

On Taiwan Patient Right to Autonomy Act: How Family Stimulates Autonomy

BunRong Kouy*

Abstract

On December 18, 2015, the Legislative Yuan of Taiwan has passed the Patient Right to Autonomy Act (PRAA). Three years later on January 6, 2019, the act is officially implemented. According to Ministry of Health and Welfare, Taiwan Patient Right to Autonomy Act is the first of its kind among Asian nations, signifying the milestone of patient autonomy of the country. Nonetheless, although the ethical value of PRAA is to offer patient Right to decide on medical decision, how PRAA is designed matters contextually and culturally. In the United States, the three main goals of Patient Self Determination Act (PSDA) are providing education regarding individual's Right to accept or refuse treatment, promoting greater formulation of advanced directives (ADs) if one becomes incapacitated, and reducing end-of life treatment cost. Unlike the States, Taiwan designed its PRAA for three main objectives: respecting patient autonomy in medical decision, ensuring the Right to good death and improving physician-patient relationship. While western bioethical principles tend to regard principle of autonomy as self-based or

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individualistic autonomy, the Asian perspective distinctly adopts a family-based approach. This paper thus aims to explore how autonomy stimulates within different social and cultural context, specifically how intimate relationship of the family might affect the behavior of individual autonomy through examining PRAA and its comparison with PSDA. An east-west comparison is sought.

Keywords: Patient Right to Autonomy Act , Patient self-determination act; Principle of autonomy; Individual autonomy; Family-based autonomy

論台灣病人自主法： 家庭干涉如何刺激病人自律

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摘要

2015年12月18日，台灣立法院通過了病人自主法案《病主法》。三年後，該法在2019年1月6日正式施行。根據衛生福利部，《病主法》是全亞洲第一部完整保障病人自主權利的專法，意味著病人自主的里程碑。然而，儘管《病主法》的倫理價值在於提供病人在醫療決定上擁有決定權，該法自身的設計會依照不同情境脈絡和文化而有所差異。在美國，《病主法》的三個目的即是透過教育保障病人擁有接受或拒絕醫療的權利、提倡預立醫囑在個人喪失行為能力時的更大表述以及減低生命末期的治療費用。有別於美國，台灣的《病主法》設計源自於三個目的：尊重病人在醫療決定上的自主性、保障善終權益以及促進醫病關係和諧。儘管西方生命倫理學原則傾向於視自主原則為基於自我或個人自主原則，東方視角明顯採用基於家庭的徑路。因此，本文旨在探討在不同社會和文化脈絡下，自主是如何被激發的？具體來說，透過探討《病主法》，家庭之間的親密關係可能如何影響個人自主行為。本文將採用東西方比較法進行探討。

關鍵詞：病人自主法案、自主原則、台灣、美國、個人自主、家庭自主

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Introduction

On December 18, 2015, the Legislative Yuan of Taiwan has passed the Patient Right to Autonomy Act (PRAA). Currently, the act is published in statutory form and will begin to take effect three year later. Three years later on January 6, 2019, the act is officially implemented. According to Ministry of Health and Welfare, Taiwan Patient Self-Determination Act is the first of its kind among Asian nations, signifying the milestone of patient autonomy of the country. Nonetheless, although the ethical value of PRAA is to offer patient Right to decide on medical decision, how PRAA is designed matters contextually and culturally. In the United States, the three main goals of Patient Self-Determination Act (PSDA)¹ are providing education regarding individual's rights to accept

¹ The American Patient Self Determination Act (PSDA) and Taiwan Patient Right to Autonomy Act (PRAA) are similar act promoting patients' autonomous decision at the end of life, though they employ different names.

or refuse treatment, promoting greater formulation of advanced directives (ADs) if one becomes incapacitated, and reducing end-of life treatment cost.² Unlike the States, Taiwan designed its PRAA for three main objectives: respecting patient autonomy in medical decision, ensuring the rights to good death and improving physician-patient relationship. While western bioethical principles tend to regard principle of autonomy as self-based or individualistic autonomy, the Asian perspective distinctly adopts a family-based approach. This paper thus aims to explore how autonomy stimulates within different social and cultural context, specifically how intimate relationship of the family might affect the behavior of individual autonomy through examining PRAA and its comparison with PSDA. An east-west comparison is sought.

