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Reflections on the Movement for the Legalization of "Death with Dignity as Withdrawal of Futile Life-Sustaining Treatment" in South Korea*

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Abstract

In this article, we will introduce Korea's medico-legal cases that are related to the withdrawal of life-sustaining treatment. This paper examines the issue of the legalization of "death with dignity" by investigating Korea's leading cases on the withdrawal of life-sustaining treatments and the current medical and legal situation in Korea. This paper also examines several preconditions for drafting a bill for such legislation.

Considering the complexity of medical circumstances, laws and policies on end-of-life decision-making may not address every possible scenario. Thus, the laws and the policies would have to reflect the differing views of people based on their social status, moral values, religious beliefs, and economic status. Therefore, it should be recognized that a public consensus is necessary for devising successful public policy and guidelines with respect to euthanasia and "death with dignity" in Korea.

So proper guidelines and public debates that incorporate the views of the public, the government, and medical and legal professional associations will help create a firmer foundation for making better laws and policies regarding the end of life care issues.

I. Introduction

Based on the Supreme Court's judgment, the first procedure of "death with dignity as terminating futile life-sustaining treatment" was performed

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in Korea in May 2009.[1)] This judgment has taken the issue of the legalization of the "right to die with dignity" from a social issue to a legal debate in Korea. This landmark case which is related to "withholding or withdrawing life-sustaining management" has aroused many politicians, doctors, scholars, lawyers, and ethicists to raise their voices to "enact a 'death with dignity' law" in Korea.

The first purpose of this article is to introduce recent Korea's medico-legal case that is mentioned above and is related to the withdrawal of life-support systems. The second purpose is to explore the necessity of the legalization of "death with dignity" in Korea. By describing and examining current public debates on "Passive Euthanasia" and "death with dignity" and the movement for the legalization of "death with dignity," we elucidate the need to examine prerequisite elements before the necessity of the legalization can be considered in Korea.

II. Debates on end-of-life decision in South Korea

1. Leading cases regarding "withdrawing life-sustaining management" in South Korea

We reviewed the recent leading case, which shows the current medical and legal situation and the debate on the "death with dignity" and "passive euthanasia" issues. This case is different in several ways from the leading cases of other countries on the same issue because various factors that influence the decision process are different, such as medical condition, subject of medical decision making, and reasons for terminating futile medical treatment, socioeconomic conditions as well as cultural and religious background in Korea.

There were two noticeable court decisions in Korea. One was so called the Boramae case[2)] and the other was Severance hospital case as we call Grandma Kim case. The former is a criminal case law and the latter is a civil case law.

1) Supreme Court [S. Ct.], 2009Da17417, May. 21, 2009 (S. Kor.).

2) Supreme Court [S. Ct.], 2002Do995, June. 24, 2004 (S. Kor.).

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In May 2009, The Korean Supreme Court ruled the removal of artificial ventilator from 77-year old persistent vegetative state patient based on the inference of the patient's presumed intent. Kim's family as a plaintiff insisted the removal of artificial ventilator if Kim was already in the irreversible death stage. While the defendant hospital has disagreed, the court ruled in favor of the plaintiff.[3)]

What is interesting is why this type of legal dispute occurred in Korea even though it could be the case of passive euthanasia or hopeless discharge considered routine practice in many other countries.

One of the most important reasons is that Korea reports another noticeable litigation case which occurred in December 1997.[4)] A fifty eight year old man was hospitalized in intensive care unit after receiving craniotomy due to traumatic epidural hematoma without any guardian. After that the patient's wife arrived, she strongly requested on discharge of the patient to the attending physician because of economic reasons. The physician at first did not accept the request, but due to a persistent and strong request from the patient's wife, finally the neurosurgeon discharged the patient. It was only thirty six hours after the operation. The Supreme Court concluded that doctor's action which allowed discharge the patient from hospital brought patient to death and sentenced the two physicians with "aiding and abetting murder"[5)] and the patient's wife with "murder."[6)] In this case, one of the critical debating focus was the decision of patient's medical futility. The court argued that in this case evaluating futility of the patient by physicians was not sufficient. And the court made the decision based on that the patient's possibility of recovery. In fact, this legal case (hereinafter "Boramae Case") was not the case of euthanasia or death with dignity but the case on discharge against medical advice (DAMA). But after this verdict, majority of Korean medical society somewhat misunderstood that this case was about euthanasia or a hopeless discharge which has been routinely done before.[7)]

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3) *Supra* note 1.

4) *Supra* note 2.

5) Hyungbeob [Criminal Act], Act. No. 10259, Apr. 15, 2010, arts. 32 and 250 (S. Kor.).

6) Criminal Act, art. 250.

