Commentary
Korean J Med Ethics 2026;29(2): 65-72
https://doi.org/10.35301/ksme.2026.29.2.65

KJME
Korean Journal of Medical Ethics
pISSN 2005-8284 eISSN 2234-3598

Optimum Use of Artificial Nutrition and Hydration Near the End of Life: Ethics, Advance Directives, Public Deliberation, and Reform of Korea's Life-Sustaining Treatment Act

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Received: May 10, 2026
Revised: Jun 2, 2026
Accepted: Jun 2, 2026

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

Acknowledgements
The authors are grateful to John Y. Rhee, a neurologist and palliative care physician affiliated with Dana-Farber Cancer Institute, Brigham and Women's

Abstract

This commentary examines the ethical implications of the mandatory provision of artificial nutrition and hydration (ANH) under Korea's Act on Decisions on Life-Sustaining Treatment. Building upon a target article derived from a policy research report, we focus on the proposal to incorporate ANH into advance directives and argue that the current legal framework creates serious clinical ethical problems. Although ANH is widely recognized as a medical intervention requiring individualized proportional judgment, the Act effectively mandates its provision even during the end-of-life process. We argue that this rigid approach violates the principles of nonmaleficence, justice, and respect for autonomy by prolonging suffering, producing unequal end-of-life options across institutional settings and according to the type of intervention sustaining patients' lives, and undermining trust between patients and clinicians. Accordingly, ANH should not be treated as a universal obligation but as a medical intervention subject to proportionality, patient preferences, and clinical judgment. Finally, we argue that active public deliberation is necessary for the ethical and legal incorporation of ANH into advance directives.

Keywords: artificial nutrition and hydration; advance directives; life-support care; personal autonomy

The target article [1], derived from a government-affiliated policy report by the same authors [2], is significant in that it examines the implementation of the Act on Decisions on Life-Sustaining Treatment [3] (the Act), assesses its societal impact, and proposes reforms attentive to patient autonomy and the broader economic

Hospital, and Harvard Medical School, for insightful discussions regarding Catholic interpretations of ANH and contemporary neuroscientific perspectives on disorders of consciousness.

Funding information
This research was supported by a grant of the Korea Health Technology R&D project through the Korea Health Industry Development Institute (KHIDI), funded by Ministry of Health & Welfare, Republic of Korea (grant number: RS-2025-25458811).

Data availability
Upon reasonable request, the datasets of this study can be available from the corresponding author.

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Writing – review & editing: Shin D, Krakauer EL, Kim CJ.

Ethics approval
Not applicable.

sustainability of end-of-life care in an aging society. This commentary focuses on one of their key proposals—the inclusion of artificial nutrition and hydration (ANH) within individualized advance directives— and further examines its ethical implications.

The issue of ANH left unresolved by the Act demands urgent attention. Article 19(2) of the Act stipulates that, when implementing a decision to forgo life-sustaining treatment, "medical measures for pain relief, provision of nutrition or water, or simple administration of oxygen shall not be withheld or withdrawn." This provision effectively mandates ANH for all patients, regardless of their clinical circumstances. One of the authors filed a constitutional challenge in 2019 arguing that this provision violates the constitutional right to pursue happiness [4,5]. Although the Constitutional Court accepted the case for review, there has been little progress over nearly six years. In contrast, the constitutional challenge to physician-assisted dying raised in late 2023 [6,7] has already generated substantial public attention [8–12], engagement within the Constitutional Court [13], and parallel legislative initiatives [14,15]. It is both paradoxical and disappointing that the right to refuse unwanted interventions has not received greater attention before the turn toward physician-assisted dying.

In line with the proposal of the target article, this commentary supports expanding patients' right to make decisions regarding ANH. Realizing this right will require both a long-delayed judicial resolution and the broader public deliberation called for by the authors of the target article [1]. However, this public deliberation must not be understood merely as the aggregation of public preferences. Rather, it should involve sustained and informed public reasoning grounded in clinical realities and in the values and experiences of patients, families, and healthcare professionals involved in end-of-life care. This commentary seeks to contribute to that process by examining why the mandatory and uniform provision of ANH risks inadvertently harming patients and thereby constitutes a serious clinical ethical problem requiring public deliberation and legal revision.

