Research Article
Korean J Med Ethics 2026;29(2): 105-118
https://doi.org/10.35301/ksme.2026.29.2.105

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

The Legitimacy of Forgoing Life-Sustaining Treatment: A Comparative Analysis of Japan and Taiwan

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Abstract

This article examines the legal frameworks governing end-of-life (EOL) care in Japan and Taiwan, focusing on how the legitimacy of forgoing life-sustaining treatment (LST) is constructed and applied clinically. Tracing the historical development of EOL care regulation in both societies, the article analyzes how different approaches shape professional discretion and patient autonomy. Japan utilizes a guideline-based framework emphasizing procedural legitimacy through communication, collective deliberation, and advance care planning over the explicit recognition of individual statutory rights. Conversely, Taiwan's legislation-based framework provides formal legal criteria for forgoing LST and grants legal force to advance directives as expressions of patient autonomy. While Japan's approach allows flexibility in clinical decision-making, it leaves uncertainties regarding legal liability, particularly in cases involving patients without family support. Taiwan's legislation offers greater legal clarity but may constrain clinical discretion during ambiguous medical trajectories. Despite these regulatory differences, both societies struggle to ensure the clinical realization of patient autonomy. Ultimately, this comparison suggests that neither procedural consensus nor legal codification alone is sufficient to address the ethical and practical complexities of EOL care.

Keywords: end-of-life care; life-sustaining treatment; personal autonomy; advance care planning; clinical decision-making

Received: Jan 31, 2026
Revised: Mar 31, 2026
Accepted: Mar 31, 2026

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

Acknowledgements
Not applicable.

Funding information
Not applicable.

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

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Author contributions
The article is prepared by a single author.

Ethics approval
Not applicable.

I. Introduction

Over the years, end-of-life (EOL) decision-making has been one of the central issues in the field of medical ethics in East Asia. In countries where the aging population grows rapidly, the debates over how and when life-sustaining treatments (LST) should be used or forgone have attracted increasing public attention. Japan and Taiwan, where all residents are covered by national health insurance systems and are entitled to universal access to medical care [1,2], have faced similar ethical dilemmas and legal challenges regarding the use of LST and the legitimacy of forgoing such treatments [3]. However, the two countries have taken different approaches to addressing these related issues.

In Japan, discussions concerning the legal regulation of EOL care have appeared

intermittently since the 1970s [4]. Civil organizations such as Japan Euthanasia Association (now the Japan Society for Dying with Dignity) drafted a legislative proposal in 1979 calling for the legalization of forgoing LST [4]. At the same time, a research report on medical law and social issues published by the Japan Medical Association (JMA) also expressed concerns regarding the legal status of forgoing LST [4]. Despite these efforts, no comprehensive statute governing EOL care has been enacted. Instead, Japan gradually developed its regulatory framework through administrative guidelines and position statements issued by professional associations. This so-called "soft-law approach" has produced a system in which the legitimacy of EOL decisions rests largely on procedural adequacy and collective deliberation among relevant parties, rather than on explicitly defined legal rights.

In Taiwan, by contrast, issues regarding EOL care were addressed primarily through legislation. There have been debates on the legalization of euthanasia since the 1980s, but substantive discussion regarding the legislation of EOL care began in the 1990s [5]. Taiwan has established its regulatory framework through two separate statutes: the *Hospice Palliative Care Act*, enacted in 2000, which clarified the legal conditions under which LST may be withheld or withdrawn for terminally ill patients [6], and the *Patient Right to Autonomy Act,* enacted in 2016, which introduced a broader legal framework for advance directives (ADs) and advance care planning, and more explicitly recognized patient autonomy in EOL decision-making [7]. This legislation-based approach, also adopted in other countries such as England and Germany, situates EOL care within written statutes and legally defined rights. In England, the Mental Capacity Act 2005 grants legal force to advance decisions to refuse LST, while in Germany, a 2009 amendment to the Civil Code made ADs legally binding [8]. It provides legal protection for both the physicians who forgo LST and patients who wish for such action. However, this approach also has its own limitations, as each statute specifies its own conditions and scope of application, which may leave certain situations or patient groups unaddressed.

