575,172) have registered their AD, and 149,361 patients have completed LST plans [A7]. Due to these changes, South Korea ranked 4th among 81 countries in the 2021 cross-country comparison of

expert assessments of the Quality of Death and Dying [A8]. Previously, in 2015, South Korea was ranked 18th out of 80 countries in the Quality of Death Index conducted by the Economist Intelligence Unit [A9].

**Japan:** Japan, as one of the world’s most rapidly aging societies, has made significant strides in integrating ACP into its healthcare system, especially after the 2018 revision of the Guidelines on the Decision-Making Process for Medical Care in the Final Stage of Life by the Ministry of Health, Labour, and Welfare. ACP focuses on patient-centered decision-making across a range of diseases, including oncology, cardiology, pulmonology, nephrology, and geriatrics [A10–13]. It is implemented in various care settings, such as hospitals, outpatient clinics, and home care. Additionally, ACP includes non-medical stakeholders like EOL journalists, legal experts, philosophers, and citizens, demonstrating the extensive community involvement in addressing the challenges of Japan’s aging population [A14,A15].

The guidelines emphasize ongoing dialogue among patients, families, and healthcare providers, recognizing that preferences may evolve over time [8]. Cultural concepts such as “sontaku” (anticipating unspoken wishes) and relational autonomy, where the family plays a pivotal role, shape ACP practices [9,10]. Despite the increasing acknowledgment of ACP’s significance, Japan does not have a formal legal framework for

ADs and surrogate decision-making, rendering ACP largely voluntary [11]. Data from palliative care units (PCUs) indicate a rise in patient involvement in do-not-resuscitate (DNR) orders and ADs [12]. Nonetheless, debates persist in Japan about the advantages and limitations of ACP, highlighting the necessity to customize ACP to align with individual patients' values, readiness, and preferences.

**Taiwan:** In Taiwan, the legislation concerning ACP can be categorized into two distinct phases: the first is marked by the enactment of the Hospice Palliative Care Act (HPCA) in 2000, and the second by the introduction of the Patient Right to Autonomy Act (PRAA) in 2016 [13]. These two acts exist concurrently, sharing some overlapping concepts. This positions Taiwan as the first country to establish a comprehensive legal framework that not only supports the implementation of ACP but also facilitates the completion of ADs. This dual legislative approach has shaped Taiwan's service delivery in a way that differs from Western countries, such as United Kingdom, United States of America, and Australia [13].

The first phase involved the implementation of the HPCA [A16], which enabled terminally ill patients, primarily those with cancer, to articulate their preferences concerning LSTs. However, only cardiopulmonary resuscitation and intubation could be withheld or withdrawn under this act. The HPCA underwent three amendments—in 2002, 2011, and 2013—to better align with clinical realities and enhance its practicability. Following this legislation, the prevalence of palliative care service provision for terminally ill patients increased.

However, a significant number of non-terminally ill patients experiencing refractory suffering—such as those with dementia, individuals in a permanent vegetative state, people with rare diseases, or those in an irreversible coma—still face challenges in accessing palliative care services, as they are not eligible under the HPCA. Even when these individuals have an AD, commonly known as a DNR form, in place under the HPCA, their preferences are not honored or acted upon until their condition is declared terminal by two relevant specialist physicians. This situation has ignited a debate over whether these patients are being denied the right to exercise autonomy over their medical treatments, especially concerning life-sustaining interventions. Therefore, these patients often suffer from a poor quality of life due to the symptoms of their diseases and

the adverse events of ongoing treatments.

The second phase, marked by the enactment of the PRAA [A16], aims to complement the HPCA by adopting a more inclusive approach. It expands the range of eligible service recipients to include not only patients in a terminal stage of illness but also those in an irreversible coma, in a permanent vegetative state, suffering from severe dementia, or other conditions determined by the central competent authority that meet the criteria of individuals enduring unbearable and incurable diseases. Additionally, the PRAA broadens the scope of treatments covered, extending beyond LSTs such as cardiopulmonary resuscitation, intubation, blood transfusion, mechanical life-support systems, and antibiotics against severe infections, to include artificial nutrition and hydration (e.g., provision of food or fluids via tubes or other invasive means).