25 years Revisited on The United States PSDA

History

A significant impetus for the development and ultimate passage of the PSDA was a 1990 Supreme Court decision (*Cruzan v. Director*, 1990), in which hospital employees refused to honor a parental request to terminate nutrition and hydration from their comatose daughter, Nancy Beth Cruzan.³ The issues in this case were compounded by the

² Gloria Duke, Susan Yarbrough and Katherine Pang, 2009, “The Patient Self-ADetermination Act: 20 Years Revisited”, *Journal of Nursing Law* 13(4), p.114.

³ *Cruzan V. Director*, Missouri Department of Health, United States Supreme court, 1990, in

patient's incompetence. The Supreme Court recognized that there are constitutionally protected rights to refuse nutrition and hydration that would preserve life but these rights typically extended to the competent patient. The complexities arose in the context of whether a surrogate (e.g., parents) can make that decision under these particular circumstances. The question essentially becomes one of balancing interests amid clear and convincing proof of the patient's intent and desires. The impact of this case was a major contributor for laying the groundwork for the PSDA legislation. Although the Cruzan case was a catalyst for the passage of the PSDA bill, the legislative intent was to standardize patient information regarding health care decisions. Under the PSDA, health care providers were required to provide written information to patients regarding their Right to participate in decisions about their own health care, their Right to complete ADs, and the health care provider's policies regarding how they honor these rights. United States, however, were free to develop legislation on the directive types, forms, and limits on the power of particular agents (such as surrogates).

While Cruzan was the most recent and influential case for the PSDA passage, the foundation was laid with earlier cases. *Karen Ann Quinlan* was 21 years old when she was placed on life support due to respiratory arrest after having ingested alcohol and medications in 1975. Quinlan, as Cruzan, was incapable of making a decision as to health care

Tom L. Beauchamp, LeRoy Walters, Jeffrey P. Kahn and Anna C. Mastroianni, 2008, Contemporary Issues in Bioethics, 7th edition, (CA: Thomson Wadsworth), pp.179-191

treatments, and Quinlan's family petitioned the New Jersey Supreme Court to remove a ventilator so she could die with dignity. However, the physicians and hospital refused to honor the father's request to terminate the life-assisting apparatus.⁴ Ultimately, the New Jersey Supreme Court held that removal was permissible. Quinlan was removed from the ventilator but breathed on her own, living for yet another 10 years before dying from an infection.

In 1985, the New Jersey Supreme Court once again considered an incompetent patient's rights of self-determination with regard to feeding tubes. The court decision distinguished elderly nursing home patients from those who were younger and in a vegetative state, such as Cruzan and Quinlan. *The case involved Claire Conroy*, an 84-year-old woman with severe dementia.⁵ The court rejected the argument that artificial nutrition via tube feedings was considered to be ordinary life sustaining measures, and supported the tube feeding withdrawal on the basis that the benefits of the tube feeding did not outweigh the burdens, and continuing the tube feeding would have been inappropriate treatment.

The Brophy v. New England Sinai Hospital case in 1986 heard the argument of Paul Brophy who suffered a ruptured cerebral aneurysm and became comatose, remaining in a persistent vegetative state.⁶ His

⁴ In re Quinlan, 70 N. J. 10, 355 A.2d 647 (NJ 1976)

⁵ In the Matter of Claire Conroy, 486 A. 2d 1209 (New Jersey, 1985)