7) Woong-Kwang Song et al., *Boramae Sageone daehan Uisawa Ilbanin saiui Insik Chaii[The*

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Since the Boramae case, many physicians believe that hopeless discharge becomes illegal regardless of patient's medical condition from that point on. Thus, physicians have shunned that kind of practice, such as withholding or withdrawal of life-sustaining treatment; even if family members have rational reasons, and physicians even distorted their medical practice obsessively intensive care regardless of patient medical condition. That is why the second case law (hereinafter "Kim's case") related to the end life decision comes.

Thus, it is worth examining how the debate on withholding and withdrawing of life-sustaining treatment has proceeded considering these two remarkable court decisions.

In May 2008, the family of a patient sued a teaching hospital for the "death with dignity" of their 76 year old mother. They requested the withdrawal of the life-sustaining treatments for the patient who was in a persistent vegetative state due to hypoxic brain damage. In this case, the futile life-sustaining treatment was limited to the artificial ventilation. The presiding court had considered the absence of the patient's advance directive in its judgment. However, the court had admitted that the patient's inferred intention may be assumed since she had rejected a tracheotomy for her dying husband which would have prolonged the life of her husband for just a few days. Another basis of the patient's inferred intention was that the plaintiff as a Christian tried to keep clean appearance wearing long sleeve clothing and skirts even in summer after she came to have scar caused by traffic accident 15 year ago. And upon looking at a person at the sick bed cared by others on the TV, she had said "I want to leave this life without becoming a burden to others"

Thus, the family claimed that mother had always opposed the use of life-support system if there is no chance of recovery. It was from inferred intention of the patient.

In November 2008, the Seoul Western District Court made a landmark ruling allowing for the removal of the life-sustaining treatment from the patient.[8] This was the first court judgment in Korea that allowed the

differences of opinion on Boramae incident between physicians and common people], 20(10) GAJEONGUIHAKHOEJI [J. KOREAN ACAD. FAM. MED.] 1224-1231(1999).

8) Seoul Western District Court [Dist. Ct.], 2008Ga-Hap6977, Nov. 28, 2008 (S. Kor.).

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removal of a futile life-sustaining treatment for a patient. However, defendant hospital in this case, took its case to the Supreme Court. After careful examination, the Supreme Court denied this motion for relief from the lower court's judgment.

The Court made its decision based on the opinion of doctors at major hospitals in Seoul and many other professionals as well as law field. The doctors claimed that the patient had no chance of revival and its assumption with regard to the patient's intent for the termination. The Court stated that, "According to individual's personal rights and the right to the pursuit of happiness as guaranteed by Article 10 of the Constitution.[9] When a life support treatment imposes physical and/or mental pain and harms a person's dignity and values, the patient can refuse a doctor's treatment, and the hospital is obligated to comply. Even though the patient Kim is not currently conscious, if one comprehensively reviews her statements from her everyday life, in which she said, 'Even if something bad happens and it is difficult to resuscitate me, do not insert a respirator,' as well as her attitude towards life and life expectancy, it can be surmised that she would have rejected the treatment if she were conscious. Even if the plaintiff did not express her wishes explicitly, her right of claim can be recognized."[10] This new precedent forces analyses into the importance of a patient's autonomous decision-making in a medical setting.

Finally the Supreme Court Decision addressed that when the patient entered the irrecoverable death stage without a patient's prior medical instruction, the patient cannot be expected to express intention to demand change in treatment acts or discontinuance by exercising a right to self decision since he has no possibility of regaining consciousness. Under the patient's usual sense of value or belief, etc., it can be acknowledged that since discontinuance of life-extending treatment objectively corresponds to patient's best interests, a patient would choose discontinuance of life-extending treatment, if a patient were given an opportunity of exercising a right to self decision, then his intention for discontinuance of life-extending treatment can be inferred. Such reasoning is rational and corresponds to social norms. Such inference of patient's intention must be done objectively.

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9) Constitutional Court [Const. Ct.], 89Hun-Ma82, Sept. 10, 1990 (S. Kor.).

10) *Supra* note 8.

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Thus, objective resources to verify patient's intention must be referred to, and upon considering objective circumstances such as patient's expression of intention to family, friends, and etc., patient's reaction to the others' treatment, patient's religion, usual life style, etc., patient's age, treatment side effect, patient's possibility of suffering, treatment process to irrecoverable death stage, degree of disease, current patient condition, etc., as a whole, his intention can be inferred only in the case where he would have chosen discontinuance of life-extending treatment, if he was offered medically sufficient information in the patient's present body condition.

After these two leading courts' decisions, debate on withholding and withdrawing of life-sustaining treatment rekindled among medical society, law makers, government, bioethicists, scholars of various field and religious leaders. Before reviewing those debates on end life decision in the Korean society, we have to know the current medical and legal situation in South Korea for understanding.