Japan and Taiwan provide a useful pair for comparative analysis: both countries share broadly similar healthcare structures, rapidly aging demographics, and universal health coverage, yet they have responded to shared ethical challenges in different ways: Japan has relied primarily on professional guidelines, whereas Taiwan has developed a statutory framework. This contrast makes them useful cases for examining how regulatory design shapes the legitimacy of forgoing LST and the realization of patient autonomy. The approaches taken by Japan and Taiwan thus represent two different ways of establishing the legitimacy of forgoing LST and protecting patients' rights in EOL care. Previous research has compared regulatory frameworks in Japan and Taiwan, South Korea and the UK, and has identified shared ethical themes across these countries [3]. Building on this comparative work, the present study focuses more specifically on the historical

development of the two frameworks and analyzes them through the lens of how the legitimacy of forgoing LST has been constructed in each context. The aim of this paper is to examine how these two regulatory frameworks shape the exercise of patient autonomy in EOL care. In particular, it considers how each approach constructs the legitimacy of forgoing LST, allocates professional discretion, and structures decision-making processes.

In this paper, patient autonomy refers not only to an individual's formal right to decide, but also to the extent to which the patient's wishes can be recognized and implemented within actual decision-making processes. Because EOL decision-making in both Japan and Taiwan often involves family members and healthcare professionals, the analysis also takes account of the relational conditions under which autonomy is exercised in clinical practice. To this end, I first examine the historical development of the guideline-based framework adopted by Japan. I then analyze the situation in Taiwan as a point of comparison. After outlining these factual backgrounds, I assess the limitations and challenges of each framework from the perspective of patient autonomy. Finally, I conclude by identifying the concerns and future tasks in Japan and Taiwan.

II. Japan: A Guideline-Based Framework

1. Legislative Efforts and the Formation of a Non-Statutory Framework

Efforts to regulate EOL care in Japan can be traced back to the late 1970s [4]. Table 1 presents the historical development of EOL care policies and guidelines in Japan. In 1978, the JMA issued a report through its Committee on Medical Law and Social Issues, followed in 1979 by a bill entitled "Law for Special Measures in Terminal Care," proposed by the Japan Euthanasia Association (later renamed as Japan Society for Dying with Dignity in 1983); [4,9]). Despite the signature campaign organized by the Japan Euthanasia in 1979 that attracted a certain degree of public attention, these initiatives failed to generate political consensus for the legislation of EOL care.

In the 1990s, legal cases such as the Tokai University Hospital case (incident in 1991; Yokohama District Court ruling in 1995) and the Kawasaki Kyodo Hospital case (incident in 1998; Supreme Court ruling in 2009) drew public attention to the legitimacy of forgoing LST as well as to active euthanasia [3]. In the Tokai case, a physician who administered lethal medication following the withdrawal of LST was convicted of murder. At the same time, the court set out three conditions under which forgoing LST might be considered permissible, including a terminal diagnosis with no hope of recovery, the patient's expressed or presumed wish, and the scope of treatments that may be forgone [3]. In the Kawasaki case, the

Table 1. Development of End-of-Life Care Policies and Guidelines in Japan

Year	Issuing organization	Document title
1978	Japan Medical Association	Research report on medical law and social issues
1979	Japan Euthanasia Association	Draft act on law for special measures in terminal care (revised draft)
1992	Japan Medical Association	Physicians' approach to terminal care (third bioethics committee report)
1995	Science Council of Japan	Report of the special committee: on death with dignity
2003	Japan Society for Dying with Dignity	Draft outline of law on death with dignity
2004	Ministry of Health, Labour and Welfare	Report of the study group on public attitudes toward end-of-life care
2006	Japan Medical Association	Reconsidering end-of-life care (ninth bioethics committee report)
2007	Parliamentary League for the Legalization of Death with Dignity	Bill on the withdrawal of life-sustaining treatment in terminal conditions (draft)
2007	Ministry of Health, Labour and Welfare	Guideline for medical decision-making process in end-of-life (terminal) care
	Japanese Association for Acute Medicine	Guideline on end-of-life care in emergency medicine
2008	Japan Medical Association	Guideline on end-of-life care (tenth bioethics committee report)
	Science Council of Japan	On the appropriate approach to end-of-life care: subacute end-of-life conditions (Clinical Medicine Committee)
2009	Japan Medical Association	Guideline on end-of-life care 2009
2009	All Japan Hospital Association	Guideline on end-of-life care: toward a better end of life
2010	Advisory Panel on End-of-Life Care	Report of the advisory panel on end-of-life care
2012	Japan Geriatrics Society	Guidelines for decision-making process of elderly care: focusing on the use of artificial hydration and nutrition
	Parliamentary League for the Legalization of Death with Dignity	Bill on the respect for patients' wishes in end-of-life care (scrapped)
2014	Japanese Association for Acute Medicine / Japanese Society of Intensive Care Medicine / Japanese Circulation Society	Guideline on end-of-life care in acute care and intensive care
2015	Ministry of Health, Labour and Welfare	Guideline for the decision-making process in medical care at the end of life (renamed)
	Japan Hospital Association	Death with dignity: reflections on a peaceful and natural death
2016	All Japan Hospital Association	Guideline on end-of-life care: toward a better end of life (revised edition)
2017	Japanese Society for Clinical Emergency Medicine	Unified procedure for withholding resuscitation by emergency medical services for terminally ill patients
	Japan Medical Association	End-of-Life care in a super-aging society (fifteenth bioethics committee report)
2018	Ministry of Health, Labour and Welfare	Guideline for the decision-making process in medical care and care at the end of life (revised)