⁶ John Jefferson Davis, 2003, "Brophy vs. New England Sinai Hospital: Ethical Dilemmas in Discontinuing Artificial Nutrition and Hydration for Comatose Patients", *Journal of Biblical Ethics in Medicine* 1(3), Retrieved on July 18, 2016 from http://www.bmei.org/jbem/volume1/num3/davis_brophy_vs_new_england_sinai_hospital.php

circumstances were different in that his life support was defined as artificial nutrition and hydration, while Quinlan's was respiratory support. Brophy had never expressed his intent regarding life-sustaining treatment but more than 12 family members argued that he would not want to continue his treatment. The Massachusetts Supreme Court reasoned that artificial nutrition and hydration was a medical procedure and as such it could be rejected as could any treatment. They found that removing the feeding tube was not the equivalent of suicide, reasoning that individuals have a right to death with dignity and a constitutional right to protection from nonconsensual invasion of one's body.

These cases highlight the complexity of legal and ethical issues inherent in situations in which there is no AD. They also highlight some of the problematic issues that arise in very difficult life-sustaining or life-terminating decisions without the benefit of an AD. The questions that continue to generate debate are whether these types of cases have changed since the implementation of the PSDA and whether the goals of the PSDA have been successfully accomplished in the last 25 years.

The PSDA's Failures

As mentioned, the three main goals of PSDA are providing education regarding individual's rights to accept or refuse treatment, promoting greater formulation of advanced directives (ADs) if one becomes incapacitated, and reducing end-of life treatment cost. Duke et.al (2009) argued that PSDA has failed to meet its intended goals. Serious issues still continue prevailing concerning AD completion rates,

compliance with completed ADs, advance planning education, and the cost and utilization of end-of-life care. One of the contributing factors is the discord between law and ethics that have seriously affected health care practitioners, health care consumers, surrogate decision makers, and others. Moreover, value system conflicts among the affected parties, varying approaches to interpretation and enforcement, and lack of adequate communication are all concerning factors to the disputes and continued struggles between the various stakeholders and constituents.⁷

The Taiwan PRAA

The Taiwan Patient Right to Autonomy Act has 19 articles. Its main spirit is to allow competent adult to create a formal advance directive counseling and document, which stipulates their autonomous decisions for certain clinical conditions regarding treatment they would wish to accept or decline if they later become incapacitated. Unlike Hospice-Palliative Care Act, enacted in Taiwan in 2000 is applicable for the terminal patients, the newly promulgated Taiwan PRAA extends the scope to other medical conditions. According to article 14 of the act, the five incapacitated conditions are terminal patients, patients with irreversible coma, patients in persistence vegetative state, patients with advanced dementia and patients with incurable diseases⁸.

⁷ Gloria Duke, Susan Yarbrough and Katherine Pang, 2009, "The Patient Self-Determination Act: 20 Years Revisited", *Journal of Nursing Law* 13(4), pp.115-118

⁸ Incurable diseases here refers to Intolerable pain, incurable disease without adequate

Taiwan PRAA has three main objectives: respecting patient autonomy in medical decision, ensuring the Right to good death and improving physician-patient relationship. From the objectives, it can be seen that the objective design adopts patient-centered approach. This entails a shifting medical culture from a traditional paternalistic sense. For instance, according to article 4, “*a patient shall be entitled to receive information about his/her personal illness, available medical treatments and probable effectiveness or risks; moreover, [they] shall also be entitled to the right of making choices and decisions on medical treatments provided by physicians*”⁹.

Carried medical culture from the west, the traditional informed consent is paternalistic in a sense that physicians must obtain the informed consent of the patients and subjects prior to any substantial intervention.¹⁰ Although the informed consent implicates a sense of autonomy-driven, but such consent is evolved from the side of the physicians. The new sense of autonomy is extended as the patients actively start the process of counseling, so as when to offer their informed decision. Although the act does not present the age limit for

solution under the current medical standard, the right to withhold or withdraw whole or part of the life sustaining treatments.