2. Current medical and legal situation regarding the end-of-life care issue in South Korea.

1) Medical situation

Human beings have achieved significant technological and medical progress. Advanced medical technology makes it possible to prolong people's lives in a positive way by providing medical treatments for incurable diseases.[11] On the other hand, it also makes it possible to prolong people's lives in a negative way by providing futile treatment through the artificial means of life-support systems, raising questions about the quality of life and dignified death as modern bio-medical technologies might impede upon the natural dying process. As more people face end-of-life decisions due to more options created by advanced medical technologies such as artificial ventilator, hemodialysis, ExtraCorporeal Membrane Oxygenation(ECMO),[12] many have claimed that people have the right to

11) According to the World Health Organization data, the average life span of Koreans is seventy-nine. http://www.who.int/en (last visited Nov. 12, 2010).

12) In intensive care medicine, **extracorporeal membrane oxygenation** (ECMO) is an extracorporeal technique of providing both cardiac and respiratory support oxygen to

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die and to maintain basic human dignity by refusing unwanted treatments. The issues vis-a-vis "Passive Euthanasia" and "Death with Dignity" are bioethical problems that have resulted from medical technology developments.

And another unique situation in Korean Medical Society is here. As we mentioned above, before the "Boramae Hospital Case,"[13] the topic of the end-of-life medical decisions had been rarely discussed in Korea. But after the Boramae Hospital Case in 1997, the issues surrounding end-of-life medical decisions have received a keen interest of the general public. Before this case, physicians had often performed the withdrawal of futile life-sustaining treatments for terminally ill patients and allowed for hopeless discharge. However, the June 2004 Supreme Court decision on the Boramae Hospital case resulted in the indictment of two physicians for aiding and abetting homicide. After this judgment, medical professionals have generally interpreted that a withdrawal of life sustaining treatment for a terminally ill patient could be regarded as homicide. Since then, they have taken a defensive attitude in addressing terminally ill patients and they have displayed a tendency to continue futile, often excessive, treatments. Physicians have kept their patients alive for a long time even though they knew that medical treatments for their patients were futile and useless[14].

There are no specific laws governing passive euthanasia or advanced directives in South Korea. The Korean medical society, however, has thought that physicians in Korea work in a context of legal ambiguity and under fear of prosecution if they do what is considered routine practice in many other countries around the world.[15]

2) The role of Physician in End Life Decision

What is the role of medicine in end life decision (hereinafter "ELD")?

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patients whose heart and lungs are so severely diseased that they can no longer serve their function.

13) *Supra* note 2.

14) Young-Ho Park, *Sogeukjeok Anlaksaui Heoyongyeobue daehan Sogo[A Study on Acceptance of Euthanasia in Korea]*, 65 JUSTICE 205-235 (2002).

15) John M. McGuire, *The Right to Refuse Life-Sustaining Medical Treatment in South Korea: The Case of Ms. Kim*, 12(1) HANGUKUIRYOYUNRIHAKHOEJI [KOREAN J. MED. ETHICS] 77-95 (2009).

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Rightfully, the role of physician is making a decision as to whether the patient reached irrecoverable death stage or not.

Through the courts' decisions, judges also suggest that, unless the patient files a lawsuit directly to the court, it is desirable that a committee composed of expert doctors, etc. makes a decision as to whether the patient reached irrecoverable death stage or not.

In this Kim's case, several expert doctors' opinions are referred. That was the plaintiff's brain MRI examination shows overall severe brain contraction and cerebral cortex was destroyed to the point of looking like a mere thin band; structure of basal ganglion thalamus was invisible; brain stem and cerebellum were contracted due to severe damage. And the plaintiff's attending physician was of the opinion that she was not in brain death condition although without self breathing and as in the vegetative human being condition, she had less than 5% possibility of consciousness. The another medical practitioner evaluating treatment records was of the opinion that the plaintiff, without self breathing, was in the more severe condition than general vegetative human being condition near brain death condition with virtually no recovery possibility. Body assessing doctors expressed the opinion that the plaintiff had virtually no recovery possibility as in the continuously vegetative human being condition and she was maintaining life relying on the artificial respiratory without self breathing.

Like this, the physician's role such as decision on medical condition should not be undervalued. One of the most important roles of the physicians is the decision about medical condition of the patient. That is the decision on medical futility of terminally ill patients as the first step of end life decision because the most important thing is whether the patient has any chance of recovery.

The second important role of physicians in ELD is a role as a communicator. Because they have available chance to communicate with patients and their family members and they are the only persons who can make them understood. Because appropriate and correct understanding of ELD related issues is important, communication between medical doctor and family members is important.

As a survey of Korean National cancer center, 87.5% of respondents agree with 'death with dignity' and 92.8% of respondents agree with the

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need for advance directives.[16] And another result of survey shows 69.3% of respondents agree that doctors should stop providing care when terminally ill patients in severe pain insist on their right to die.[17]

But we have to confirm that the respondents of those surveys fully understand the concepts related with ELD such as "futile medical treatment and condition."