## ACP CONVERSATIONS

**South Korea:** ACP conversations are open to all adults at any time. However, AD tends to attract more interest from older adults and patients with serious illnesses. Consequently, ACP conversations are often initiated either at the request of an elderly individual, a patient, or upon a doctor's recommendation when a serious illness is aggravating [A3]. ADs written at AD registration agencies act as an ACP initiation based on community. The doctor involved in the LST plan is responsible for informing the patient about their disease status and future treatment options, including the advantages and disadvantages, the various types of LST available, and the choices regarding hospice and palliative care. The fee for an LST plan is set at approximately 100,000 KRW (around 75 USD), while there is no reimbursement for AD.

It is recommended that healthcare providers, patients, and their families engage in joint discussions about the patient's preferences, views, and lifestyle to assist in making informed decisions about future healthcare. Government guidelines advocate for "shared decision-making" through a stepwise approach. If conflicts arise between patients and families, a step-by-step resolution process is necessary. Sharing information should be done in an understandable manner, and patients and families need time to reconsider [A17].

**Japan:** ACP discussions in Japan are predominantly family-

centered, reflecting the cultural value of collective autonomy [4,8]. Patients, families, and healthcare providers often collaborate on determining the best course of action, with healthcare providers facilitating these sensitive conversations. Primarily responsible physicians and nurses (e.g., general practitioners, subspecialists, and palliative care nurses) play crucial roles in initiating ACP, ensuring that decisions align with the patient's values and medical needs across both outpatient and inpatient settings [14,A18])

While family involvement is significant, many palliative care physicians in Japan face challenges in fully implementing patient-centered ACP. A nationwide survey of PCUs showed that although physicians recognize the importance of ACP, they often give priority to family preferences [A19]. However, an increasing number of patients are expressing their desire to participate in decision-making, even during the transition to palliative care or hospice settings [A20]. Healthcare providers are encouraged to balance patient hope with achievable goals, assisting families in preparing for EOL care [A21].

**Taiwan:** Before completing an AD, individuals are required to undergo a designated ACP consultation. This consultation requires the presence of a healthcare team, consisting of a physician, a nurse, and either a social worker or a psychologist. The process is designed to provide comprehensive information regarding the prognosis of the disease and the corresponding treatment options, with a fee around NTD 3,500 (approximately 110 USD). To date, around 1,000,300 DNR forms have been completed, but only about 86,000 ADs have been finalized.

## BARRIERS

Discussing death has long been a taboo in Asia. The cultural tradition of respecting older adults complicates the prospect of children initiating EOL conversations with their aging parents [A22]. Several other factors hinder the implementation of ACP in Asia, including a lack of public awareness, limited knowledge and skills among healthcare providers, fear of conflict with the patient's family and potential legal consequences, concerns about patients' emotional readiness for ACP discussions, and a lack of standardized systems and institutional support for ACP [A23].

**South Korea:** The LST Decisions Act primarily emerged from legal disputes concerning LST, focusing specifically on LST decisions at the EOL. It encounters four systemic barriers. First, discussions about the LST plan often occur too late. Healthcare providers consider the optimal time to initiate ACP conversations as when a patient's life expectancy is less than six months or a patient with a serious illness is hospitalized [A23]. However, ACP discussions tend to resemble EOL discussions in practice. Second, there is a lack of ongoing and integrated ACP discussion. Continuous updates of ADs are not feasible, and ACP discussions frequently occur without regard to previous ADs, treating them merely as a legal formality. Third, implementation is legally permitted only when death is imminent. Lastly, determining the end of disease or dying stages requires confirmation from at least two doctors, including one specialist. This requirement poses significant challenges for smaller geriatric hospitals, where many deaths occur. In summary, while the LST Decisions Act has advanced ACP and palliative care in South Korea, its narrow focus on LST decisions and procedural requirements may inadvertently delay crucial EOL conversations and overlook the broader aspects of patient-centered care.