Supreme Court upheld a homicide conviction for a physician who withdrew ventilator support, finding that the conditions necessary to justify the withdrawal had not been sufficiently established, including the patient's wishes and the relevant clinical circumstances [3]. In both cases, although the defendants were found guilty, the courts also articulated conditions under which forgoing LST might be regarded as acceptable, and these cases shaped subsequent professional debate on the permissibility of such decisions. In parallel, professional associations such as the JMA and the Science Council of Japan issued reports highlighting the need to clarify legal responsibilities in EOL care [10].

In the 2000s, despite continued legislative proposals made by the Japan Society for Dying with Dignity, Japan took the route of defining the practical boundaries of acceptable medical practice through professional guidelines. The list of permissible conditions articulated in the Tokai University Hospital case served as an important reference point for this approach. In addition, the Imizu Incident, in which two physicians at a municipal hospital in Toyama Prefecture withdrew ventilators from seven terminally ill patients, after which all seven patients died, highlighted uncertainty among clinicians regarding legal liability and underscored the need for clearer guidance on the forgoing of LST [3].

Against this background, soon after the exposure of the Imizu Incident, the

Ministry of Health, Labour and Welfare (MHLW) issued the *Guidelines on the Decision-Making Process for Terminal Care* (hereafter, the Process Guideline) in 2007 [11]. Thereafter, other professional associations also published their own professional guidelines regarding the forgoing of LST, including the Japanese Association for Acute Medicine (2007), the Japan Medical Association (2008), the All Japan Hospital Association (2009), and the Japan Geriatrics Society (2012) [3,10]. At the same time, the Parliamentary League for the Legalization of Death with Dignity proposed the *Bill on the Respect for Patients' Wishes in End-of-Life Care* in 2012 [12]; however, the bill was not deliberated upon, and the legislative efforts have since stalled.

In 2015, the MHLW renamed the Process Guideline by removing the term "terminal care" from its title and later published a revised version of Process Guideline in 2018 [11]. As shown in Table 1, in addition to the MHLW guideline, many professional associations, most notably a joint guideline issued by the Japanese Association for Acute Medicine, the Japanese Society of Intensive Care Medicine, and the Japanese Circulation Society, have published their own guidelines [10]. As a result, the regulatory framework governing EOL care in Japan is multilayered, consisting of multiple overlapping yet parallel non-statutory norms rather than a single unified legal statute.

2. Emphasis on the Decision-Making Process and Collective Deliberation

A key feature of the Process Guideline issued by the MHLW is its emphasis on decision-making processes rather than on the permissibility of forgoing LST itself. In the 2007 version, the definition of terminal stage was not specified. Instead, the focus was placed on how decisions are reached through communication and deliberation, rather than on specifying substantive thresholds for forgoing LST [13]. This tendency became even more evident when the MHLW revised the guideline and formally introduced the concept of Advance Care Planning (ACP) in 2018 [11]. In this context, the legitimacy of forgoing LST is grounded not only in the existence of formal ADs made by the patient, but also in ongoing dialogue among patients, families, and healthcare professionals.

In addition to the emphasis on decision-making process, the professional guidelines issued by multiple associations place strong emphasis on collective decision-making and shared deliberation regarding the forgoing of LST and EOL care [13]. By adhering to the guidelines issued by the MHLW and other professional associations, the act of forgoing LST is framed as part of accepted medical practice [13]. As a result, the practice of forgoing LST in Japan has come to be understood as legitimate through the accumulation of professional norms that emphasize consensus-building and procedural transparency, rather than through the explicit recognition of individual legal rights in EOL care [13].