If so, what is the appropriate and correct understanding of futile medical treatment and condition? As the Supreme Court, that is a treatment (hereinafter "life-extending treatment") in the clear case where a patient medically has no possibility of recovering consciousness, or lost life-related important bio-function, and patient's body condition is near death in short time (hereinafter "irrecoverable death stage") does not aim at betterment of disease. It is merely for keeping the current conditions and criteria different from other cases should apply in deciding whether to permit discontinuance of treatment. Where a possibility of recovering consciousness is lost and no more activity as a person is expected, and irrecoverable death stage is reached where the natural death stage had already begun, if a life-extending treatment as the medically meaningless body invasion is forced, then human dignity and value are rather harmed.[18]

As we mentioned, that kind of decision could be made by the physicians or a committee composed of expert doctors. But even in case of the medical decision by professionals, we have to understand the uncertainty of medicine and medical practice. One of evidences on uncertainty is that, Ms. Kim has shown stable vital sign despite the removal of life support equipment for about 200 days. The law makers, non-medical scholars, bioethicist including the public should understand the feature of those medical decisions.

16) Young-Ho Yun et al., *Pumwi itneun Jukeumgwa Hospice · Wanhwauiryoe daehan Ilban Gukmindeului Taedo[Public Attitudes Toward Dying with Dignity and Hospice · Palliative Care]*, 7(1) HANGUKHOSPICEWANHWAUIRYOHAKHOEJI [KOREAN J. HOSPICE & PALLIATIVE CARE] 17-28 (2004).

17) In-Young Lee, *Anraksa Yuhyeongbyeol Gyubeomhaeseokgwa Sahoejeok Insikdo[A Study on the Legal Analysis and Public Opinion Survey on Euthanasia]*, 20(2) HYEONGSABEOBYEONGU [KOREAN J. CRIM. L.] 167-200 (2008).

18) *Supra* note 1.

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3) Legal situation

Before the Supreme Court decision acknowledging the unconscious patient's right to die with dignity, there had been no precedent in Korea that ordered the removal of life-support systems from unconscious patients.

And there are no specific laws in Korea governing passive euthanasia or physician assisted suicide. For reviewing withholding and withdrawal of life sustaining treatment in Korea, we have to understand the Korean criminal act and be able to apply the regulation into each case.

There are several articles in criminal act related with euthanasia or physician assisted suicide. Those are here. Korean Criminal Act article 250 (Murder, Killing Ascendant) that is a person who kills another shall be punished by death or imprisonment for life or for not less than five years. And a person who kills one's own or one's spouse's lineal ascendants shall be punished by death or imprisonment for life or for not less than seven years.

Korean Criminal Act article 252 (Murder upon Request or with Consent) that is a person who kills another upon one's request or with one's consent shall be punished by imprisonment for not less than one year nor more than ten years. The preceding paragraph shall apply to those who instigates or aids and abets another to commit suicide. And there is another article 253 (Murder upon Request through Fraudulent Means, etc.) in Korean Criminal Act.

In Korea, a person who obtains other's request, consent or resolution to commit suicide in the case of preceding article through fraudulent means or by the threat of force shall be punished in accordance with Article 250.

So, under the current law, the removal of a respirator from a patient could be officially regarded as murder. In that case we have to find the conditions for justification such as not violating the social rules, necessity and consent of victim as well as patient's medical condition.

III. End life decision process in South Korea

What is the best process on ELD? Is referring each case to the court decision the best way?

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How should we make the decision on withholding and withdrawing of life-sustaining treatment in this situation?

As the courts' decisions, the judge suggest that, unless the patient files a lawsuit directly to the court, it is desirable that a committee composed of expert doctors, etc. makes a medical decision as to whether the patient reached irrecoverable death stage or not.

Decisions by hospital ethics committee could be one of the solutions.

Recently, for such decisions, the Korean Medical Association had established the "Code of Ethics" and announced it in 2001.[19] (Revised 2006. 04. 22) The Code which was announced in 2001 contains stipulations about euthanasia and the termination of life-sustaining treatments.

According to articles 58 and 59 of the Code, doctors are prohibited from involving themselves in euthanasia and assisting suicide. However, articles 30 and 60 seem to address the termination of medical treatments for incurable patients differently. According to article 30, doctors have to carefully determine the issues with respect to hospital discharges and the termination of medical treatments for incurable patients; doctors are allowed to accept requests for the termination of futile medical treatments that are issued by a patient's autonomous decision and by the patient's family, and by the request of the patient's proxy with a written document. Also, doctors are allowed to refuse a request by the patient, the patient's family, or the patient's proxy for medically futile and useless treatments. In addition, under article 60, doctors are allowed to withhold or withdraw medically futile and useless treatments for incurable patients.