The Act is the only legal framework in Korea directly governing decisions to forgo treatment at the end of life. Notably, however, it explicitly prohibits the withholding or withdrawal of nutrition and hydration. In contrast, legal frameworks in other countries generally recognize patients' rights to refuse medical treatment [16–19], provide statutory provisions specifying which treatments may be withheld or withdrawn and under what conditions [20], or rely on judicial decisions affirming such rights [21–26]. By contrast, the Korean Act allows the forgoing of legally defined life-sustaining treatments only when a patient is diagnosed as being in the end-of-life process [27], while explicitly prohibiting the withholding or withdrawal of nutrition and hydration even then. ANH is nearly universally recognized as a medical intervention [28], although ethical and religious traditions

attach varying moral significance [29–32] to feeding and hydration.[1)] Like any medical intervention, it may confer benefit in some situations and harm in others. Therefore, its use should be determined on the basis of proportionality—balancing benefits and burdens [29,31–34]. Major palliative care textbooks [35] and clinical guidelines [36,37] consistently emphasize the need for individualized clinical judgment in decisions regarding ANH. However, the current law precludes such individualized clinical judgment.

Our argument for repeal of this provision rests on three grounds. First, the unconditional application of ANH regardless of the individual circumstances of each patient directly violates the principle of nonmaleficence by risking substantial harm [38]. Second, the arbitrary distribution of end-of-life options across institutional settings and disease categories violates the principle of justice [38,39]. Third, mandatory ANH and the physical restraint that often accompanies it become a vivid symbol of compromised autonomy [38], thereby undermining trust between patients and physicians [40]. Each of these ethical violations and their consequences will be discussed in turn below.

First, the mandatory provision of ANH under Article 19(2) violates the principle of nonmaleficence [38]. While ANH may provide meaningful therapeutic benefit in some clinical situations, in others—particularly near the end of life—it may cause more harm than benefit. Artificial hydration, whether intravenous or enteral, sometimes exacerbates pulmonary edema, pleural effusions, ascites, or anasarca and resultant pain or dyspnea. Artificial enteral feeding also can lead to regurgitation or vomiting with aspiration, again resulting in dyspnea as well as infection, or diarrhea. For these reasons, ANH also can hasten death, while in other cases it can prolong the suffering of dying patients whose primary goals are comfort and dignity. Despite the widely accepted clinical principle that ANH should not be initiated or continued when its burdens outweigh its benefits [35–37], the current law eliminates the possibility of such judgment. This rigid application prolongs suffering in many cases and forces clinicians into ethical dilemmas, effectively compelling them to violate the principle of nonmaleficence.

Second, the unequal distribution of end-of-life options based on morally

1) It should also be acknowledged that, in some ethical and religious traditions, artificial feeding and hydration are regarded not only as medical interventions but as expressions of basic care and human solidarity. Within Catholic bioethics in particular, strong emphasis has sometimes been placed on protecting the fundamental dignity of highly vulnerable patients, including those in a vegetative state, and on safeguarding their right to basic care, including artificial nutrition and hydration. Even within Catholic bioethics, however, differing interpretive approaches appear to remain regarding the meaning of ordinary and extraordinary means. Whereas some approaches tend to treat the distinction in more categorical terms, others understand ordinary and extraordinary means more as general moral principles requiring contextual specification through proportionality in individual clinical circumstances. These ongoing interpretive tensions further suggest that this area may require individualized moral and clinical judgment rather than rigid legal uniformity.