Japan's continued reliance on guidelines rather than statutory regulation reflects several factors, including concerns about legal liability among healthcare professionals and concerns expressed by professional associations about formal legislation. As Tanaka et al. have noted, legal cases such as Tokai and Kawasaki, together with the Imizu Incident, heightened concerns about legal and social sanctions and made the clarification of permissible practice an urgent priority [3]. This point will be examined further in the comparative discussion in Section IV.

III. Taiwan: A Legislation-Based Framework

1. Debates on Euthanasia and the Legislation of End-of-Life Care

In contrast to Japan, where EOL care has been primarily regulated through administrative and professional guidelines, Taiwan has adopted a legislative approach that directly specifies the permissibility of forgoing of LST through statutory frameworks. Since the 1990s, with the introduction of hospice care in Taiwan, a central concern in clinical settings has been how decisions to forgo LST, most notably cardiopulmonary resuscitation (CPR), at the end of life could be legally justified [5]. At the same time, debates on the permissibility of euthanasia, including the forgoing of LST, can be traced back to the early 1980s, when the "Wang Xiaomin case" attracted public attention.

The name of Wang Xiaomin, a female patient in a persistent vegetative state (PVS), became known to the public when her mother submitted a petition to the Legislative Yuan in 1983 requesting euthanasia for her daughter [14]. As shown in Table 2, which lists the major events related to the legislation of EOL care in

Table 2. Development of End-of-Life Care Legislation in Taiwan

Year	Event / proponent	Content and significance
1983	Wang Xiaomin case	Wang Xiaomin's mother submitted a petition to the Legislative Yuan requesting euthanasia. This case made social debates surrounding end-of-life care and euthanasia publicly visible.
1983	Legislative Yuan	A temporary legislative proposal was discussed to legalize euthanasia as a special exception for Wang Xiaomin, but no conclusion was reached.
1989	Renewed petition	Wang Xiaomin's mother again submitted a petition requesting euthanasia. Legislative action was once more deferred.
1989	Administrative directive	An administrative directive required life-saving measures, including cardiopulmonary resuscitation, even for patients with little prospect of recovery, reinforcing physicians' duty to preserve life without explicit exceptions.
1999	Legislative Yuan	Submission of the "Right to Good Death Act" (aimed at legalizing euthanasia).
1999-2000	Legislative Yuan	Five bills related to end-of-life care were submitted in parallel during the same legislative session.
2000	Legislative Yuan	Submission of the "Hospice Care Act" bill, which included provisions oriented toward euthanasia under the concept of painless death; rejected at the committee level.
2000	Legislative Yuan	Enactment of the *Hospice Palliative Care Act*. Limited to terminally ill patients and legalized the withholding or withdrawal of life-sustaining treatment under specified conditions.
2002	Legislative Yuan	First amendment to the *Hospice Palliative Care Act*.
2011	Legislative Yuan	Second amendment to the *Hospice Palliative Care Act*.
2013	Legislative Yuan	Third amendment to the *Hospice Palliative Care Act*.
2016	Legislative Yuan	Enactment of the Patient Right to Autonomy Act. Granted legal force to advance directives and was not limited to terminal illness.
2019	Administrative	Implementation of the *Patient Right to Autonomy Act* began.

Taiwan, this petition can be regarded as a symbolic moment in the public debate on euthanasia in Taiwan. Wang Xiaomin suffered a traffic accident at at the age of 17 and entered a PVS in 1963 [15]. With donations from the public, as well as their own financial resources, her family was able to provide medical treatment and long-term care for her at home. After 20 years of caring for Wang, her mother requested mercy-killing and the termination of Wang's life [14]. Media coverage of the Wang Xiaomin case brought public attention to the care of patients in PVS and the burdens borne by Wang's family, prompting broader societal debates over whether euthanasia should be legalized as an exceptional measure in her case [14]. Although the petition was discussed in the Legislative Yuan, no conclusion was ultimately reached [16,17]. Nonetheless, the case had a lasting impact on public awareness. At a time when Taiwan had not yet established national health insurance, a system introduced only in 1995, the Wang Xiaomin case made visible the financial and emotional burdens that long-term care could impose on families and brought issues surrounding LST into broader public consciousness.