⁹ The Gazette of the Office of the President, 2016, Global Legal Information Legislative Yuan, Taiwan R.O.C, Retrieved on September 01, 2016 from <http://glin.ly.gov.tw/web/nationalLegal.do?isChinese=false&method=legalSummary&id=5633&fromWhere=legalHistory>

¹⁰ Tom L. Beauchamp and James F. Childress, 2009, *Principles of Biomedical Ethics*, (New York: Oxford University Press), p.118

one to sign advance directive form, the possible interpretation could be that perspective patients now can join the advance directive planning (known as ADP) and possibly sign the advanced directive form as long as they are competent adult.

The major different between Taiwan PRAA and PSDA of the U.S is that Taiwan tends to greatly focus on “good death”¹¹. By and large, there is no precise definition on the term, so as there are no universal criteria and objectives in constituting a good death itself. One of the earliest definition by the Institute of Medicine of National Academy of Science (1997) refers a good death to “[A] decent or good death is one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical, cultural, and ethical standards”.¹² Emanuel and Emanuel (1998) proposed a framework for a good death published in the Lancet that the framework includes the evolving insights in the end-of-life field and characterizes dying as a multidimensional experience.¹³ It synthesizes the dying experience as a process with four critical components: 1) the fixed characteristics of the patient; 2) the modifiable dimensions of the patient’s experience, or elements that may respond to events or interventions; 3) the potential

¹¹ Good death here refers in the context of terminal ill patients and palliative care

¹² Institute of Medicine, 1997, *Approaching Death: Improving Care at the End of Life*. (Washington DC: National Academy Press), p.677.

¹³ Ezekiel J Emanuel, Linda L Emanuel, 1998, “The Promise of a Good Death”, *The Lancet* 351, p.SII22

interventions available to family, friends, health-care providers, and others; and 4) the overall outcome.

Empirical studies conducted to explore the views on Chinese on good death showed seven important elements including 1) being aware of dying (death awareness), 2) maintaining hope (hope), 3) being free from pain and suffering (comfort), 4) experiencing personal control (control), 5) maintaining social relationships (connectedness), 6) preparing to depart (preparation), and 7) accepting the timing of one's death (completion). Awareness of dying was found to be most important of the seven elements while accepting the timing of one's death is also essential, and the extent of acceptance was found to depend on whether the patients had completed their social roles, died at an old age, had religious beliefs and experienced meaningful lives with hope and control.¹⁴ Similarly, research found from interviewing terminal cancer patients in Taiwan found that there are three important elements in constituting a good death. They are peace of mind, peace of body and peace of thought. Peace of body refers to “minimizing the agony of physical symptoms, a short period of the dying process, cleanliness, neatness and integrity of the body, mobility”. Peace of mind indicates “yielding, non-attachment, not being lonely, settling all affairs, being in a preferred environment and enjoying nature”, and peace of thought means, “getting through each day without thinking, having a meaningful

¹⁴ Wallace Chi Ho Chan, Heung Sang TSE & Timothy Hang Yee Chan, 2006, *What Is Good Death: Bridging the Gap between Research and Intervention*, (HK: Hongkong University Press), p.129

life, an expectation that the suffering would end”¹⁵.

Although the concept of good death is perceived different based on social expectation, cultures, geography, religions and generations, there are still overlap criteria between east and west. The scope of good death should encompass awareness, acceptance, propriety and timelines. Settling down patients’ relationship with their family is one of the critical factors in achieving a good death. Nonetheless, concerns were raised the participation of the family in the dying process would violate the individual autonomy and thus such autonomy is not “true”. However, this paper argues that family influences individual autonomy positively in attaining to a good death.