The Act aims to protect patients' best interests through "self-determination". However, this concept might be unfamiliar to some Koreans, leading to confusion and potential family disharmony. Under current law, only immediate family members can serve as legal representatives, which contrasts with Asian ACP recommendations that include closely related persons [15]. A bigger issue arises when patients become unconscious without having expressed their intentions regarding LST. There can be a discrepancy between the wishes of the patients and their families, or the families may struggle to reach a unanimous decision about LST. Unrepresented, unconscious patients need special considerations as they represent a blind spot in the current legislation. As nuclear families increasingly replace extended family structures, non-blood caregivers often play a key role in advocating for the patient's preferences. However, the current law restricts surrogate decision-making to immediate family members only.

While legislation has heightened public awareness, there remains a significant gap in comprehensive knowledge about ACP. A study revealed that although over 90% of the public

recognizes the LST Decisions Act, 45% do not fully understand it, and 79.9% have incorrect perceptions of the details [16]. Underprivileged groups, including the disabled, superaged elderly, and immigrants, require tailored support for better ACP access. Community AD registry counselors, voluntary lay health workers, often lack sufficient knowledge and experience to explain LST and palliative care [17]. Additionally, fears that initiating ACP discussions might indicate giving up curative treatment, along with prognostic uncertainty, hinder timely ACP conversations [18].

**Japan:** Several systemic challenges impede the effective implementation of ACP in Japan. The absence of a legal framework for ADs, limited financial support for ACP consultations, and regional disparities in the uptake of ACP are key barriers [11]. Furthermore, ethical and legal perspectives on withdrawing and withholding LST are addressed inconsistently, complicating the initiation of time-limited trials for critically ill patients. Healthcare providers also frequently lack effective communication skills for meaningful EOL discussions.

A nationwide survey of oncologists has identified several obstacles including the emotional difficulty of supporting patients and families, differing viewpoints among healthcare providers, unclear roles of palliative care, and time constraints in clinical practice. These challenges underscore the need for greater standardization, systemic support for ACP, particularly in palliative care settings.

**Taiwan:** Evidence has highlighted the challenges of initiating ACP and palliative care-related discussion in Taiwan, largely due to cultural and spiritual values surrounding death and dying, feelings of uncertainty regarding treatment and prognosis, the perception that it is not the right time and could wait until the disease deteriorates, and the desire to maintain family harmony over prioritizing personal care needs [19]. Moreover, patients, their family caregivers, and healthcare staff often fail to recognize a poor prognosis as a terminal stage, leading to the belief that ACP conversations and access to palliative care are unnecessary. This stems from misunderstandings about ACP and palliative care, as well as a lack of awareness of the benefits of implementing timely interventions and service provision [20].

## STRATEGIES AND SUPPORT SYSTEMS TO OVERCOME BARRIERS

Evidence in Asia showed that a cultural shift towards more open discussions about death and dying, supported by public education, is essential for the implementation of ACP. Equally important is the establishment of a legal and standardized system, along with institutional support for ACP. This includes comprehensive training and education for healthcare providers, the provision of incentives, the allocation of dedicated time for ACP discussions, and a clear definition of roles and responsibilities [3].