However, as soon as the Code was announced, the Korean Medical Association became a target of criticism, because some people regarded this issue as a debate on euthanasia. For example, article 28 could be subject to ethical and legal debates because the boundary of the termination of medical treatments could be interpreted broadly.[20] According to article 28, if the patient or the patient's family provides a written request for hospital discharge, the attending physicians must honor the request even though

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19) Korean Medical Association Code of Ethics. 19 April 2001. Revised 22 April 2006. http://www.kma.org (last visited Nov. 12, 2010)

20) Sang-Yong Lee, *Chiryojungdangwa Anraksa[Withholding Medical Treatment and Euthanasia]*, HANGUKHYEONGSAJEONGCHAEKYEONGUWON [KOREAN INST. CRIMINOLOGY] 38 (2001).

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they may disagree with the decision. Finally, the Korean Medical Association revised the "Code of Ethics" in 2006.

During rekindling the ELD issues, many other ethical guidelines on ELD are pronounced, such as Ethical guidelines of Korean Medical Association which are guidelines for withdrawal of life sustaining treatment, ethical guidelines of Institution and guidelines by National Evidence based Healthcare Collaborating Agency which are done after a series of seminars and hearings.[21)]

Making such guidelines is one of the trial for making a social consensus.

Korean government also made a committee made up of members from various medical associations in Korea for making official guidelines for a patient's right to die.

But we do not think ethical guidelines could solve the problems. And as we mentioned, referring each case to the court decision is not the best way. Moreover, neither does new legislation of euthanasia or death with dignity.

We think all of the activities are important because those are attempts to clarify matters and standardize treatment for terminally ill patients.

And we think that it is too early for National Assembly to legislate a law allowing euthanasia because there is no national consensus on this sensitive issue and we still have the risk of abused-euthanasia being performed in order to save medical fees or prevent mild pain.

For example, in 2006 several members of the National Assembly proposed a bill that included a stipulation on passive euthanasia for the first time. Regarding the legislation for futile medical treatment and "death with dignity" in Korea, several members of the National Assembly had proposed three bills.[22)] According to one of the proposed bills, "Medical

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21) On the 10th of July, 2009, the National Evidence-based Healthcare Collaborating Agency in Korea held an open forum regarding the issue of using unified terminology and conception that would refer to futile medical treatment. People who had attended the abovementioned forum on the 10th of July, 2009 made several mutual agreements. First, they limited their discussions on futile life-sustaining treatment to "withholding futile life-sustaining treatment" or "natural death." They rejected "euthanasia" and "assisted suicide." Also, because the terms "passive euthanasia" and "death with dignity" might cause confusion, they decided that using these terms in a public discourse is not appropriate.

22) First bill was about allowing the withdrawal of futile medical treatment (2006). Second bill was about "legistration of death with dignity and government policy" (2008). Third bill was the "death with dignity act" (2009). http://likms.assembly.go.kr/bill/jsp/

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professionals can ask the 'Central Medical Screening and Controlling Committee' for a medical decision when they feel the necessity of terminating medical treatments by the request of patients and medical considerations." This bill did not pass. This bill had not addressed the types and categories for withholding and withdrawing medical treatments, and it had passed over stipulations such as writing and confirming of advance directives through a living will and it suggested ensuring due process of law through shared decision making, such as a hospital ethics committee.[23]

Debate on advance directives in Korea shows one of good examples.

Although advance directives are essential for communicating intentions before death, it is almost impossible for the majority of Korean patients to provide such an advance directive.

In Korea, living wills (or advance directives) are used only in a minority of responders' cases.[24]

This is may be related to the difficulties with the immediate availability of the document encountered in an emergency situation and to the social tendency of Koreans not to write a formal living will, other than one involving financial matters. Why are advance directives and living wills not widespread in Korea?

In East Asian countries where family-oriented values are shared (i.e. Confucius values), most decision making, even medical decisions, are made by families. In particular, most medical decisions depend on the value-laden decisions of family members and physicians. The truth with regard to the seriousness of a patient's illness is generally kept hidden by the family members to prevent any negative influence emotionally.[25] Moreover, offspring often consider the withdrawal of life-sustaining treatments from their parents as unthinkable, even through such action may be the best

main.jsp (last visited Nov. 12, 2010).

23) In-Young Lee. A proposal of respecting terminally ill patients' right to self decision on death with dignity, paper presented at the Symposium for the proposal of a legislation for respecting terminally ill patients' right to self decision. Seoul, Korea. Oct. 2, 2008.

24) Hyuna Bae et al., *The Ethical Attitude of Emergency Physicians Toward Resuscitation in Korea*, 34(4) J. Emergency Med 485-490 (2008).