Autonomy in the West

In the west, principle of autonomy maintains that patients are the final authority to make medical decisions. It indicates a manner of self-sovereignty that every person has a privilege to make decisions regarding his or her own body and other aspects. Such individualistic perspective has been explicitly expressed and can be found anywhere in western principle of autonomy. For instance, Beauchamp and Childress (2009) states principle of autonomy in two-sense obligations: negative and positive obligation. In negative obligation, “autonomous actions

¹⁵ Chao CC, 1999, The Meaning of Good Dying of Chinese Terminally Ill Cancer Patients in Taiwan. Presentation at 3rd Asia Pacific Hospice Conference, Hong Kong.

should not be subjected to controlling constraints by others”¹⁶, whereas in a positive obligation, principle of autonomy requires respectful treatment in disclosing information and actions that foster autonomous decision making¹⁷. Therefore, autonomous actions can be understood as followed: X acts autonomously only if X acts 1) intentionally, 2) with understanding, and 3) without controlling influences.¹⁸ Such conception of respecting “individualistic” autonomy has been lamented as the “triumph of autonomy”¹⁹ in western bioethical development. That is questionable how “controlling influences” might affect the patient’s ability to choose or decide over their medical choices. Lee (2015) points out the limitation of such individual autonomy that,

“in general, individual consent is necessary before medical treatment, even in cases in which the patient’s refusal does not seem entirely reasonable. One of the consequences of these related concepts of autonomy and consent is that any explicit or implicit undue pressure on the patient is regarded as invading the individual’s autonomy and undermining voluntary consent”.²⁰

¹⁶ Tom L. Beauchamp & James F. Childress, 2009, *Principles of Biomedical Ethics*, (NY: Oxford University Press), p.104.

¹⁷ Ibid.

¹⁸ Ruth Faden & Tom Beauchamp, 1986, *A History and Theory of Informed Consent*, (NY: Oxford University Press), p. 238.

¹⁹ Tom L. Beauchamp & James F. Childress, 2009, p.105.

²⁰ Shui-Chuen Lee, 2015, “Intimacy and Family Consent: A Confucian Ideal”, *Journal of Medicine and Philosophy* 40, p.419.

The limitations pointed above prevails that the western way of autonomy praises individual “preference” or decision that although one encounters ethical dilemma especially one in clinical settings, individual ought to maintain the mentality of independency because such independency is overwhelmingly more important than other values (says family and professional advices), that one is the ultimate important of all.

Nonetheless, a shifting trend in autonomy emerged in the mid-1990 and into 2000s, one that has questioned the role of patients as an individual acting separately to their relation to family orientation. Such emergence is known as relational autonomy, an outgrowth of the feminist movement’s attempt to meet the challenges of balancing individual choice and action within the push and pull of the society. According to this school of thought, relational autonomy refers to the premised perspectives on a shared conviction that “persons are socially embedded and that agents’ identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity”²¹. Regardless of culture influence, people live within a sphere of intimate relationships and stay connected with others more or less throughout their entire life. Such relationship ranges from intimate familial to societal one. It is relationship that serves as the attachment between individuals for that shapes one personal identity. Thus, one ought to take into account all

²¹ Catriona Mackenzie & Natalie Stoljar, 2000, “Introduction: Autonomy Refigured”, in Catriona Mackenzie & Natalie Stoljar (ed.), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*, (NY: Oxford University Press), p.4

related stakeholders especially their family members before any medical decision is finally made.

Although rigorous debates have been continuing regarding the concept of autonomy, Western bioethics and policy makers remains giving more weights to the individualistic one. This could be illustrated through the promulgation of the PSDA in the United States. Although the act itself imposes compulsory obligation from the health care institutions and professionals to patients, patients are now “trump” their autonomy in the fullest sense. In other words, their autonomy is now fully protected by law for that the only person they have to be in charge of is the person himself or herself. Although a surrogate is appointed as written in the first objective of the PSDA1990, “to inform such individuals of an individual's rights under State law... when such individuals are incapacitated such as through the appointment of an agent or surrogate to make health care decisions on behalf of such an individual”,²² the patient's autonomy is far beyond from the obligated involvement of a surrogate in the medical decision-making.

From the triumph of the personal or individualistic autonomy to the striving effort of debating relational autonomy, Western conception of “autonomy” signifies the preference of an individual entity rather than acting “autonomously” in accordance to obligations to relational agents.