A related but distinct line of debate developed in parallel within the clinical and policy domain, focused specifically on the permissibility of withholding CPR for patients receiving hospice care. As the hospice movement developed in Taiwan in the late 1980s, healthcare professionals began to question whether forgoing CPR at the end of life could be legally justified. In 1989, the Ministry of Health issued an administrative directive clarifying that withholding CPR from hospital patients was contrary to the Medical Care Act, which required medical institutions to provide emergency measures [5]. This directive created a legal obstacle for clinicians involved in hospice care, who regarded the requirement to perform CPR on terminally ill patients as inconsistent with the goals of hospice care [5]. In response, advocates within the hospice movement began to seek statutory recognition of what they termed "natural death," namely, the right of terminal patients to die without CPR and called for legislation that would provide legal protection for both patients and physicians who chose this course [5]. In 1996, the Ministry of Health revised its position and indicated that withholding CPR could be permissible in the context of palliative care under certain conditions. This policy shift paved the way for subsequent legislative efforts in the late 1990s [5].

In the late 1990s, following a shift in the position of the Ministry of Health, the legislation of EOL care became politically feasible in Taiwan. Between 1999 and 2000, five legislative bills concerning EOL care were submitted to the Legislative Yuan. Among them, one bill extended beyond EOL care and aimed at the legalization of active euthanasia. The *Right to Good Death Act* was the first euthanasia-related bill submitted to the Legislative Yuan [18]. The bill was soon rejected by lawmakers during deliberation [18].

Nevertheless, it is noteworthy that a wide spectrum of issues concerning EOL care was addressed during these legislative debates. The primary focus at the time

was not the legalization of euthanasia per se. Rather, the central issue concerned how decisions not to perform CPR at the end of life should be positioned as a legitimate medical act, and how physicians' legal responsibilities should be clarified to promote hospice and palliative care [19]. In this sense, the parallel deliberation of euthanasia bill alongside EOL care legislation functioned as a reference point that helped delineate what should, and should not, be codified into law, thereby indirectly reinforcing the legal justification of EOL care itself. In this way, the public debate around euthanasia served less as a direct legislative agenda than as a backdrop against which CPR withholding emerged as the core issue around which the *Hospice Palliative Care Act* was ultimately framed.

2. Legal Recognition of Patient Autonomy

Following these debates, the *Hospice Palliative Care Act* was enacted in 2000 [6]. This law legally recognized EOL care by permitting, under specified conditions, the forgoing of LST for terminally ill patients [6]. In comparison with Japan, the significance of this Act lies in its provision of explicit statutory grounds for such medical decisions, rather than reliance on professional guidelines. The Act was subsequently amended several times, in 2002, 2011, and 2013, to better align its provisions with evolving clinical practices [6].

In 2016, Taiwan further expanded its legislative framework with the enactment of the *Patient Right to Autonomy Act,* which came into force in 2019 [7]. Unlike the *Hospice Palliative Care Act*, which is centered on terminal illness, the *Patient Right to Autonomy Act* provides a broader legal framework for ADs and advance care planning in several legally specified clinical conditions beyond terminal illness [7]. In this sense, its broader scope concerns the legal basis for advance decision-making rather than unrestricted implementation of directives in any medical circumstance. The enactment of a second, distinct statute rather than an amendment to the existing *Hospice Palliative Care Act* also reflects the different normative aims of the two laws. The *Hospice Palliative Care Act* had been criticized for not fully protecting patient self-determination, as legal scholars noted that it focused primarily on terminal patients and left the autonomy of non-terminal patients, including those in a PVS , with severe dementia, or with rare diseases, without legal protection [20].

In response to these limitations, patient advocacy groups and legislators began pushing for a new law from 2014 onward. The *Patient Right to Autonomy Act* was ultimately enacted through a member-initiated legislative process, as the Ministry of Health and Welfare was unable to respond directly to these demands [20]. This institutional dynamic helps explain why the two laws address overlapping but distinct aspects of EOL decision-making rather than being consolidated into a single statute. Prior to the Patient Right to Autonomy Act's enforcement in 2019,

a Control Yuan investigative report published in January 2016 [21] identified a structural problem in the Act's penalty provisions: physicians who violated patients' ADs by continuing LST faced no administrative or criminal sanctions, whereas those who withheld or withdrew treatment could be subject to penalties under the existing *Hospice Palliative Care Act* [21]. The report noted that this asymmetry might discourage compliance with patients expressed wishes. However, direct reference to the report could not be identified in the available legislative records, and its influence on the implementation of the *Patient Right to Autonomy Act* in 2019 therefore remains unclear.

