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Chih-hsiung Chen

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## Legislating the Right-to-Die with Dignity in a Confucian Society—Taiwan’s Patient Right to Autonomy Act

BY CHIH-HSIUNG CHEN\*

### ABSTRACT

*In Confucian societies, people tend to avoid the discussion on death matters, let alone making advance directives to reject life-sustaining treatments at the end of life. Taiwan might be a pioneer in legislating the right-to-die with dignity among Confucian countries. As early as 2000, the Hospice Palliative Care Act was declared in Taiwan, which give terminally-ill patients the options to forgo life-sustaining treatments. Furthermore, in 2016, Taiwan passed the Patient Right to Autonomy Act to enhance patients’ choice at the end of life and expanded the coverage to certain types of non-terminally ill patients. On the other hand, end-of-life issues in Japan are regulated mainly through courts’ judgments and medical societies’ guidelines. Korea passed a law to legalize passive euthanasia, which became effective in 2018, but only contains limits to terminally-ill patients.*

*This paper is divided into three sections. First, this paper analyzes the sociocultural emphasis on family unity in East Asia and attitudes toward death in East Asian cultures, and then the methods adopted in Japan and South Korea of solving related disputes through the judiciary or legislation are explained. Second, the paper describes the legislative background of the aforementioned two laws in Taiwan, including futile medical care, the denial of citizen autonomy with respect to serious injury and death by criminal law theory, the unwillingness of the judiciary to intervene, and disputes encountered at medical sites. Subsequently, we explain the primary content of these two laws, including patients’ rights to self-determination, the*

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\* Associate Professor and Director of Institute of Technology Law, National Chiao Tung University School of Law; J.S.D., Washington University in Saint Louis School of Law. I thank Professor Rebecca Dresser’s kind comments, and my students Hui-Hsin Kao, Wei-Ting Tseng, and Yu-An Tai for their excellent assistance. Specially thanks to my wife, Carol Chih-Chieh Lin, for her love and support to make this article possible.

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*judgment procedures of medical institutions, and the operation of advance directives. Finally, this paper analyzes inadequacies in the Patient Right to Autonomy Act, including a lack of penalties, insufficiencies in medical institutions' scope of duty of disclosure, and the lack of a settlement mechanism for individuals who have not yet established advance directives.*

**Keywords:** End-of-Life, Right to Die with Dignity, Euthanasia, the Hospice Palliative Care Act, the Patient Right to Autonomy Act

## 1. Introduction

In March 2017, Yao Chiung, the most famous romance novelist in Chinese society, published an open letter in a Taiwanese newspaper advocating for voluntary euthanasia to die quickly and gracefully.<sup>1</sup> She did this because her husband had severe dementia that had progressed from him not recognizing his family to a clinical loss of consciousness, and his breathing was being maintained by intubation.<sup>2</sup> Conflict arose between her and her husband's children regarding whether to remove life support.<sup>3</sup> Chiung maintained that her husband had established an advance health care directive prior to losing consciousness and was a willing "do not resuscitate" ("DNR") patient.<sup>4</sup> However, her husband's children believed that their father was not in the terminal stage and his condition did not meet the requirements for DNR.<sup>5</sup> The Taiwanese legal system had no precedent for resolving such a dispute, and Chiung and her children did not want to seek a solution through a lengthy judicial process. Consequently, the situation has remained in a stalemate.

In the second half of the same year, another well-known terminally ill

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1. *Queen of Romance Novels Wants Simple Send-Off After Death*, THE STRAITS TIMES (Mar. 14, 2017), <https://www.straitstimes.com/lifestyle/entertainment/queen-of-romance-novels-wants-simple-send-off-after-death>; Heidi Hsia, *Chiung Yao Wants to Educate Society About Euthanasia*, YAHOO! LIFESTYLE (Aug. 4, 2017), <https://www.yahoo.com/lifestyle/chiung-yao-wants-educate-society-082800355.html?src=rss>.

2. *At the Last Moment of Her Husband, Why Did Chiung Yao Betray Him?*, BEST CHINA NEWS (May 9, 2017), <http://www.bestchinanews.com/Health/10094.html>.

3. *Id.*

4. *Id.*

5. *Chiung Yao Writes Book on Caring for Sick Husband*, THE STRAITS TIMES (Aug. 3, 2017), <http://www.straitstimes.com/lifestyle/chiung-yao-writes-book-on-caring-for-sick-husband>; Dr. Winnie Tang, *When A Loved One Is Dying, Advance Directives Matter*, EJINSIGHT ON THE PULSE (July 14, 2017), <http://www.ejinsight.com/20170714-when-a-loved-one-is-dying/>.

public figure and former sports anchor, Da-Jen Fu, not only publicly requested presidential support for his wish to die and legalize active euthanasia, he also traveled to Switzerland — known for its law permitting physician-assisted suicide — to end his life.<sup>6</sup> These two individuals acted after Taiwan's passage of the Patient Right to Autonomy Act (hereinafter "PRA") in 2016. The law, which is implemented in January 6th, 2019, enhances patients' autonomy in end-of-life decision-making after prompting heated public discussion.<sup>7</sup> If the law was passed before Yao Chiung's husband lost conscious, he could make an advance directive to prevent this dilemma. Though the law cannot help Da-Jen Fu, his voice had raised some people's support on active euthanasia and might lead to another milestone in Taiwan's end-of-life law in the future.<sup>8</sup>

East Asian cultures generally avoid discussing the issue of death.<sup>9</sup> It was not easy for Taiwan to become the first of any Asian country to safeguard the right of patients to death with dignity through legislation.<sup>10</sup> In contrast to Japan and South Korea, Taiwan has never had a court decision where the right of terminal patients to withdraw medical treatment has been recognized. This is probably because Taiwan enacted legislation before disputes came to courts.

As early as 2000, Taiwan passed the Hospice Palliative Care Act

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6. George Liao, *A Former Popular Sportscaster Pleads with President Tsai to Pass a Euthanasia Law*, TAIWAN NEWS (Dec. 08, 2016), <https://www.taiwannews.com.tw/en/news/3047408>; George Liao, *President Tsai States She Places Importance on Legislation of Euthanasia in Taiwan*, TAIWAN NEWS (Dec. 14, 2016), <https://www.taiwannews.com.tw/en/news/3051628>; Hsiao Fang-chi & Jake Chung, *Fu Da-ren Ends His Life at Facility in Switzerland*, TAIPEI TIMES (June 8, 2018), <http://news.ltn.com.tw/news/focus/breakingnews/2451430>.

7. Wen Kuei-hsiang & Kuo Chung-han, *Legislature Passes Act Giving Patients Rights on End-of-Life Care*, FOCUS TAIWAN (Dec. 18, 2015), <http://focustaiwan.tw/search/201512180029.aspx?q=euthanasia>.

8. Inspired by Da-Jen Fu, a few people began to promote a referendum to legalize active euthanasia. I participated this movement and assisted to handle some procedural issues. See THE CENTRAL NEWS AGENCY, *Promoting euthanasia referendum, Retired teachers set up a joint office for signature*, UNITED DAILY NEWS [推安樂死合法公投 退休教師設攤連署] (Sept. 29, 2018), <https://udn.com/news/story/10958/3393747>. By the submission of this article, the referendum is still at the stage of getting people's signature. Only after getting enough people's signature, the referendum proposal will be announced officially for the people to vote.

9. See Kathryn L. Braun & Rhea Nichols, *Cultural Issues in Death and Dying*, 55 HAWAII MED. J. 260 (1996). The authors describes how Chinese people have traditionally thought it was bad luck to discuss death.