²² Patient Self-determination Act 1990, the United State, HR 4449 IH 101st CONGRESS 2d Session H. R. 4449, Retrieved on September 05, 2016 from <https://www.congress.gov/bill/101st-congress/house-bill/4449/text>

Autonomy in Asian Context

Distinct features can be found in the Asian principle of autonomy, one that taking into account the role of family intimacy in the decision making process. In other words, one should make his or her decisions and action harmoniously in cooperation with other relevant persons, i.e. family members. Such spirit can be found in major Asia cultures such as Confucian China, Japan and Southeast Asia. The role of family involvement in the medical decision-making has been questioned. Many think that it adds up complication and thus the patient's autonomy is controlled by this external influence. Nonetheless, such accusation mistakenly charges the role of family to have no role to play in either a liberal society especially in Asian context. A healthy family relationship is usually entrusted with the responsibility of surrogate decision making for three reasons. Firstly, the family is usually more knowledgeable about the values, preferences and best interests of the incompetent patient. Secondly, the family is more concerned about the patient's best interests, and lastly, the family needs to be protected from unnecessary intrusion.²³

If we track back to examine the leading scenarios to the legislation of PSDA, it is found that, for instance, the lamentation of Nancy Beth Cruzan's father plays a reminding role in term of the essentiality of the family. As Nancy fell into a PVS after an accident in 1983, only after a

²³ A.E. Buchanan & D.W. Brock, 1990, *Deciding for Others: The Ethics of Surrogate Decision Making*. (Cambridge. Cambridge University Press), p. 136

lengthy legal battle did the court allow the removal of the life-support system so that she could die in peace in late 1990. Her father sighed that his daughter's life had been interrupted by too many "strangers" including physicians, lawyers, the press, judges and protestors, but at the end of the day only Cruzan's parents would be at Cruzan's bedside, weep after the US Supreme Court decision, or visit her grave long after the courts and healthcare professionals had moved on to another case.

In accordance to such family bond, Lee (2007), grounded on relational autonomy, also made a commensurate response to how one's personal identify is formed and how family formulates the final decision consent while autonomy is exercised in a Confucian society. Since everyone is born to a mother or born into a family in a strict sense, this family relationship develops our imprinted personality and self-identity through living together under the love and protection of our parents from our early years. This eventually affects parent-child relation in term of mutual responsibility. Such locus of the family is so closely connected with our lives and closely bounded to where our moral acts starts.²⁴ He further points out that:

We are devoted to making decisions collectively with our family. My consent is the consent of the family as a whole. We have no choice but

²⁴ Lee Shui-Chuen, 2007, "On Relational Autonomy: From Feminist Critique to Confucian Model for Clinical Practice", in Lee Shui-Chuen (ed.), *The Family, Medical Decision-Making and Biotechnology: Critical Reflections on Asian Moral Perspective*, (Netherlands: Springer), p.89

to observe deeply felt moral commands that come from this core of our life. We become lost and hurt our personal integrity when we betray our responsibilities to our family. Indeed, this is why we feel shame and self-denial.²⁵

Lee's explanation best illustrates how Taiwan fosters the spirit of Confucianism into her newly passed Patient Right to Autonomy Act. This could be clearly seen from several articles. For instance, in article five of the Taiwan PRAA, in addition to the main statement stating that, "*when a patient is seeking medical treatment, the medical institution or physician shall inform his/her personal illness condition and relevant affairs*", there is an additional condition. That *in case the patient does not "obviously oppose" [in the written AD], the medical institution or physician shall also inform their related person*²⁶. Moreover, in the same article, *medical institution or physician shall chose the right way to inform the patient and a related person if the patient is no longer competent or has limited competency*. Furthermore, article six states, "*medical institutions shall obtain the consent from a patient or a related person as well as the signature from either of them on the letter of consent before undergoing a surgery or any invasive examination or treatment regulated by the central competent authority; however, in case of emergency, the abovementioned provision shall not apply*".

²⁵ Shui-Chuen Lee, 2015, p.427.