Taken together, Taiwan's approach to EOL care is characterized by a stepwise process of legal codification, grounded in the development of hospice and palliative care, and distinguished by its reliance on legislation rather than guideline-based regulation.

IV. Japan–Taiwan Comparison: Legitimacy and Patient Autonomy

1. Legitimacy of Forgoing Life-Sustaining Treatment

Having examined the situations in both Japan and Taiwan, this section compares the two frameworks in terms of how the legitimacy of forgoing LST is established in each context, and how this difference shapes professional discretion and patient autonomy in clinical practice.

First, with regard to the legitimacy of forgoing LST, in Japan, as reflected in the Process Guideline issued by the MHLW, legitimacy is grounded primarily in repeated communication and deliberation among the relevant parties. The importance of advance care planning (ACP) was further emphasized in the 2018 revision of the guideline. In contrast, Taiwan places greater emphasis on formal legal criteria, relying on statutory requirements set out in the *Hospice Palliative Care Act* and further expanding patient-related rights through the *Patient Right to Autonomy Act* [7]. The latter specifically emphasizes the legal significance of advance decisions made by patients themselves following ACP consultations with healthcare professionals [7].

Second, with regard to the scope of professional discretion and the practices of respecting patient autonomy, both differences and similarities can be observed between the two countries. Japan's guideline-based approach avoids rigid statutory regulation and thereby preserves a degree of flexibility in clinical settings [12]. Although legislative initiatives concerning EOL care have existed since the late 1970s, professional associations such as the JMA have consistently expressed concerns about formal legislation. Their primary concern is that statutory regulation might constrain professional discretion and reduce flexibility in clinical

judgment [12]. At the same time, the criminal prosecutions in the Tokai and Kawasaki cases, together with the Imizu Incident, heightened concerns about legal and social sanctions and made the clarification of acceptable practice more urgent than statutory codification [3]. In this context, Japan's guideline-based approach can be understood as emphasizing procedural legitimacy rather than the explicit legal codification of patients' rights. As a result, Japanese guidelines on EOL care tend to frame the forgoing of LST as part of accepted medical practice, rather than as an explicit realization of patients' legal rights or individual self-determination [22].

The historical development of EOL care guidelines also revealed this tendency. As publicly stated by the MHLW, the Process Guideline was formulated in response to the Imizu Incidents, which occurred between 2001 and 2005, in which some LST were forgone solely at the request of patients' family members [3]. As the term "right" is never used in the Process Guideline, it is reasonable to assume that the establishment of patient autonomy is not its primary focus [13]. Rather, the guideline seeks to clarify how the forgoing of LST can be justified through appropriate decision-making procedures. In other words, Japan's soft-law approach has prioritized collective decision-making in procedural terms, rather than the explicit recognition of individual rights in EOL care.

However, this emphasis on the decision-making process does not necessarily imply an underestimation of patient autonomy or self-determination. Instead, by adopting the concept of "presume consent," the guideline-based framework allows for the forgoing of LST even in cases where the patients' wishes are not known in advance. In societies such as Japan, where explicit discussions about EOL care and death are relatively uncommon, collective decision-making may better reflect the realities of clinical practice [13].

At the same time, the flexibility inherent in the guideline-based framework has its limitations. One major limitation concerns uncertainty regarding legal liability [3]. Although there have been no criminal prosecutions related to the forgoing of LST since the publication of the Process Guideline, the legal status of patient autonomy remains unclear [3]. Decisions to forgo LST continue to rely heavily on the discretion of healthcare professionals and require ongoing dialogue with patients, their families, or other relevant parties [23]. Decision-making can be particularly challenging when disagreements among the relevant parties remain unresolved or when the patient has no family at all [24].

At the same time, the contrast between the two frameworks should not obscure an important common feature. In both Japan and Taiwan, EOL decision-making is rarely carried out by the patient alone. Family members often play a substantial role in communication, deliberation, and the practical implementation of decisions. In this sense, patient autonomy in both settings is exercised not only through individual choice, but also within decision-making processes shaped by

family involvement and clinical discussion.