25) Do-Youn Oh et al., *Discrepancies among Patients, Family Members, and Physicians in Korea in Terms of Values Regarding the Withholding of Treatment from Patients with Terminal Malignancies*, 100(9) Cancer 1961-1966 (2004).

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option for the patients. Such actions or thinking are perceived to be closely related to irreverence; thus, no one wants to take a social blame from other family members and the society. Thus, if the social perception is not an accompanied factor, the legislation might oversimplify the medical situation that need only minimum ethical conflict and might increase distortions in medical decision making such as obsession of intensive care or not considering starting life sustaining treatment.

About the advance directives, the Korean Supreme Court addressed in the case where a patient, preparing for his reaching the irrecoverable death stage, expressed his opinion as to life-extending treatment rejection or discontinuance to a medical practitioner (hereinafter "prior medical instruction"), although a right to self decision is not exercised at the time of treatment discontinuance, barring special circumstance where a patient's intention was changed after prior medical instruction, an exercise of right to self decision can be acknowledged.[26]

However, such prior medical instruction should satisfy elements for genuine exercise of a self decision right. Thus, after a patient capable of decision-making is offered with medical information from a medical practitioner directly and, based on the medical information and according to his own sense of value, he or she must decide soberly as to specific treatment act. The above decision making process can be acknowledged as valid as prior medical instruction, if it is clearly proved at the time of treatment discontinuance that the patient himself either prepared a writing to the medical practitioner, or the treatment records, etc. exist revealing the contents of decision-making made during treatment process by medical practitioner.

Even though a document is acknowledged to be made by the patient himself, if it is not made directly to a medical practitioner or with participation of medical practitioner, since the document does not objectively verify that it has met the elements of patient's decision making capability, medical information offer, expression of serious intent, etc., binding effect of prior medical instruction cannot be acknowledged. It can only be viewed as one of the objective resources which allow inference of

26) *Supra* note 1.

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patient’s intention.

So we want to suggest that before urgent legislation, building public consensus on ELD should be preceded such as understanding what life extending treatment is and understanding this uncertainty of medicine by public as well as advance directives.

We think the ideal process of ELD is the decision by patient and physician through enough communication process. That is truly self-regulating and autonomous society without intervention by law. But unfortunately current situation shows that the trust on medical society is not sufficient, making medical society not entrusted with ELD by the public, lawmakers and bioethicist. For medical doctors regaining the trust from the public should be done.

Furthermore, for securing patient autonomy as well as the procedural justice, they should refer them to the ethics committee if the medical doctors are undecided on specific cases.

Nevertheless, if no conclusion has been reached, a litigation process must be sought.

IV. Reconsideration of the movement for “death with dignity” legislation

What we are going to discuss now is whether Korea need legislation on “death with dignity” or not.

Based on the leading case and Korea’s medical and legal situation, what are the key implications for public policy regarding end-of-life care decision-making in Korea? Can the legalization of ‘death with dignity’ really secure patient dignity and improve the end-of-life care system in Korea? Before legalization on ELD, in order to achieve a mutual agreement among the public regarding the issues surrounding “euthanasia” and “death with dignity,” several important factors need to be discussed.

1. Necessity of using Unified Terminology and Concept

As scholars and institutions use different terms and definitions when they discuss futile medical treatment, there has been a need to develop

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clear conceptions and definitions with regard to futile medical treatment. In addition, a consideration on whether those definitions would fit Korea's situation and sentiment is warranted.[27)]

First, there is a definition problem with respect to the terms "death with dignity" and "passive euthanasia" in Korea. In public debates, many people use these terms interchangeably, which leads to confusion among the people. "Death with dignity" means that a terminally ill patient has the right to refuse futile medical treatment which only prolongs the process of dying and interferes with the natural process of dying. And "passive euthanasia" means the cessation of life-support systems for a terminally ill patient.

Second, there is a problem with the term "medical futility." The term "futility" is a value term; as such, definition depends on the person interpreting it. This is also related to the ambiguity of current medical decision-making. Due to the progress of bio-medical technology, there is usually a way to resuscitate a patient, though the patient's doctor may see such treatment as futile.

As we mentioned above, as the Supreme Court also define "futile", in the clear case where a patient medically has no possibility of recovering consciousness, lost life-related important bio-function, and patient's body condition is near death in short time (hereinafter "irrecoverable death stage") does not aim at betterment of disease. It is merely for keeping the current conditions and criteria different from other cases should apply in deciding whether to permit discontinuance of treatment.

Where a patient entered into the irrecoverable death stage, the patient entirely relies on mechanical devices to extend life. He just waits for the stage of no possibility of extending life even if mechanical devices are used due to loss of other bodily function as well. In the medical meaning, it continues a body invading act without purpose of treatment and it does not prevent beginning of death process, but extends the final stage artificially which had already begun naturally.