10. Ministry of Health and Welfare of Taiwan, *Protect Patient's Autonomy, The Patient Right to Autonomy Act has Passed the Third Reading* [保障病人自主，病人自主權利法三讀通過] (Dec. 18, 2015), <https://www.mohw.gov.tw/cp-2651-19687-1.html> (in Chinese).

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(hereinafter “HPCA”) <sup>11</sup> which allows terminally ill patients to preemptively issue advance health care directives to forgo cardiopulmonary resuscitation (“CPR”) and life-sustaining treatment.<sup>12</sup> Although this law solved dilemmas for physicians facing such situations, it could not be applied in a variety of cases, such as those of unconscious patients without terminal illnesses who have been bedridden for long periods. In the PRA, the rules governing advance directives were expanded to cover patients in a vegetative state and those with nonterminal illness. The PRA also allowed patients with certain clinical conditions to make advance directives regarding whether to accept or refuse life-sustaining treatment, artificial nutrition and hydration, and other types of medical care.<sup>13</sup> This law could be considered the most advanced law in East Asia protecting the rights of patients to informed consent and death with dignity.

The case of Yao Chiung is a good opportunity to examine laws in Taiwan related to end-of-life decisions, which have led to many legal and medical dilemmas. When many Western countries have established a number of laws to handle such cases, why do East Asian countries, by contrast, generally lack such laws? Although Taiwan has long maintained the medical right of patients to informed consent, why did it take so long to enact a law like the PRA? Should the right to refuse medical treatment be restricted to terminally ill patients? How should situations where a patient’s spouse and children disagree be handled? Should Chiung’s husband’s physician follow the patient’s earlier wish to withdraw the life-sustaining treatment? What is the view of the medical profession on this issue and what procedures could truly enhance patients’ autonomy and prevent wrongful death? Why is the current end-of-life legal system in Taiwan unable to solve Chiung’s dilemma? These are the questions that this paper tries to answer.

In this article, active euthanasia is defined as prescribing medication or treatments aimed at shortening a person’s life and alleviating his or her suffering. The attending physician may do it using a poisonous injection or prescribing large doses or drugs with the intention of cutting short the patient’s life. Passive euthanasia may take two forms: one is abstention from performing acts that prolong the patient’s life. An example may be refraining from connecting a patient to a respirator or to a resuscitation machine. The

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11. Ministry of Health and Welfare of Taiwan, Hospice Palliative Care Act, amended Jan. 9, 2013.

12. Chen RC, *From Do No Resuscitation to Advance Care Planning*, 1 BAOJ PALL MEDICINE (ISSUE 2) 1 (2015), <https://bioaccent.org/palliative-medicine/palliative-medicine09.pdf>.

13. Chen RC, *A Personal Journey in Taiwan’s Hospice Palliative Care Movement*, 2:2 BAOJ PALL. MED. 1, 2 (2016), <http://www.lotus.org.tw/doc/palliative-medicine19.pdf>.

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other form involves discontinuation of actions designed to sustain life. This means withdrawing machines to which the patient has already been connected. Physician-assisted suicide means that it is the patient performs the action, with physicians' assistance to prescribe or prepare the medication or injection.<sup>14</sup>

This paper is divided into three sections. The first section describes the sociocultural emphasis on family unity in East Asia and analyzes attitudes toward death in East Asian cultures, as well as the methods adopted in Japan and South Korea to resolve treatment disputes through the judiciary rather than through legislation. The second section describes the legislative background of the aforementioned two laws in Taiwan. These background considerations include the problem of futile medical care, the criminal law's denial of citizen autonomy with respect to serious injury and death, the unwillingness of the judiciary to intervene, and disputes encountered at medical sites. The third section describes the content of the two laws, including the provisions addressing patients' rights to self-determination, the judgment procedures of medical institutions, and the operation of advance directives (ADs). Finally, this paper analyzes inadequacies in the PRA, including a lack of penalties, insufficiencies in medical institutions' scope of disclosure duty, and the lack of a settlement mechanism for individuals who have not yet established ADs.

## **2. Confucian Societies' Slow Progress on Right-to-Die Law: A Comparison with Japan and Korea**

Japan, South Korea, and Taiwan are among the most progressive democratic countries in Asia, and the spread and migration of Confucian culture spans mostly the entire East Asia region. In addition to the similarity of political democratization, a backdrop of Confucian thought generally remains in these three societies. Moreover, the current aging of populations and prolongation of life spans are challenging the culture of filial piety among Asian people. With similar cultural backgrounds, Taiwanese, Japanese, and South Korean societies exhibit similar caution and fear toward the end of life issue. Hospice and palliative care have gradually taken root in Taiwan, Japan, and South Korea. Despite similarly conservative societies, however, the development and history of hospice and palliative care and end-of-life law differs among these three countries.

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14. Raphael Cohen-Almagor, *Euthanasia and Physician-Assisted Suicide in the Democratic World: a Legal Overview*, 16 N.Y. INT'L L. REV. 1, 3-5 (2003).

## 2.1 Japan's Approach: Rules by Courts' Precedents

Although society in Taiwan and Japan is influenced similarly by the background of Confucian thought, the countries exhibit strong differences in the development of hospice law. The greatest difference between Taiwan and Japan in this regard is that Taiwan passed the HPCA in 2000 and the PRA, while the effort to legalize the right to die with dignity in Japan remains in the drafting stage and has yet to become proposed legislation.<sup>15</sup>

Japan was the first country in Asia to legally recognize a form of passive euthanasia through judicial decisions.<sup>16</sup> However, no legislative standards exist for euthanasia in Japan. The lack of legislation leaves Japan without an official definition of euthanasia.<sup>17</sup> Legal problems surrounding euthanasia and death with dignity are handled based on legal decisions concerning homicide,<sup>18</sup> whereas operations related to death with dignity depend on clinical guidelines.<sup>19</sup>

In 2006, the Japanese Society of Intensive Care Medicine ("JSICM") published the first clinical guideline addressing end-of-life care in Japan entitled, "Nature of Terminal Care of Critically Ill Patients in Intensive Care." The Japanese Ministry of Health, Labour and Welfare issued "Guidelines for Decision-Making Process of End-of-Life Care." The guidelines addressed three points: (1) decisions should be based on adequate information; (2) withdrawal of aggressive treatment should be determined by a healthcare team; (3) the healthcare team has an important role in relieving patients' discomfort and pain and providing mental and social support to patients and the family. The Japanese Association for Acute Medicine (JAAM) and the Japanese Circulation Society also have issued guidelines on end-of-life care. In 2009, a treatment team withdrew percutaneous cardiopulmonary support based on a patient's prior wishes and the JAAM guidelines and was not subsequently prosecuted. This case drew intense media attention and reassured Japanese physicians that they could

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15. Soichiro Iwao, *Reexamining the Contents of the Living Will in Preparation for the Upcoming Ultra-Elderly Society of Japan*, JAPAN SOC'Y FOR DYING WITH DIGNITY NEWSLETTER, JSDD Found. (Jan. 1, 2016), [http://www.songenshi-kyokai.com/content/files/NewsletterPdf/Newsletter\\_160.pdf](http://www.songenshi-kyokai.com/content/files/NewsletterPdf/Newsletter_160.pdf).

16. As early as 1962, a Japanese high court gave six requirements to make euthanasia lawful. See Katsunori Kai, *Euthanasia in Japanese Law*, EUTHANASIA IN INT'L & COMP. PERSP. 185, 187 (Marc Groenhuijsen & Floris van Laanen eds., 2008).