**South Korea:** In-depth analysis and expert group research have addressed structural issues within the LST Decision Act. To resolve the problem of the excessive burden of documentation, reimbursement for the ACP process has been increased to strengthen its implementation. Additionally, a proposal has been made to shift the timing of LST decisions from the terminal stage to the advanced stage, and a bill amending the law is currently under discussion to gather opinions [21]. The Act also requires complex legal documents and procedures, highlighting the need to be simplified. Regarding the promotion of ACP, the government promotes ACP through websites, mass media, publications, and brochures. Discussions about dying and death appear implicitly in dramas, movies, and social media. Citizen organizations actively conduct community-based public education programs, with research indicating that such initiatives significantly increase the likelihood of earlier ACP discussions [22]. Continuous education is needed to enhance healthcare providers' understanding of the system and to improve communication skills. Furthermore, systematic support from institutions is necessary to address burnout and moral distress that healthcare providers may face during the ACP process.

The application of hospice and palliative care is limited to patients with conditions such as cancer and certain chronic non-cancer diseases. Expanding the scope of palliative care is necessary, and ACP will then follow it naturally. As seen in Taiwan's case, it is crucial for Koreans to engage in discussions about LST and the expansion of palliative care within the Korean context, through broad social consensus [13]. Although hospice and palliative care is included in the LST Decision

Act, the law primarily focuses on LST. Therefore, it would be desirable for the laws governing hospice and palliative care to be separated from LST [A24]. Policies and laws should support goal-concordant EOL care, ensure adequate resources, and reflect individualized wishes, such as the preferred place of death. Recently, the Korean government announced the 2nd Comprehensive Plan (2024~2028, originally Comprehensive Plan for Hospice, Palliative Care, and Determination to Terminate LST) in 2023. This second plan aims to focus on qualitative improvements and the practical empowerment of all citizens [A25].

**Japan:** Addressing these challenges requires promoting a patient-centered and family-based approach while increasing public awareness [23]. The 2024 update to Japan's hospitalization fee structures introduces incentives for hospitals to support decision-making for patients in the final stages of life [A26]. Cancer care coordination hospitals are now required to provide dedicated palliative care services, implement ACP practices, and hold interdisciplinary conferences on ethical issues.

Public awareness campaigns led by local governments encompass a variety of resources, including websites, videos, brochures, and lectures aimed at both citizens and healthcare providers. A national survey conducted in 2022 showed that awareness of ACP has significantly increased, with 27% of the general public and 77~88% of healthcare providers now informed about the topic, marking a substantial improvement over the past 5 years. Training programs developed in Japan, such as the Program on Symptom Management and Assessment for Continuous Medical Education (PEACE) [24], Education for Implementing End of Life Discussion (E-FIELD) [25], and Advance Care Planning Patient-centered approach with public awareness programs (ACPice) [A27], along with Western-adopted programs like the End-of-Life Nursing Education Consortium-Japan Core Curriculum (ELNEC-J) [A28], the established training program (VitalTalk) [A29], and the Serious Illness Care Program [14,26], have proven their effectiveness in enhancing communication skills and improving patient outcomes. In addition, innovative initiatives such as IT-based ACP interventions [A30] and the use of card games to promote public engagement [A31] are making strides in advancing awareness and facilitating complex ACP conversa-

tions.

Various academic societies, such as the Japan Medical Association, Japanese Society for Palliative Medicine, and Japan Psycho-Oncology Society, have developed guidelines and guidance to recommend sensitive ACP practices and EOL communication.

**Taiwan:** It is crucial to emphasize that ACP is a means to prepare for future care, not just EOL care. ACP discussions provide an opportunity to address uncertainties and enhance access to palliative care by allowing individuals to express their life goals and care preferences in advance [A32]. We advocate strongly for integrating ACP conversations into routine care provision, treating them as a process of shared decision-making rather than solely focusing on death and dying discussions. Regular training in communication skills and interprofessional teamwork is essential for facilitating smooth ACP service delivery [21]. Moreover, shifting from a "diagnosis-based referral" to a "need-based referral" approach would facilitate earlier ACP interventions as it is recommended in palliative care [27].

Above mentioned barriers and strategies in Asia are summarized as Table 1.