Third, there is a problem associated with the term "death with

27) On the 10th of July, 2009, the National Evidence-based Healthcare Collaborating Agency in Korea held an open forum regarding the issue of using unified terminology and conception that would refer to futile medical treatment.

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dignity."[28] That is, there is a need to define what "dignified death" is and when the term "death with dignity" can be used. There could be many situations and conditions upon which people voluntarily choose active euthanasia, physician-assisted suicide, or withholding or withdrawing life-sustaining treatment for their "dignified" death. In this regard "death with dignity" has been defined as passive euthanasia or as the process of natural death.

In the field of bio-medical ethics, some of the terms and concepts do not properly convey a clear meaning. Defining usages and distinctions between "passive euthanasia" and "death with dignity" are complicated. Raphael Cohen-Almagor said, "Because phenomenology is important - language does play a critical role in the shaping and reshaping of our existence - we must reflect on the language people use to describe their experiences, especially those concerning life and death."[29] Cohen-Almagor pointed out the importance of using correct language; defining and using appropriate terms and concepts are crucial in bioethical debates and policy making.

In order to preserve human dignity, especially a patient's dignity, and to reflect the patient's will and autonomy, which terms and concepts should be adopted? Even though each term represents a specific point of view on end-of-life issues, people use the terms "passive euthanasia" or "death with dignity" interchangeably to mean the securing of human dignity. In order to develop public policy and regulations for end-of-life issues, the usage and the implication of each term need to be examined.

The Korean Supreme Court also mentioned about dignity of human being. Even though a right to life is the most important fundamental right, it must be protected by the means which correspond with utmost value of existence, i.e., dignity of human being. Thus, where a possibility of recovering consciousness is lost and no more activity as a person is

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28) People who had attended the abovementioned forum on the 10th of July, 2009 made several mutual agreements. First, they limited their discussions on futile life-sustaining treatment to "withholding futile life-sustaining treatment" or "natural death." They rejected "euthanasia" and "assisted suicide." Also, because the terms "passive euthanasia" and "death with dignity" might cause confusion, they decided that using these terms in a public discourse is not appropriate.

29) Raphael Cohen-Almagor, *Language and Reality at the End of Life*, 28(3) J. L. MED. ETHICS 267-278 (2000).

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expected, and irrecoverable death stage is reached where the natural death stage had already begun, if a life-extending treatment as the medically meaningless body invasion is forced, then human dignity and value are rather harmed and so, in the above exceptional circumstance, a patient's decision to face death should be respected and to protect the patient's dignity, value and right to pursuit of happiness as a human being corresponds to social norms and it does not violate the spirits of Constitution.

Therefore, in case where it is acknowledged that, upon reaching the irrecoverable death stage, the patient exercises a right to self decision based on dignity, value and the right to pursuit of happiness as human being, discontinuance of life-extending treatment can be allowed, barring special circumstance.

2. Other Concerns around "Death with Dignity" Legislation

In Korea, some people have warned the danger of acquiring justified reasoning through the legalization of "death with dignity." The Article 20 of the Korean Criminal Act allows for an exemption of criminal liability; it states that "an act which is conducted in accordance with Acts and subordinate statues or in pursuance of accepted business practices or other actions that do not violate social rules shall not be punishable." There still is the problem of interpretation.

Currently, the center of the public debates on "death with dignity" legislation is the issue of terminating medically futile treatment for terminally ill patients. People who support either "passive euthanasia" or "death with dignity" perspective use the same term "death with dignity" to mean dignified death for patients. As previously discussed vis-à-vis the problems related to the terminologies used, many people have expressed concerns on the usage of the term "death with dignity" in developing the "death with dignity" act.

If the term "death with dignity" is used for terminally ill patients, two things need to be considered. First, should "active or passive euthanasia" be considered equivalent to the term "death with dignity?" Second, if and when the public agrees to the idea that withdrawing medically futile treatment is acceptable for terminally ill patients, the use of the term "death

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with dignity" to describe the idea that a terminally ill patient has the right to refuse futile medical treatment should be reviewed.

When the need for a "death with dignity" act is addressed in public debates in Korea, most people agree that the boundary for terminating life-sustaining systems is only limited to terminally ill patients who are at the last stage of their lives. People have not generally used the term "death with dignity" for the legislation of euthanasia. Therefore, in order to avoid ambiguities regarding the issues surrounding the use of the term, an alternative term that describes a terminally ill patient's right to refuse medically futile treatment is necessary.

Allowing the termination of life-sustaining systems for terminally ill patients provides patients with the choice of a natural death. This is independent of any meaning related to euthanasia. The purpose of allowing the termination is not providing an "easy" death or relief from pain. On the contrary, it allows a patient to take a step into the natural process of dying by eliminating artificial life-support systems that interfere with the natural death process.