17. *Id.*

18. *Id.*

19. Jun Makino et al., *End-of-life Considerations in the ICU in Japan: Ethical and Legal Perspectives*, 2:9 J. INTENSIVE CARE 2014.

safely provide end-of-life care.<sup>20</sup>

Sociocultural differences remain the primary influence in legislative progress in Japan and Taiwan. Regarding religion, 84 percent of Japanese people follow Shintoism and Buddhism, whereas only 0.7 percent follow Christianity.<sup>21</sup> However, the hospice concept originated in the Christian-based West and was introduced to Asian countries through Christianity. Accordingly, the development of hospice palliative care in Taiwan, which has a much higher Christian population, has been more successful than in Japan. Moreover, spiritual care is a crucial aspect of hospice palliative care. Hospitals in Taiwan combine assistance from religious clergy, such as priests and masters (some hospitals subdivide these into Christians and Buddhist figures), to assist patients in relieving their fear of death and understanding their regrets.<sup>22</sup> By contrast, medical policies in Japan prohibit religious personnel from entering hospitals or hospices to assist with hospice care, instead employing psychologists.<sup>23</sup> This measure not only reduces acceptance of hospice care but also lowers its quality.

The first case in Japan on end-of-life issue was determined in 1962. The Nagoya High Court stipulated the following six conditions under which legally euthanasia can be administered:<sup>24</sup> (1) The patient has a disease recognized by modern medicine and technology as impossible to treat and is close to death; (2) others cannot bear to witness the patient suffering; (3) euthanasia can alleviate pain during death; (4) the patient is conscious and gives authorization and approval to be euthanized; (5) euthanasia is performed by the physician on principle; and (6) the method of euthanasia is considered ethical. The six requirements were criticized for its vagueness, and therefore been recognized only the legality of passive euthanasia but not active euthanasia.<sup>25</sup>

After this case, precedents in Japan generally do not permit surrogate decision-making. In the Tokai University Hospital Euthanasia Case of 1995, the Yokohama District Court held that if a living will (“LW”) or other form

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20. *Id.*

21. KAI, *supra* note 16, at 187.

22. For example, Chang Gung Memorial Hospital, one of the largest hospitals in Taiwan, provides a variety of prayer rooms for Buddhists, Christians, Muslims with spiritual support. See Chang Gung Memorial Hospital, *Religious Sanctuary* (Feb. 13, 2019), <http://www.chang-gung.com/en/about.aspx?id=116&bid=9>. See also Shao-Yi Cheng et al., *Advances of Hospice Palliative Care in Taiwan*, 19 KOR. J. HOSP. PALLI. CARE 293 (2016).

23. Anne P. Glass et al., *A Cross-Cultural Comparison of Hospice Development in Japan, South Korea, and Taiwan*, 25 J. CROSS CULT. GERONTOLOGY 1 (2010).

24. KAI, *supra* note 16, at 187.

25. *Id.*

of AD exists at the time that an end-of-life decision is made or the physician acts on the patient's presumed wishes as suggested by an LW, AD, or family members' opinions, life-sustaining treatment can be withdrawn.<sup>26</sup> Family members' opinions are used only in reference to the patient's presumed wishes and cannot make surrogate decisions.<sup>27</sup>

The most recent Japanese end-of-life case is the 2005 Kawasaki Kyodo Hospital Case, which the Yokohama District Court handled.<sup>28</sup> In this case, a terminally-ill patient had not previously expressed his wishes. After the physician removed the respirator, the patient exhibited difficulty breathing and curled up on the bed. To prevent the family members from witnessing this, the physician ordered a nurse to inject a muscle relaxant, which caused death. The case is in fact related to murder instead of euthanasia. The court sentenced the physician to 3 years of hard labor and 5 years of probation according to Article 199 of the Penal Code.<sup>29</sup>

The court subsequently proposed more detailed judgment criteria: (1) medical treatment should be terminated only to respect the patient's right of autonomy; (2) respecting patient autonomy requires allowing patients to decide the process and method of their death — not allowing patients to commit suicide or exercise a right to die; (3) patients, while mentally capable, must be informed of their incurable near-death condition; (4) patients must be sufficiently informed of their circumstances and clearly and voluntarily express a willingness to die; (5) when the physician cannot directly determine the wishes of the patient, he or she should take the initiative to ascertain these wishes; (6) when no relevant documents of the patient's medical wishes exist (e.g., an LW), and family members are unable to infer the patient's wishes, the physician should continue to perform the medical treatment deemed most suited to the patient; (7) the physician is not obligated to provide ineffective or harmful medical treatment, even at the patient's request; and (8) the recommendations of the physician are only suggestions for the patient; the final decision should be made by the patient, not the physician.<sup>30</sup>

One thing must be emphasized is that Japan is a Civil Law tradition

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26. KAI, *supra* note 16, at 189-91

27. Katsunori Kai, *Euthanasia and Death with Dignity in Japanese Law*, 27 WASEDA BULL. OF COMP. LAW 1, 4-5 (2010), <https://www.waseda.jp/foiaw/icl/assets/uploads/2014/05/A02859211-00-000270001.pdf>.

28. *Hanrei-Times*, No. 1185. P. 114 (citing Katsunori Kai, 'Shuumatsuki Iryou / Songenshi To Ishi No Keijisekinin', *Jurist*, No. 1293, 2005, p. 98 ff, forwarding from KATSUNORI KAI, EUTHANASIA IN JAPANESE LAW, *supra* note 16 at 190).

29. KAI, *supra* note 16, at 191.

30. KAI, *supra* note 16, at 190-91.

country. Courts must make judgements according to law and regulations, but not binded by other courts' decisions. As a result, although the above judgements proposed criteria for euthanasia, it does not mean that other courts are obligated to follow these requirements. Physicians, patients, and patients' relatives cannot fully predict the results of their behaviors according to those judgements.

In sum, Japan does not permit assisted suicide and is cautious about surrogate decision-making. If patients do not make informed decisions before losing consciousness, physicians are obligated to treat them unless family members can clearly infer the patients' wishes. However, because there is no law governing the process of obtaining informed consent, and patients rarely sign documents to forgo treatment, it is uncertain how to handle cases involving unconscious terminally-ill patients who have no living will.

## 2.2 Korea: From Landmark Cases to Legislation

Of the aforementioned three Asian countries, South Korea was the earliest to introduce hospice and palliative care. This form of care was introduced to South Korea in 1963 by a group of Catholic nuns from Australia.<sup>31</sup> Hospice palliative care in South Korea primarily serves patients with terminal cancer because only the Cancer Control Act of 2004 covers such care.<sup>32</sup> National health insurance covers only the medical costs of hospice palliative care; it does not cover the service costs of consultations or bereavement care.<sup>33</sup> Funding for independent and private (not hospital-provided) hospice services comes mostly from donations and sponsorships, and home hospice care is not even recognized by the government.<sup>34</sup> Hospice palliative care in the home and free-standing facilities primarily emphasizes emotional and social support and involves a low level of medical intervention.<sup>35</sup> Hospice units in hospitals provide more palliative care, but the total number of beds in hospitals is very limited.<sup>36</sup> Hospice palliative care

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31. GLASS ET AL., *supra* note 23, at 7.

32. Yong Joo Rhee, *Hospice and Palliative Care Services in South Korea Supported by the National Health Insurance (NHI) Program*, 7 HEALTH 689, 690 (2015), [http://file.scirp.org/Html/5-8203347\\_57103.htm](http://file.scirp.org/Html/5-8203347_57103.htm).

33. *Id.* at 692.

34. So-Hi Kwon, *End-of-Life Care in Korea: Issues and Trends*, 11 Nursing Science Study (看護科学研究) 54, 55 (2013), [http://www.oita-nhs.ac.jp/journal/PDF/11\\_2/11\\_2\\_4.pdf](http://www.oita-nhs.ac.jp/journal/PDF/11_2/11_2_4.pdf).