## Clinical Implications and International Perspectives

ACP should be implemented at any point along the disease trajectory. Effective ACP implementation requires a dynamic approach that begins in the community and evolves through various stages of medical care, ultimately guiding EOL decision-making to align with the patient and family's wishes for the final stages of life. However, discussions with healthcare providers often occur too late, resulting in fragmented care planning. To overcome this, future efforts must focus on fostering ongoing communication among healthcare providers, patients, and families [28]. Healthcare providers should be trained to regularly reassess the goals of care, ensuring alignment with current treatment plans, and engage in transparent discussions including communication about the prognosis. Simultaneously, patient and family education initiatives should promote open dialogue about care preferences. Developing systems to document and share these serial discussions is also essential.

Meanwhile, it is necessary to determine the optimal point at

**Table 1.** Barriers to ACP in Asia and Strategies to Overcome Those Barriers.

	Barriers	Strategies
Common in Asia	<ul style="list-style-type: none"> <li>- Discussions about death are taboo</li> <li>- Cultural respect for older adults makes starting EOL conversations difficult</li> <li>- Lack of public awareness and healthcare providers' knowledge/skills</li> <li>- Fear of family conflict and legal consequences</li> <li>- Lack of standardized systems and institutional support</li> </ul>	<ul style="list-style-type: none"> <li>- Encourage open discussions about death</li> <li>- Public education</li> <li>- Proper training and incentives for healthcare providers</li> <li>- Allocate dedicated time and define clear roles for team members</li> <li>- Establish legal and standardized systems with institutional support</li> </ul>
Region-specific		
South Korea	<ul style="list-style-type: none"> <li>- Cultural unfamiliarity with self-determination</li> <li>- Lack of public awareness of the law and LST system</li> <li>- Fear of signaling the end of curative treatment hinders ACP discussions</li> <li>- Emotional burden during ACP counseling</li> <li>- Lack of social consensus for EOL decision making</li> <li>- Focus of the Act on LST, end stage of disease and dying phase</li> <li>- Complex and strict documentation and processes regarding the execution of LST decisions</li> <li>- Legal representatives confining to immediate family members only</li> </ul>	<ul style="list-style-type: none"> <li>- Encourage family discussions on EOL care</li> <li>- Governmental promotion of ACP via mass media and education programs by citizen organizations</li> <li>- Education about prognostic communication for healthcare providers</li> <li>- Preventive measures for healthcare providers' burnout at organizational level</li> <li>- Broad social consensus to support EOL care and allocate its resources</li> <li>- Extension of period to the "advanced stage" of disease, to more diverse diseases by law</li> <li>- Simplify legal documents and processes</li> <li>- Flexible surrogate designation including closely related persons</li> </ul>
Japan	<ul style="list-style-type: none"> <li>- No specific legal framework for ADs and the withdrawal of LSTs</li> <li>- Financial support and regional disparities in ACP uptake.</li> <li>- Lack of confidence in communication skills among healthcare providers and concerns about addressing ethical challenges</li> </ul>	<ul style="list-style-type: none"> <li>- Patient-centered approach with public awareness programs</li> <li>- 2024 hospitalization incentives for end-of-life decision-making</li> <li>- Training programs (e.g., PEACE, SHARE) improve communication skills</li> <li>- Use IT and card games to facilitate ACP</li> <li>- Academic societies developing guidelines for end-of-life practices</li> </ul>
Taiwan	<ul style="list-style-type: none"> <li>- Cultural values around death hindering the initiation of ACP</li> <li>- Prioritizing family harmony over individual wishes</li> <li>- Misunderstanding and lack of awareness of the need for ACP and palliative care</li> </ul>	<ul style="list-style-type: none"> <li>- Considering ACP as preparation for future care, not just EOL care</li> <li>- Integrate ACP into routine care provision</li> <li>- Emphasizing shared decision-making</li> <li>- Training in communication and teamwork</li> <li>- Need-based referral for earlier ACP</li> </ul>