3. *Need for Establishing a Social System such as Guidelines and Education Regarding End-of-Life Care Issues.*

However, there still has been a need for legal consideration for protecting patient's right to self determination and dignity in a distorted medical situation that is therapeutic tenacity. In this regard, the existing laws need to be examined to determine whether they are inadequate and need reforming, or whether a new law is needed. If a new law is needed, it should be generalized, so that it could adequately encompass the wide-ranging medical situations. In this light, developing clear guidelines that can be enforced legally may be more effective than establishing new laws.

In order to make such guidelines, the public's views on this issue need to be assessed. According to a national survey on the general public's attitude toward "euthanasia" and "death with dignity,"[30] 1,025

30) In-Young Lee, *Anraksa Yuhyeongbyeol Gyubeomhaeseokgwa Sahoejeok Insikdo[A Study on the Legal Analysis and Public Opinion Survey on Euthanasia]*, 20(2) HYEONGSABEOBYEONGU [KOREAN J. CRIM. L.] 167-200 (2008).

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respondents were asked about their attitudes toward the termination of life-sustaining treatments for incurable patients who are in a permanent vegetative state and gave their consent to stop the treatments. The result showed that over 87.9% of the respondents agree to the termination.

Despite the social awareness, there is no medical law or social policy on this issue in Korea. In medical situations, many terminally ill patients attempt to claim their right to die by refusing futile medical treatments. However, in most cases, these requests have been ignored by their doctors and families. Also, the absence of law and policy forces patients, doctors, and families to struggle with end-of-life issues.

We make the following suggestions for public policy and legal measures with respect to end-of-life issues. We believe that there is a need for establishing a social security net that helps patients autonomously make decisions. In this regard, despite problems related to the legalization of "death with dignity," it is necessary to establish a basic set of regulations that can protect the rights of patients and medical professionals.

Currently, we need government regulations on futile medical treatment in Korea. Korea needs regulations for apparatus such as living wills, advance directives, and special power of attorney related issues, rather than legislation on "death with dignity." Out of respect for patient autonomy, we need to establish such regulations first.

Most importantly, each hospital should establish their own guidelines on the end-of-life care issues based on government regulations, under which end-of-life care issues would be decided. Under these guidelines, each hospital would have to establish a medical advisory committee that would review every case regarding the life-sustaining treatment withholding decisions. This committee would be comprised of medical professionals, patient's families, ethicists, lawyers, and religious leaders. In addition, the government and hospitals would be required to provide educational programs for people who are involved in end-of-life issues.

V. Conclusion

This paper examines the issue of the legalization of "death with dignity" by investigating Korea's leading case on the withdrawal of life-sustaining

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treatments and the current medical and legal situation in Korea. This paper also examines several preconditions for drafting a bill for such legislation; this is because many politicians, journalists, and doctors have tried to push the legalization of “death with dignity” as quickly as possible, even though there has not been a general agreement among the public regarding the permissible scope of “death with dignity” and the necessity of the institutionalization of “death with dignity.”

Before any legislation is enacted, practical guidelines and a social system that adequately reflect the legal, ethical, and medical aspects regarding the termination of life-sustaining treatments for terminally ill patients in Korea must first be established. Once laws are enacted, it is difficult to change a provision. With a “death with dignity” law, there may be many who may be vulnerable to the negative effects of the law. Since there is currently no guideline or a social security net for these people, many gray areas may arise that could be harmful to the society.

Each country has its own unique set of social, cultural, and political circumstances. Thus, the content and allowance of policies and laws on end-of-life decision-making may be different. Also, considering the complexity of medical circumstances, laws and policies on end-of-life decision-making may not address every possible scenario. One person’s death is not only a personal and family issue but also a social issue. Thus, the laws and the policies would have to reflect the differing views of people based on their social status, moral values, religious beliefs, and economic status. Therefore, it should be recognized that a public consensus is necessary for devising successful public policy and guidelines with respect to euthanasia and “death with dignity” in Korea.

The Korean Supreme Court made a landmark ruling in favor of death with dignity. After that decision, the Korean society is still discussing.

At this point, in Korea, process of ELD should be preceded by enough communication between patients and physicians because that is the most self-regulating and autonomous society without intervention by law. And then referring to the ethics committee which is composed of government officials, religious leaders and medical and legal experts to screen case is need for considering for the family’s mental and financial burden. Nevertheless, if no conclusion has been reached, finally a litigation process must be sought. That kind of litigations will be another pivotal case in the

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process of establishing the ethical and legal consensus in Korea.

Such processes are expected to accumulate the foundation for making national consensus although there is still a long way to go, obstacles to overcome, and misconceptions to clear away in order to bring about this consensus in Korea.

KEY WORDS: death with dignity, withdrawing and withholding life sustaining treatment, futility, advance directives

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