35. GLASS ET AL., *supra* note 23, at 9.

36. *Id.* In 2003, 45.1 % of people dies in hospitals, compared to 18.1% in 1993. In 2004,

in South Korea primarily relies on the grassroots movements of religious groups.<sup>37</sup> Until 2002, only one nursing institution officially provided hospice services.<sup>38</sup> However, the 2008 “Grandma Kim” case, discussed below, promoted enactment of the Hospice Life Prolonging Medical Care Act in February 2016, which was officially implemented in February 2018.<sup>39</sup>

In South Korea, Christians account for 50 percent of the population and Buddhists account for 47 percent.<sup>40</sup> The influence of religion is weaker than it is in Japan and hospice services are primarily provided by Christian hospitals. South Korea was the first of the three Asian countries to develop hospice palliative care and there was less resistance to its initial development than there was in Japan. The Chosun dynasty (1392-1910) revered only Confucianism.<sup>41</sup> This reverence substantially influenced contemporary South Korea by emphasizing that social moral order takes precedence over spiritual needs, societal collectivism takes precedence over individual pursuits, and fulfilling our own responsibilities can ensure global harmony. Similar to Japan, in South Korea, “family” is a core value and the concepts of harmony and filial piety are emphasized.<sup>42</sup> In contrast to Taiwan’s greater acceptance of Western individualism,<sup>43</sup> South Korean society continues to follow traditional ethics.

Despite the low level of religious observance, challenging traditional ethical beliefs can be difficult. The public generally believed that they did not need caregivers and that hospice services were targeted toward low-income individuals; these beliefs were based on the initial provision of hospice care by churches to low-income individuals who had no one else to depend on.<sup>44</sup> In addition to education for the public, educational training for professional personnel needed to be strengthened, because medical personnel did not recognize hospice palliative care as a medical measure and generally believed that pain control was not appropriate.<sup>45</sup> Besides, the

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42 hospitals provided hospice care, but only 13 had hospice departments, with 253 beds.

37. GLASS ET AL., *supra* note 23, at 9; Kwon, *supra* note 34, at 57.

38. GLASS ET AL., *supra* note 23.

39. JSDD FOUND., *supra* note 15.

40. GLASS ET AL., *supra* note 23, at 8.

41. *Id.*

42. Chee, Y. K. & Levkoff, S. E., *Culture and Dementia: Accounts by Family Caregivers and Health Professionals for Dementia-affected Elders in South Korea*, 16 J. CROSS CULT. GERONTOL. 111–25 (2001), forwarded from GLASS ET AL., *supra* note 23, at 8.

43. GLASS ET AL., *supra* note 23.

44. Moon, H., A study on the activation program of Korean hospice management (2004), (unpublished Master’s Thesis, Chosun University, Korea), forwarded from GLASS ET AL., *supra* note 23, at 10.

45. GLASS ET AL., *supra* note 23.

government had no insurance plans or subsidy systems for hospice services; as expected, hospitals failed to take the initiative to provide such services. Even if hospitals provided hospice services, the government had no basis for monitoring the quality of hospitals. As a result, promotion of the bills on hospice care in South Korea was primarily accomplished only after assistance from a few leading physicians.<sup>46</sup>

Two rulings have deeply influenced the right-to-die law in South Korea. The Boramae Hospital case in 1997 severely set back the development of end-of-life care. In this case, a patient undergoing a craniotomy was admitted to the hospital's intensive care unit because of a subarachnoid hemorrhage. The patient's wife requested that the patient be discharged because they could not pay for the care.<sup>47</sup> The physician discharged the patient, who died 36 hours later. The wife was charged with homicide. The 2004 Supreme Court decision in this case led to the indictment of two physicians for aiding and abetting the homicide.<sup>48</sup> The court considered this a case governed by the law on voluntary discharge, not euthanasia or death with dignity. At that time, the South Korean public had little discussion on euthanasia or death with dignity, and terminal discharge were yet to be legal. After the case, many physicians believed that terminal discharge was illegal and avoided the withdrawal of life-sustaining treatment where possible, even if family members had reasonable justification for requesting withdrawal.<sup>49</sup>

The legal situation changed with the Grandma Kim case in 2008. Grandma Kim was a 76-year-old patient in a permanent vegetative state who had no AD. The family asked the physician to withdraw life-sustaining treatment. The request was rejected by the hospital, and the family filed a petition with the court. The district court agreed that in the absence of the patient's AD, the patient's wishes could be inferred because she had rejected a tracheotomy for her dying husband. The patient had also said while she was conscious that "I want to leave this life without becoming burden to others." As a result, the district court issued a landmark ruling that life-sustaining treatment could be withdrawn.<sup>50</sup> Although the hospital appealed to the Supreme Court, the appeal was dismissed.

The Supreme Court reviewed relevant information, such as the patient's statements to relatives and friends, the age of the patient, and her reactions

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46. JSDD FOUND., *supra* note 15.

47. Kyongjin Ahn & Hyuna Bae, *Reflections on the Movement for the Legalization of "Death with Dignity as Withdrawal of Futile Life-Sustaining Treatment" in South Korea*, 10 J. KOR. L. 43, 45 (2010).

48. *Id.* at 49.

49. *Id.* at 46.

50. *Id.*

to life-sustaining equipment. The Court affirmed that she would wish for the termination of life-sustaining equipment under such circumstances. The Supreme Court emphasized that the point of contention in this case was whether people have the right to decide on medical measures rather than to actively seek death. Based on the constitutional value of “human dignity,” dignity must be achieved through free will, even in the final stages of life. The patient — not the hospital or physician — is the primary decision maker regarding the medical treatment that he or she receives. When a patient cannot recover consciousness and other basic functions and is nearing death, he or she has entered a process of dying. For such patients, the termination of life-sustaining measures according to the patient’s explicit or informed wishes is consistent with social norms that protect human dignity and the constitutional right of people to pursue happiness.<sup>51</sup> Partially inspired by the Supreme Court’s ruling, the congress ultimately passed a law in 2016 to set standards for patients to forego life-sustaining measures.

There are two laws regulating patients’ end-of-life decisions in South Korea. The Cancer Control Act ensures that patients with cancer have the right to receive palliative care. However, such care is limited to patients with cancer. Physicians have no obligation to explain terminal conditions to patients and their families, and relevant provisions for informed consent do not exist.<sup>52</sup> Another law, the Hospice Life Prolonging Medical Care Act enacted in 2016, allows terminally-ill individuals aged 19 years and older to request withdrawal from life-sustaining treatment. This act was implemented in February 2018.<sup>53</sup> Life-sustaining treatment is legally defined as any of the following: cardiopulmonary resuscitation (CPR), hemodialysis, cancer drugs, and artificial respirators. This act does not cover palliative care, artificial nutrition and hydration, or oxygen masks (respiration without reliance on machinery).<sup>54</sup> To authorize the patient’s wishes, the signatures of the patient, two professional physicians, and a witness are required.

This law also stipulates that when patients cannot express themselves or make decisions, those with a LW and life prolonging medical care plan may receive hospice care. In addition, two or more family members may agree to hospice care based on the patient’s presumed wishes and personality. If this is not possible, hospice care can be performed if all family

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51. *Id.* at 47.

52. Dong Wook Shin et al., *End-of-life communication in Korean older adults: With Focus on Advance Care Planning and Advance Directives*, 16 GERIATR GERONTOL INT. 407, 410 (2016), <https://www.ncbi.nlm.nih.gov/pubmed/26459613>.