ACP: advance care planning, AD: advance directive, EOL: end-of-life, LST: life-sustaining treatment, PEACE: Program on Symptom Management and Assessment for Continuous Medical Education, SHARE: S-setting up a supportive environment for the interview; H-considering how to deliver the bad news; A-discussing various additional information that patients would like to know; RE-providing reassurance and addressing patient's emotions with empathic responses, IT: information technology.

which to begin ACP for patients with serious illnesses. Identifying the appropriate timing involves both quantitative and qualitative research that includes healthcare providers, patients, and their families, while considering cultural influences. A consensus about the timing should address the logistics of implementation, the roles of stakeholders, the time required, and appropriate reimbursement.

Prognostic awareness is closely linked to the engagement of patients in ACP conversations, as it leads to more goal-concordant care through informed decision-making. We recognized the presence of prognostic uncertainty, especially in this era when innovative treatments appear rapidly. Healthcare

providers may consider international recommendations for palliative care as a minimal starting line for ACP conversations. The Supportive and Palliative Care Tool suggests indicators such as progressive weight loss [A33]. Similarly, the National Agency for the Management of LST in South Korea has suggested "general indicators for ACP" that include the following [A34]: requests by patients or families to discontinue or reduce treatment, or to seek medical care that prioritizes quality of life in situations such as unplanned admissions more than twice a year; deterioration of performance status (more than Eastern Cooperative Oncology Group performance status scale 3); the need for assistance in daily activities; and refractory suffering



symptoms despite treatment.

Japan's emphasis on relational autonomy and family involvement in ACP offers insights into culturally sensitive EOL care. Although the importance of ADs is acknowledged, Japan's model of collective decision-making balances patient preferences with family input, offering a framework for other aging societies, particularly in Asia. However, Japan is still refining ACP approaches across different diseases and care settings. The ongoing accumulation of experience and shared knowledge will be essential for improving ACP practices in the future.

In Taiwan, relational autonomy is prevalent and increasingly adopted to address challenges in palliative care. The clinician-patient-family relationship plays a significant role in fostering patient autonomy [29]. Therefore, involving family members and significant others in the ACP discussion is crucial for achieving an efficient and consensus-driven conversation.

Finally, international collaboration moves ACP forward to draw culturally sensitive recommendations in Asia. Recently, a Delphi consensus for an Asian ACP guideline across five sectors was successfully completed. This international network will promote the further development and dissemination of culturally tuned ACP in various populations in Asia.

## CONCLUSION

ACP and palliative care share the common aim of respecting patient autonomy and providing goal-concordant care. In the context of Asian cultures, facilitating the ACP process requires acknowledging and addressing barriers such as cultural taboos about discussing death and the traditional respect for elders. Therefore, it is important to approach these conversations in ways that are sensitive to and respectful of existing cultural norms. Public education plays a key role in promoting awareness and acceptance of ACP while encouraging open discussions about death. At the healthcare provider level, barriers include time constraints, limited knowledge and skills, fear of conflict with the patient's family, and concerns about patients' emotional readiness for ACP discussions. Establishing standardized legal frameworks and institutional support, combined with targeted training for healthcare providers, can facilitate the effective implementation of ACP.

From a clinical perspective, engaging patients in ACP discussions earlier can help promote autonomy and ensure care that aligns with their personal values. In the Asian context, integrating relational autonomy – where family involvement plays a significant role – is vital to shared decision-making and fostering trust between patients and healthcare providers. The experiences of South Korea, Japan, and Taiwan offer valuable insights that can inform ACP practices in other Asian sectors. Finally, reinforcing international collaboration will be crucial in translating these insights into actionable strategies that support culturally sensitive ACP conversations across Asia.

## CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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Conception or design of the work: YJL, SYS, MM. Data collection: all authors. Data analysis and interpretation: all authors. Drafting the article: all authors. Critical revision of the article: YJL, DM, SYS, MM. Final approval of the version to be published: all authors.

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## Appendix

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