2. Professional Discretion and the Limits of Patient Autonomy in Clinical Practice

Taiwan's legislation-based framework seeks to enhance legal clarity by explicitly specifying the legally permissible conditions for forgoing LST. Both the *Hospice Palliative Care Act* and *Patient Right to Autonomy Act* stipulate clinical criteria of forgoing LST, including a statutory definition of the terminal stage [3]. Such provisions offer a degree of legal stability that is largely absent from Japan's soft-law approach. However, as noted above, the explicit legal conditions may also constrain professional discretion in forgoing of LST. For example, the law requires that certification of terminal stage be made by two physicians who agree on the diagnosis. However, the determination of terminal stage, while grounded in medical evidence, remains subject to professional interpretation. In other words, despite the existence of a legal definition, a gray zone persists regarding what qualifies as terminal stage [25]. Long-term ventilator-dependent patients represent a typical example of this ambiguity. Some physicians consider such cases to fall within the terminal stage, while others maintain that as long as patients can be physiologically stabilized with ventilator support, they should not be classified as terminal [25]. As a result, patients' wishes to be withdrawn from ventilator support may not be fulfilled, depending on physicians' clinical judgments [25].

Another challenge in Taiwan's legislation-based framework concerns the risk that ACP may be treated as an end rather than as a means [26]. As the *Patient Right to Autonomy Act* expanded the legal framework beyond terminal illness to include additional clinical conditions, and as it formally recognized the legal status of ADs and the procedure for ACP consultations, EOL care policy in Taiwan has increasingly emphasized the promotion of ACP and the completion of ADs. Because individuals who wish to sign an AD are required to pay a fee for ACP consultation, questions have emerged regarding whether and how these costs should be subsidized [26]. Some institutions have introduced group-based ACP consultations to reduce users' financial burden; however, this practice has raised concerns about the legitimacy and accountability of the resulting ADs [26]. Ultimately, there is a risk that the pursuit of higher numbers of completed ADs becomes an end in itself, while patients' substantive wishes regarding EOL care receive less attention.

Despite these challenges, Taiwan's legislation-based framework has generally been welcomed by healthcare professionals. Professional associations in Taiwan tend to regard statutory law as authoritative guidance for medical practice. Challenges similar to those observed in Japan, such as difficulties in reaching consensus among family members, also exist in Taiwan. The key difference is that

Taiwan has attempted to address such challenges primarily through legislation. Nevertheless, as discussed throughout this paper, ensuring patient autonomy in EOL care remains a persistent challenge in both societies.

Ⅴ. Conclusion

This paper has examined the legal frameworks governing EOL care in Japan and Taiwan, focusing on how different modes of legitimizing the forgoing of LST shape professional discretion and the realization of patient autonomy. Japan's guideline-based framework constructs legitimacy through procedurally appropriate communication and collective deliberation, whereas Taiwan's legislation-based framework grounds legitimacy in statutory authorization and legally specified conditions. Despite this contrast, both countries face persistent challenges in ensuring that patient autonomy is realized in clinical practice.

As both frameworks presuppose the involvement of family members or other relevant parties, additional challenges arise as the number of patients without family supports increases. Japan's guideline-based framework, which relies on repeated dialogue and consensus-building and often implicitly assumes the presence of family members, becomes more difficult to operate when no such person exists. In these situations, decision-making responsibility tends to be diffused, delays are more likely to occur, and healthcare professionals may face considerable practical and ethical difficulties. As the birth rate continues to decline and the aging population grows, how Japanese society addresses this challenge remains an important task for future research.

As for Taiwan, while the legislation-based framework provides clear legal standing for the forgoing of LST and legal protection for healthcare professionals, recent debates on voluntarily stopping eating and drinking (VSED) have highlighted difficulties surrounding the certification of the terminal stage within this framework. Discussions of VSED have revealed unresolved questions about whether long-term ventilator-dependent patients should be certified as being in the terminal stage. By challenging rigid interpretations of terminality, the VSED debate may prompt a reconsideration of how existing legal categories align with lived clinical realities and patient experiences. Whether this debate will lead to legal reinterpretation, policy adjustment, or expanded clinical discretion remains an open question.

Taken together, the Japan–Taiwan comparison suggests that the assurance of patient autonomy in EOL care cannot be achieved solely through either procedural consensus or formal legal codification. Instead, both approaches reveal important limitations, most notably in situations involving patients without family and clinically ambiguous trajectories. Future developments in both societies warrant con-

tinued empirical and normative examination, particularly as demographic change, medical technology, and evolving social values place increasing strain on existing EOL care system.

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