53. JSDD FOUND., *supra* note 15, at 6.

54. *Id.* at 7.

members agree.<sup>55</sup> The definition of “family members” includes a spouse, immediate children, grandchildren, and parents. If none of these relatives are present, siblings may be considered family members. Although this law covers all terminal patients, physicians are still not obligated to explain terminal conditions to patients and family members.<sup>56</sup>

Japan and Korea’s approaches share some similarities. They both allow terminally-ill patients to forgo life-sustaining measures, but are cautious about surrogate decision-making, particularly by family members. When patients’ true wishes cannot be determined by their previous behavior, Korea requires a complete agreement among all family members. As the analysis in the following section observes, Taiwan’s HPCA does not have such rigorous requirements for surrogate decision-making. Some criticize this as a flaw of the HPCA. The PRA corrects this flaw, however, and provides more clear procedures to make patients’ wishes effective. The PRA also extends decision-making authority to patients who are not terminally-ill. This is a milestone in East Asian law.

### **3. End-of-Life Law Development in Taiwan**

#### **3.1 Medical Futility as the Driving Force to End-of-Life Legislation**

Taiwan’s penal code punishes assisted suicide and provides that hospitals and physicians have an obligation to provide first aid.<sup>57</sup> Until 2000, when terminally ill patients were in a critical condition and had lost consciousness, hospitals and physicians were obligated to “save patients until their last moment,” even if patients endured extreme pain as a result. Although a small number of physicians worked to promote hospice and palliative care, most physicians believed that to “save lives until death” was always the duty of physicians. Over time, the concept of palliative care gained increased recognition; however, no definitive protocols for determining when to withdraw terminally ill patients from treatment were developed before the HPCA was enacted in 2000.

Despite the effort to promote palliative care, the major factor that facilitated the legislation permitting patients in Taiwan to die with dignity was the cost of futile treatment. Futile treatment applies when medical interventions lack therapeutic effects or provide patients with only a life of

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55. *Id.* at 8.

56. *Id.* at 7.

57. Criminal Code of the Republic of China, art. 275 (2018); Medical Care Act, art. 60 (2018); Physicians Act, art. 21 (2016).

low quality, despite considerable health care expenditures.<sup>58</sup> Since Taiwan is among the few nations that continually collect data on causes of death, health expenses, and cause of death, the problem of medical futility has been exposed and is widely discussed. It has been claimed that one-third of healthcare expenditures paid by the national health insurance is for futile treatment, and that end-of-life legislation is helpful to the sustainability of the national insurance system.<sup>59</sup> The National Health Insurance (“NHI”) program in Taiwan covers approximately thirty percent of expenses for patients three to six months before death.<sup>60</sup> Data from the NHI Research Database shows that NT\$36.7 billion was spent on the hospitalization of patients 1 year before death in 2011; this amount constituted 7.5 percent of NHI spending and four percent of self-paid medical expenses.<sup>61</sup> An empirical study revealed that between 2004 and 2006, Taiwan contained half of the world’s patients with extracorporeal membrane oxygenation, an expensive high-tech intervention with questionable benefit.<sup>62</sup> In 2010, 30.9 intensive care unit beds were used per 100,000 people in Taiwan; this was the world’s highest national figure in terms of density and was 1.5 times higher than that in the United States and seven times higher than that in Japan.<sup>63</sup> In 2012, 11,573 patients were chronically ventilated, accounting for NT\$16.1 billion of all hospitalization expenses claimed.<sup>64</sup> In 2006, the number of chronically ventilated patients per 100,000 people in Taiwan was

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58. Ian Kerridge et al., *Defining Medical Futility in Ethics, Law and Clinical Practice: An Exercise in Futility?* 4 J.L. MED. 235, 235-37 (1997), <https://ses.library.usyd.edu.au/bitstream/2123/10806/3/JLM%20defining%20medical%20futility.pdf>; Shih-Yi Lee et al., *Attaining Good End-of-Life Care in Intensive Care Units in Taiwan—the Dilemma and the Strategy*, 3 J. GERONTOLOGY 26, 28 (2009), <https://www.sciencedirect.com/science/article/pii/S1873959809700171>.

59. For example, Dr. Huang Sheng-Jean, a leader in hospice care, said to the public: “Of the NT\$570 billion [US\$18.9 billion] healthcare expenditure paid by the NHI, about NT\$170 billion is spent on futile medical treatment,” and “By operating preventive healthcare, including building quality end-of-life care and promoting the signing of DNR [do not resuscitate] to have ‘a good death,’ a lot can be saved, benefiting the sustainability of the NHI system.” See Alison Hsiao, *Government Looks into ‘Futile Care’*, TAIPEI TIMES (July 08, 2013), [http://www.taipetimes.com/News/taiwan/archives/2013/07/08/2003566\\_617](http://www.taipetimes.com/News/taiwan/archives/2013/07/08/2003566_617).

60. Tang Gao-Jun (唐高駿) & Lan Zuo-Yun (藍祚運), Lin Zhong Qian Wu Xiao Yi Liao Yan Jiu Bao Gao Shu (Report on Futile Treatment Before Death, 臨終前無效醫療研究報告書), 393 CITIZEN 7 (2014), [http://www.393citizen.com/file.php?n=upload/2014\\_11\\_11\\_14\\_16\\_50.pdf&txt=medical+futile+report.pdf](http://www.393citizen.com/file.php?n=upload/2014_11_11_14_16_50.pdf&txt=medical+futile+report.pdf).

61. *Id.* at 7-8.

62. Bradley Chen & Yao-Mao Chang, *CPR with Assisted Extracorporeal Life Support*, 372 LANCET. 1879 (2008), [https://doi.org/10.1016/S0140-6736\(08\)61805-X](https://doi.org/10.1016/S0140-6736(08)61805-X), forwarded from Tang & Lan, *supra* note 60 at 8.

63. Tang & Lan, *supra* note 60, at 9.

64. *Id.*

5.8 times higher than that in the United States.<sup>65</sup> The dilemma for physicians regarding saving chronically ill patients versus allowing them to die with dignity, coupled with the need to reduce NHI spending, was the rationale behind the promulgation of the HPCA in Taiwan.

### 3.2 Cultural Factors in Legislation

Another factor in legislation is Taiwan's unique culture on death. In countries with Confucian cultures, patients and their family members tend to be viewed as a single unit, because the opinions of family members can often affect the decisions of patients. The connection between patients and their family members continues even after the patient has passed away. Chinese people traditionally hold the belief that if no family members provide offerings after an individual has passed away, the deceased individual becomes a hungry ghost because they receive no food in the underworld.<sup>66</sup> Therefore, regarding inheritance of distributed property, some large families designate specific pieces of land as ancestral worship property; the revenue generated from the utilization of such land is allocated to conduct ancestral worship. Taiwan has even developed a unique law for this practice, called the Act for Ancestor Worship Guild,<sup>67</sup> to regulate the real estate for ancestral worship. This custom comes with a strong belief that the soul will not be able to return home from the hospital if patients die in the hospital. Many Taiwanese want to go back home to die even if they later become unconscious. As a result, most Taiwanese terminally-ill patients and family members want doctors to stop treatment so that they can return home to die.<sup>68</sup> This could explain why Taiwan was the first country with a Confucian culture to pass laws on the right-to-die with dignity.

One cultural exception exists: people of Mainland Chinese descent (*wàishěngrén*) account for approximately fourteen percent of the population in Taiwan.<sup>69</sup> During the 1949 Chinese Civil War, many Mainland Chinese

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65. Neill KJ Adhikari, et al., *Critical Care and the Global Burden of Critical Illness in Adults*, 376 LANCET. 1339, 1339- 1346 (2010), [https://doi.org/10.1016/S0140-6736\(10\)60446-1](https://doi.org/10.1016/S0140-6736(10)60446-1), forwarded from Tang & Lan, *supra* note 58, at 9.