arbitrary differences in institutional setting and in the type of intervention sustaining a patient's life violates the principle of justice [38,39]. The provisions of the Act concerning the forgoing of life-sustaining treatment were designed primarily with tertiary hospitals in mind—particularly institutions centered around intensive care unit–based interventions and equipped with sufficient personnel to establish Institutional Ethics Committees as required by the Act [41]. Consequently, although 36% of hospital deaths in Korea occur in long-term care hospitals [42], these facilities were not adequately considered in the design of the system, and the legal framework is poorly suited to their institutional and staffing capacities. Despite governmental efforts encouraging either the establishment of Institutional Ethics Committees or contractual affiliation with an Institutional Ethics Committee, only 179 long-term care hospitals—13.7% of all such hospitals—are currently able to implement the formal forgoing of life-sustaining treatment under the Act [43]. Indeed, substantial inequality among medical institutions is clearly observable in the implementation of decisions to forgo life-sustaining treatment [44]. As a result, while many long-term care hospitals remain functionally excluded from the Act, a considerable number of patients in such institutions are likely being "kept alive" through ANH that may prolong or exacerbate suffering. Nevertheless, unlike patients in tertiary hospitals, they are deprived of the opportunity to undergo legally recognized procedures for forgoing treatment and to die in the manner they themselves would have wished. Instead, ANH—which the law effectively mandates—may be administered without any meaningful evaluation of proportionality or inquiry into the patient's values or wishes, since the law leaves no legally recognized alternative. In long-term care hospitals, communication between physicians and families is often particularly is often particularly delicate and legally fraught, while individual clinicians may also perceive themselves as especially vulnerable to legal disputes and professional risk. Under such circumstances, the legal requirement to continue ANH may further encourage defensive practice by creating the perception that the legally "safe" course of action has effectively already been predetermined. Thus, even among patients with similar prognoses, available end-of-life choices differ depending on the type of hospital in which they are treated and on which medical intervention is sustaining their lives. This disparity is in clear conflict with the principle of justice.

Third, the violations of autonomy [38] and the erosion of trust [40] caused by mandatory ANH give rise to deeper ethical problems. Patients and their families are told that "removing the feeding tube is illegal," and consequently come to feel that medical professionals are ignoring the patient's suffering. At the same time, clinicians are compelled to refuse requests to forgo ANH because compliance with such requests would be regarded as unlawful. In this way, institutional coercion undermines trust within clinical practice and may shift clinicians' attention from compassionate responsiveness to concerns about legal and professional risk. One

possible interpretation of the recent rapid rise in public interest in physician-assisted dying [45] is that it may reflect, at least in part, the experiences of patients and families exposed to suffering either inadequately relieved or exacerbated by ANH. What patients seek may not be a broadly construed right to die—which could be understood as imposing upon medical professionals an obligation to actively facilitate death—but rather the more limited right to refuse unwanted life-sustaining interventions. Unlike the former, the latter imposes upon medical professionals the obligation to respond sensitively to patients' suffering and to alleviate it to the greatest extent possible, obligations central to the ethical practice of medicine. However, the current law fails to guarantee even this more limited right, while forcing even compassionate clinicians into conflict between ethical action and protecting their careers.

ANH is not a universal obligation that must be imposed on all patients but a medical intervention that should be determined according to each patient's clinical condition, values, and goals of care. Decisions regarding ANH should not be governed solely by the singular criterion of life preservation, but should instead be made prudently on the basis of proportionality, patient autonomy, and professional clinical judgment. Accordingly, Article 19(2) of the current Act prohibiting the withholding or withdrawal of ANH should be amended.

In this context, the target article's proposal for the gradual incorporation of ANH into advance directives only after sufficient public deliberation deserves a more expansive interpretation. It should be understood as a call to actively foster public deliberation rather than passively await social consensus. Without such efforts, ethically significant end-of-life options are unlikely to be incorporated into law and policy, as the legislative history of the Act itself suggests [46]. In particular, the medical community has a responsibility to communicate clearly the clinical realities of end-of-life suffering, the medical nature of ANH, and the ethical necessity of proportional judgment. At the same time, government and legislative institutions bear responsibility for convening and sustaining transparent public discussion [47] on ANH and for creating meaningful opportunities for participation by patients, families, and healthcare professionals.[2] They must also ensure that relevant information is made publicly available in ways that are understandable and protective of patient privacy. Civil society, in turn, should have greater opportunities to learn about the medical, ethical, and institutional realities of end-of-life care, so that public understanding is shaped not only by emotionally immediate and highly visible end-of-life debates—such as physician-

2) More recently, deliberative-democratic methodologies from various public policy contexts have also been introduced and discussed in Korea as possible frameworks for future public deliberation in bioethics, suggesting that practical methodologies for such discussions are already available should governmental and institutional support be provided.

assisted dying—but also by a deeper understanding of suffering, proportionality, and invasive intervention at the end of life. Without such efforts, end-of-life policy risks continuing to be shaped less by public understanding and ethical reflection than by the absolutist rhetoric of life preservation at any cost. In this sense, the target article's proposal ultimately calls for the ethical evaluation of ANH through active public deliberation as a necessary step toward its legal incorporation into advance directives.

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