²⁶ According to Taiwan PRAA, related person here includes legal surrogate, spouse, direct-blood relatives, medical surrogate or a person having intimate relation to the patient.

Specific criteria is listed in article 9 of Taiwan PRAA regarding who could serve as the medical surrogate agent with legal capacity as well as who shall be presented during AD procedure and conditions. It states that during the advance directive counseling, a patient shall be at least accompanied by one of the second-degree relative and a medical surrogate agent. It adds that as long as the patient approves, other relatives could also participate in the process.

The three major articles above clearly convey the spirit of family involvement in the medical affair of their family member, the patient in respective circumstances including advance directive counseling, surgery and any invasive examination and treatment. This corresponds to a generally accepted Chinese saying that, once a person is sick, the whole family is sick. In other words, by participating in the medical process, both the patient and the family share the same interest for that they have mutual responsibility towards each other. In this regard, consultation of the family and collective decision could be finally made. In case that the patient and the family has a conflicted point-of-view, compromise and dialogue is often carried. If the conflict does not resolve, the patient, very often, would choose to do what is less burdensome to the family. In a broad sense, Taiwan PRAA is designed to legally enforce the legal rights of patient self-autonomous decision. In a strict sense, this act is designed to fit the needs of the incapacitated patients especially those in their end-of-life stage.

In addition to Taiwan, Japan shares similar practice when one faces with medical decisions. While in the West, a competent patient is

generally the agent who gives the final words for their medical situation, the Japanese patient and their family must reach a mutual agreement before any medical or clinical decision can be made.²⁷ For example, as Kazumasa Hoshino describes:

Japanese people are not accustomed to making medical decisions regarding their own diseases by themselves without consulting the family. This is because of their deep regard and respect for the opinions and feelings of the family. When one member of the family becomes sick, it is the responsibility of the entire family to look after him...The family knows that the care of the sick member is a family matter.

In these circumstances, it seems rather natural for the family to first decide on the best medical procedures and to care for him...Eventually, *decision-making for medical procedures and care for the patient may be done with the mutual consent of both himself and the remaining members of the family.*²⁸

Similarly, a family-based or family-centered approach responds better to the traditional and cultural values of Southeast Asian population in a medical or clinical situation. In Southeast Asia, it is the family that constitutes autonomous social unit and doctors usually conforms to such

²⁷ Ruiping Fan, 1997, "Self-determination Vs Family-determination: Two Incommensurable Principle of Autonomy", *Bioethics* 11(3&4), p.316 (309-322).

²⁸ Kazumasa Hoshino, 1996, "Bioethics in the light of Japanese sentiments", in Kazumasa Hoshino (ed.), *Japanese and Western Bioethics*, (Dordrecht: Kluwer Academic Publishers), pp. 16-17.

practice. In these societies, an individual is viewed as part of the family unit and importance is placed on the harmonious dependence within that unit. Even at the extreme case where physicians are asked not to inform a critically ill patient on the request of their family, it is a belief that this serves as the best interest of the patient at that time.

In conclusion, although upholding different cultural values, autonomy in Asian context endorses the same value – one that encompasses the involvements and care of the patient and their family before any mutual consent and medical decision-making is drawn out. By sharing the disastrous moment of sickness and consulting harmoniously about the end of life stage or even achieving a good death does not implicate a lack of self-autonomy. It is such autonomy that is truly selfless.

Conclusion

In conclusion, Taiwan Patient Right to Autonomy Act brings the subject of how autonomy should be exercised. This paper has compared the different spirit and objectives of the United States PSDA 1990 and PRAA of Taiwan. Even though the overall objective appears to be the same, the United States PSDA stresses on institution-doctor-patient relationship while Taiwan PRAA values the family involvement and stimulation into the end-of-life subject. Different conception of autonomy, namely individualistic autonomy and family-based autonomy between Western and Asian context was drawn out to serve as contextual

features for the alert that autonomy is still a vague conception and it is subject to culturally interpretation. One should respect the common practice in different settings as long as it is ethically exercised and responsively carried out in that culture.

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