66. BRAUN & NICHOLS, *supra* note 9, at 261.

67. Ministry of the Interior of Taiwan, Act for Ancestor Worship Guild (2007), <https://law.moj.gov.tw/Eng/LawClass/LawAll.aspx?PCode=D0020063>.

68. Shao-Yi Cheng et al., *A Cross-Cultural Study on Behaviors When Death Is Approaching in East Asian Countries: What are the Physician-Perceived Common Beliefs and Practices?*, 94:39 MED. 3-4 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4616852/pdf/medi-94-e1573.pdf>.

69. Taiwan's ethnic groups can be divided into four: Hoklo (75%), Hakka (10%),

traveled to Taiwan with Chiang Kai-shek's army.<sup>70</sup> Since it was difficult to bring entire families to Taiwan during the war, few people who moved to Taiwan had lived with their families. These people tended to have weak familial bonds. The beliefs of this group were relatively unconstrained by tradition and more favorable to individualism. Chiung Yao and Fu Da-jen are both of Mainland Chinese descent, which probably explains their views about death.

### 3.3 The Hospice Palliative Care Act

In 2000, Taiwan enacted the HPCA which was most recently revised in 2013. The primary purpose of this act was to ensure that terminal patients had the freedom to request DNR or refuse emergency first aid and life-sustaining treatment (i.e., medical measures that sustain the vital signs of the patient without treating the patient's underlying condition). The act also changed the obligation of physicians to perform life-saving treatment.<sup>71</sup> It stipulated that terminal patients are "those who suffer from serious injury or illness, and are diagnosed by a physician as incurable, and there is medical evidence showing that the prognosis is fatal within near future."<sup>72</sup> While conscious, adults with full legal capacity can sign a letter of intent to choose to receive hospice and palliative care and reject life-sustaining treatment and CPR.<sup>73</sup> Two individuals with no conflicts of interest are required to serve as witnesses.<sup>74</sup> The government annotates such wishes on patients' proof of National Health Insurance, thereby enabling hospitals and physicians to easily determine the wishes of a patient when administering first aid.<sup>75</sup> Such wishes can be withdrawn at any time.<sup>76</sup> Additionally, patients may appoint a medical surrogate agent to sign the letter of intent on their behalf in the event

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Mainlander (14%), Aborigines (around 1%). See Michael Rudolph, *the Emergence of the Concept of "Ethnic Group" in Taiwan and the Role of Taiwan's Austronesians in the Construction of Taiwanese Identity*, 2 HISTORIOGRAPHY E. & W. 86, 90 n.1 (2004), <https://us scholar.univie.ac.at/get/o:291784.pdf>.

70. Dominic Meng-Hsuan & Mau-Kuei Chang, *Understanding the Nuances of Waishengren*, 3 CHINA PERSP., 108, 110 (2010), <http://journals.openedition.org/chinaperspectives/5310>.

71. CHENG ET AL., *supra* note 22.

72. *Supra* note 12, at art. 3, sec. 2. <https://law.moj.gov.tw/Eng/LawClass/LawAll.aspx?PCode=L0020066>.

73. *Id.* at art. 4.

74. *Id.* at art. 4, sec. 3.

75. *Id.* at art. 6-1.

76. *Id.* at art. 6.

that the patients are unable to express their wishes.<sup>77</sup> Moreover, when two physicians have confirmed that a patient is terminally ill, they can forego life-sustaining treatment or CPR if the patient has given consent.<sup>78</sup> Later court decisions have indicated that defendants who have chosen to end the lives of their family members without following the relevant legal procedures under the HPCA have committed homicide.<sup>79</sup>

The greatest problem with the HPCA is that it emphasizes exempting physicians from legal responsibility, rather than adhering to the true wishes of patients. According to Section 3 of Article 7, when terminal patients have not signed the letter of intent and are unable to express their wishes, consent can be given by their closest relative.<sup>80</sup> The definition of “closest relative” is decidedly much wider than it is in Japanese or Korean law. In addition to spouses and adult children, it includes grandchildren, parents, siblings, grandparents, great grandparents, great grandchildren and third-degree collateral relatives, and first-degree direct relatives by marriage. The law includes a priority order for these relatives.<sup>81</sup> If family members disagree with each other, the priority order determines whose views are more decisive. If individuals in higher prioritized positions express different opinions from those in lower prioritized positions, the decision must be put in writing before first aid or life-sustaining treatment is abandoned.<sup>82</sup> Additionally, if a patient has no relatives, after the hospice palliative care team at the hospital has examined the patient, a medical advice for the best interest of the terminal illness patient would be issued instead after the examination of the hospice palliative care team.<sup>83</sup>

Once the above conditions are met, a physician can forego first aid or life-sustaining treatment without the threat of facing legal action. Accordingly, when patients are unable to express their wishes, the end-of-life decision can be made directly by their closest relative or physician.

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77. *Id.* at art. 5

78. *Id.* at art. 7.

79. Prosecutor’s Off. of the Kaohsiung Dist. Ct. in Taiwan v. Gong Xinyi, 2017 CHINESE (TAIWAN) SIFAYUAN JIANSUO XITONG (Kaohsiung Dist. Ct. Feb. 23, 2017), [http://jirs.judicial.gov.tw/FJUD/index\\_1\\_S.aspx?p=F5aC0OSViIc5Kk2d0TLD0%2f%2fzxTLJpMw8lOd54m0bNzk%3d](http://jirs.judicial.gov.tw/FJUD/index_1_S.aspx?p=F5aC0OSViIc5Kk2d0TLD0%2f%2fzxTLJpMw8lOd54m0bNzk%3d) (last visited Oct. 2, 2018) (in the criminal case Zhong Su No. 41, the Taiwan Kaohsiung District Court said that since the Hospice Palliative Care Act has passed, the defendant can end his parents’ life in hospital through the act’s procedure, therefore his parents’ terminal status cannot be an excuse for his refusing to provide food and water to them).

80. *Supra* note 12, at art. 7, sec. 3

81. *Id.* at art. 7, sec. 4

82. *Id.* at art. 7, sec. 5

83. *Id.* at art. 7, sec. 3.

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Judgment criteria are the presumed best interests of the patient as opposed to the true wishes of the unconscious patient, which are unknown. In contrast, in the new South Korean law, the scope of what is meant by “family member” is narrower than in Taiwan, and when judging the wishes of patients based on their statements and actions prior to losing consciousness is impossible, *all* family members must agree to abandon first aid and life-sustaining equipment.<sup>84</sup> In this regard, the HPCA provisions provide family members in Taiwan with the same decision-making status as that of the patient, which arguably fails to promote patient autonomy.

Another piece of evidence that the HPCA was intended to absolve the physician of responsibility, rather than to promote patient autonomy, can be found in Article 8, which stipulates that physicians should inform terminal patients or their family members of hospice palliative care treatment guidelines and life-sustaining treatment alternatives.<sup>85</sup> Article 8 says that patients should be informed of their condition and treatment options if they clearly indicate a wish to be informed.<sup>86</sup> In other words, if a patient does not clearly indicate his or her wishes and the physician informs only the patient’s family members, the physician has fulfilled the obligation to inform the patient. Therefore, the patient’s right to informed consent has not been fully incorporated into this act.

Giving family members the right to replace patients in decision-making places physicians in a difficult position. Under such circumstances, legal complainants against physicians are not dying, unconscious patients, but rather their family members. If, as in the case of Chiung, the closest family members (e.g., spouses and children) disagree, whether life-sustaining treatment should be abandoned based on the consent of only one family member or whether consent from all family members should be required — as in Japan and South Korea — is a question worthy of consideration. The laws in Japan and South Korea provide more certainty to physicians seeking to avoid medical disputes. However, a terminal patient’s condition can develop rapidly, and thus conducting a thorough investigation to confirm wishes previously expressed by the patient or forcing all family members to reach a consensus may cause the patient to miss the opportunity to abandon burdensome treatment. The HPCA enables rapid decision-making and enables physicians to justifiably avoid legal responsibility; however, this may cause conflict between family members.

As to the case of Chiung’s husband, the HPCA in Taiwan provides no

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84. *See* note 55 and corresponding context.

85. *Supra* note 12, at art. 8.

86. *Id.*

procedure for terminating life-sustaining treatment in nonterminal patients such as those with dementia. In addition, this act is completely unsuitable for patients in the vegetative state or those with a low quality of life who have not yet reached the terminal stage. The The Patient Right to Autonomy Act was enacted to resolve these issues.

### 3.4 The Patient Right to Autonomy Act (“PRAA”)

The HPCA was perceived as a forward-thinking law in Asia because it permitted terminally ill patients to sign a “do not resuscitate” (“DNR”) order. Despite the passage of the HPCA, DNR orders signed by family members of terminally ill patients were limited because many citizens were not aware of the rules.<sup>87</sup> The primary driving force behind the PRAA was legislator Yu-Hsin Yang.<sup>88</sup> When Yang was nineteen years old, she was diagnosed with distal muscular dystrophy — a rare disease. The disease caused muscular atrophy in her toes and legs that gradually spread, leading to hemiplegia. Despite her condition, she was steadfast in working as an anchor for the Tzu Chi Foundation’s television station and hosting a radio program. She was eventually nominated as a legislator-at-large to represent disadvantaged groups.<sup>89</sup> Her husband, philosophy professor Johannes Hsiao-chih Sun, gathered information on relevant law in different countries and drafted related provisions. Yang made considerable effort to persuade members of Parliament from both major political parties and members of the medical profession to pass the act,<sup>90</sup> and in 2016, the act was passed.

The PRAA was enacted to respect patient autonomy in health care, safeguard patients’ rights to a “good” death, and promote a harmonious physician–patient relationship.<sup>91</sup> The HPCA accords only the terminally ill the right to refuse medical treatment and protects a limited concept of their right to be informed. By contrast, the PRAA is more sophisticated in terms of its application, the scope of a DNR order, and the appointment of health care agents. In particular, the act stipulates that patients must be informed of

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87. Rong-chi Chen, *the Policy of Hospice Palliative Care in Taiwan*, TAIWAN PEOPLE NEWS (Sept. 21, 2015), <http://www.peoplenews.tw/news/2f940e15-c874-448a-8933-eb7537d9cca3>.

88. I-chia Lee, *Advanced Healthcare Directives Legalized*, TAIPEI TIMES (Dec 20, 2015), <http://www.taipetimes.com/News/front/archives/2015/12/20/2003635211>.

89. TED X TAIPEI, Speaker Profile: Yu-Hsin Yang, <http://2016-en.tedxtaipei.com/speaker/yu-hsin-yang/> (last visited Oct. 2, 2018).

90. Chen R. C., *Providing Patients with Dementia and Neurological Diseases a Dignified Peaceful Demise*, 2:1 BAOJ PALL. MED. 1, 1 (2016).

91. The Patient Right to Autonomy Act, art. 1.

their illness status and risk prognosis and must be allowed to decide among the health care options available.<sup>92</sup> More crucially, this act is the first legislation in Taiwan to grant patients the right of informed consent.<sup>93</sup>

The PRAA differs from Taiwan's Medical Care Act (the law regulates hospitals and health institutions) and Physicians Act (the law regulate physicians), both of which require health care institutions and physicians to provide patients or their family members with required information as a professional duty rather than out of concern for patients' rights.<sup>94</sup> Before the promulgation of the PRAA, the right to informed consent was established by court precedents. In contrast to the HPCA, the PRAA obligates physicians to provide patients with necessary information and offer such information to patients' family members only after approval from patients. Furthermore, the PRAA grants the right of informed consent to patients receiving health care and forbids family members or health care agents from interfering with health care institutions' or physicians' execution of health care options selected by patients. Accordingly, the PRAA ensures patients of the right to informed choice by allowing them to finalize their health decisions and safeguarding their right to obtain information about and participate in making said decisions.

The PRA applies not only to terminally ill patients but also to those in an irreversible coma or persistent vegetative state, and those afflicted with severe dementia or other untreatable diseases recognized by competent authorities.<sup>95</sup> Whether a patient meets any of the criteria set forth in the act is determined by two specialist physicians and ascertained through at least two consultations by a hospice and palliative care team.<sup>96</sup> The act has arguably set a precedent in Asia for permitting patients with terminal illnesses or unbearable and incurable conditions to choose a natural death; other governments in Asia at most allow only the terminally ill to do so.<sup>97</sup>

With respect to patients' informed consent, the PRAA pays special

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92. The Patient Right to Autonomy Act, art. 4.

93. Sun Xiao-zhi (孫效智), *Bing Ren Zi Zhu Quan Li Fa Ping Shi (Comment on the Patient Self-determination Act in Taiwan, 《病人自主權利法》評釋)*, 13 CHENG CHING MED. J. 4, 5 (2017) (in Chinese), [http://readopac2.ncl.edu.tw/nclJournal/search/detail.jsp?sysId=0006905988&dtdId=000040&search\\_type=detail&la=ch](http://readopac2.ncl.edu.tw/nclJournal/search/detail.jsp?sysId=0006905988&dtdId=000040&search_type=detail&la=ch).

94. Medical Care Act, art. 63, 64; Physicians Act, art. 12-1.

95. The Patient Right to Autonomy Act, art. 14, § 1.

96. The Patient Right to Autonomy Act, art. 14, § 2.

97. The country which passed the first end-of-life law in East Asia is Singapore. The Advance Medical Directive Act of 1996 limited only for terminally ill patients. The text can be found at <https://sso.agc.gov.sg/Act/AMDA1996>. Except Taiwan, no Asian country provide unconscious non-terminally ill patients the legal procedure to forgo life-sustaining treatment.

attention to the requirement that patients be informed about their situations. The act requires that patients are adequately informed of their health status before advance decisions are made. A patient must first consult with health care institutions and make an advance decision in front of a notary public or at least two persons.<sup>98</sup> Once made, a patient's decision is registered on his or her NHI card.<sup>99</sup> At least one declarant and one relative of the first or second degree of affinity must participate in advance care planning.<sup>100</sup> Patients who make advance decisions can choose among life-sustaining treatments, artificial nutrition, and hydration.<sup>101</sup> By contrast, the HPCA offers only two treatment options: cardiopulmonary resuscitation and life-sustaining treatment.<sup>102</sup>

Another topic the PRAA addresses is the role of health care agents. In addressing this topic, Taiwan is unique among Asian countries. The HPCA gives health care agents only the power to sign a DNR order on behalf of a patient,<sup>103</sup> whereas the PRAA bolsters the role of health care agents by allowing them to participate in consultations on advance decision-making and consider potential treatment scenarios that could arise.<sup>104</sup> Through the appointment of a health care agent, a patient extends his or her autonomy when he or she is unconscious.

### 3.5 Challenges in the Application of the PRAA

The PRAA marks a step forward for Taiwan's laws regarding patients' rights in end-of-life decision-making. However, the act has limitations because its formulation involved political negotiation. All punitive measures originally set forth in the act were excluded during the legislative process to prevent patients' family members from threatening to sue physicians, thereby enabling physicians to make more independent health care decisions.<sup>105</sup> This exclusion puts the PRAA in stark contrast with the

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98. The Patient Right to Autonomy Act, art. 9, § 1.

99. *Id.*

100. The Patient Right to Autonomy Act, art. 9, § 2

101. The Patient Right to Autonomy Act, art. 8, § 2.

102. The Hospice Palliative Care Act, art. 7, § 5.

103. The Hospice Palliative Care Act, art. 5, § 2.

104. The Patient Right to Autonomy Act, art. 10, § 1.

105. Bo-zhang Li (李伯璋), *Bing-Ren-Zi-Zhu-Quan-Li-Fa-Nei-Han-Jiyi-Chu-Tan (A Glance at the Meaning and Issues of the Patient Self Determination Act, 病人自主權利法內涵及疑義初探)*, 212 FORMOSA TRANSNAT'L L. REV. 2, 6 (2017) (in Chinese), [http://reado.pac3.ncl.edu.tw/nclJournal/search/detail.jsp?sysId=0006928837&dtdId=000040&search\\_type=detail&la=ch](http://reado.pac3.ncl.edu.tw/nclJournal/search/detail.jsp?sysId=0006928837&dtdId=000040&search_type=detail&la=ch). During the legislative process, the office of legislator Yang, Yu-Hsin issued

stringent punitive measures in the HPCA, namely that physicians who violate the end-of-life decision procedure can receive a fine of up to NT\$60,000, a suspension from practice of up to one year, or even the revocation of their medical license.<sup>106</sup> In terms of the healthcare institution's duty to inform patients, other countries have more stringent rules. For example, the Patient Self-Determination Act in the United States stipulates that in extreme cases, health care institutions that fail to provide adequate information to patients can be withdrawn from partnerships with federal insurance companies.<sup>107</sup> By contrast, since the PRAA imposes no punitive measures, it could be difficult to recognize patients' autonomy when health care institutions or physicians refuse to implement the end-of-life decision procedures. In terms of efficacy and timeliness, an act with no teeth would not sufficiently safeguard patients' right to make personal health decisions.

Under the PRAA, when health care institutions or physicians acting based on their professional expertise or personal beliefs refuse to implement patients' advance decisions, they must inform the patients or other concerned parties that they may refuse to implement such decisions.<sup>108</sup> Moreover, if a health care institution cannot provide palliative care because of a lack of personnel, equipment, or expertise, the institution must recommend that the patient be referred to another health care institution and assist in the referral.<sup>109</sup> By contrast, the Patient Self-Determination Act in the United States requires health care institutions to arrange for referral *before* admission if they deem it necessary, rather than informing the patient that they are unwilling to implement advance decisions after the patient's condition has deteriorated.<sup>110</sup> The reluctance of hospitals or physicians to forego treatment may be common in some religious hospitals in Taiwan. In theory, they should inform patients of their inability to make advance decisions as early as possible, but the PRA does not require to do so. As a

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a document to response the concerns from the medical profession, claiming the final version will delete all sanction provisions so that physicians do not worry about legal risk. See Yang Yuxin, Advisor to the Legislative Council Office of Taiwan, *A Probe into the Connotation and Doubt of the Law of Patient Autonomy* (Oct. 6, 2015) (in Chinese), <http://www.lean.dli.org.tw/download/%E6%B3%95%E7%90%86%E6%83%85%E8%AB%87/201601/%E7%97%85%E4%BA%BA%E8%87%AA%E4%B8%BB%E6%AC%8A%E5%88%A9%E6%B3%95%E5%B8%B8%E8%A6%8B%E5%95%8F%E9%A1%8C%E9%87%8B%E7%96%91.pdf>.

106. The Hospice Palliative Care Act, art. 10.

107. Steven K. Hoge, *The Patient Self-Determination Act and Psychiatric Care*, 22 BULL. AM. ACAD. PSYCHIATRY L. 577, 578 (1994).

108. The Patient Right to Autonomy Act, art. 14, §§ 3, 4.

109. The Patient Right to Autonomy Act, art. 16.

110. 42 U.S.C. §§ 1395cc(f)(1)(A), 1396a(w)(1)(A).

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result, whether the PRAA successfully influences the implementation of patients' advance decisions remains to be seen.

One major challenge facing the PRAA is its likely conflict with the HPCA. Both acts specify treatment options for terminally ill patients and allow them to make advance decisions; however, whether advance decisions made under the HPCA or those made under the PRAA should be prioritized is unclear. The HPCA punishes physicians who refuse to implement advance decisions,<sup>111</sup> whereas the PRAA does not. Thus, determining the legal effect of the PRAA will be important. Moreover, under the HPCA, family members can make advance decisions on behalf of comatose terminally ill patients if the patient failed to make such decisions.<sup>112</sup> Whether this contradicts the spirit of the PRAA is open to interpretation. The PRAA forbids a patient's family members from making advance decisions on said patient's behalf under four specific conditions; that the act treats such scenarios differently from the HPCA may seem unfair. The HPCA might be revoked; however, because it contains some provisions (e.g., consent rights of family members and punitive measures against physicians) that are not currently stipulated in the PRAA, it might be necessary for the PRAA to be amended if the HPCA is eliminated.

Although the PRAA extends to non-terminally ill patients, the definitions of the four clinical conditions included in the provisions on making advance decisions are controversial. For example, it is unclear what constitutes an "irreversible" coma and what constitutes severe dementia. In addition, it can be difficult to determine whether patients meet the act's fifth clinical condition defined in the act, which states that a disease must be unbearable and incurable. Determining whether no other appropriate treatment options are available can also be difficult. Another problem is that pain tolerance varies among people and determining whether a specific unconscious patient is in unbearable pain may not be possible. Furthermore, if clinical trials are evaluating a possible effective treatment option for a previously incurable disease, whether the disease should be considered incurable is open to interpretation. The government could develop specific criteria for such cases; however, patients' family members or health care agents may challenge such criteria or even seek legal action. The judicial authorities in Taiwan have yet to adjudicate cases on end-of-life decision-making because it is almost impossible for terminally ill patients to await court decisions, which take considerable amounts of time to make. However, after the PRAA takes in effect, judges in Taiwan may need to handle legal issues involving patients who survive for relatively long periods.

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111. The Hospice Palliative Care Act, art. 10.

112. The Hospice Palliative Care Act, art. 7, § 3.

### **Conclusion**

Since many Asian countries are becoming aging societies, the importance of the end-of-life issues is growing. The benefit and difficulties presented in the implementation of the PRAA might be an excellent example for the reference of relevant reforms in East Asia. The PRAA protects patients' right to make advance decisions and their absolute autonomy over end-of-life decisions and specifies procedures for the making of such decisions. This act constitutes progress in an Asian culture where family relations are held in high esteem. The potential problems regarding implementation of the act can be addressed in light of the cases discussed at the beginning of this article. The husband of Chinese writer Yao Chiung is on chronic ventilation; he could communicate with his children and physicians by using simple language, and thus could not be regarded as terminally ill. Fu Da-jen, the former TV sports anchor in Taiwan, was in the terminal stage of pancreatic cancer before he passed away in Switzerland; however, he did not require emergency or life-sustaining treatment. In addition, the physician's assistance he requested is not allowed in Taiwan. Neither the husband of Yao Chiung or Da-jen Fu is covered by the HPCA or PRAA. As the Taiwanese public becomes increasingly accepting of the concept of a "good death," the next step of Taiwan may be to legalize physician-assisted suicide, if PRAA is well adopted and implemented.