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Life-Sustaining Medical Treatment for Terminal Patients in Korea

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Life-sustaining medical treatment like mechanical ventilation has contributed much for acute illnesses. However, it might be harmful for the terminal patients with chronic illnesses like metastatic cancer, because it just prolongs dying process without reversing the underlying medical condition.

In Korea, 86.6% of terminal cancer patients admitted the hospital near the end-of-life period in 2010, in contrast to 19.3% in 1991. About 180,000 patients are dying with terminal diseases due to chronic illnesses like metastatic cancer and more than 30,000 patients had futile life-sustaining treatments at the end-of-life period (1, 2). Despite the fact that most cancer patients are resistant to chemotherapy at the end of life, 30.9% of Korean cancer patients in the last month of life received chemotherapy (3). The proportion who visited an emergency room more than once during the last months of life was 33.6% (4). In contrast, only 12% of cancer patients utilized hospice-palliative care service at the end-of-life period.

Active euthanasia or physician-assisted suicide is not an issue in Korea, but futility near the end-of-life is a big problem.

Legal Issues

Due to lack of law or national guidelines for end-of-life care, there have been confusion and controversies regarding life-sustaining treatments, especially mechanical ventilation.

In 1997, a court convicted a family of murder and a hospital of assisting in the crime for removing a ventilator from a comatose patient after head trauma. Even though the court's decision was based on the assumption that the patient was reversible with treatment, physicians have since shunned the practice. The incident raised the issue of futility in the Korean medical society.

In 2009, the Supreme Court ruled to have the life support system to be removed on a case in which family members of a 75-yr-old patient in a coma have asked doctors at the hospital to withdraw ventilator support from her.

The decision was made on the following assumptions: 1) a patient must have no possibility of recovery, 2) a patient has a serious intention of stopping treatment, 3) the treatment to be stopped must be only linked to prolonging dying process, and doctors are not allowed to stop any pain-reducing or other medical treatment, and 4) only a doctor may unplug the artificial respirator.

This incident exerted a great social impact on the public awareness of 'death with dignity' issue. Thereafter, 'well-dying' movement has become popular, and public debates have been on the legislation.

Public Awareness

The Organization for Economic Cooperation and Development said in the Korea report of its 2007 Economic Surveys that Korea faces "exceptionally rapid population aging" and that it needs to address social-economic problems associated with the demographic trend. Medical care near the end-of-life is one of top priorities for the public.

A study on 3,840 Korean individuals showed that a large majority supported withdrawal of futile life-sustaining treatment (87.1%-94.0%) and use of active pain control (89.0%-98.4%). A smaller majority (60.8%-76.0%) supported withholding of life-sustaining treatment (5).

About 50% of those in the patient and general population groups supported active euthanasia or physician-assisted suicide, as compared with less than 40% of the family caregivers and less than 10% of the oncologists. Higher income was significantly associated with approval of the withdrawal of futile life-sustaining treatment and the practice of active pain control. Older age, male sex and having no religion were significantly associated with approval of withholding of life-sustaining measures. Older age, male sex, having no religion and lower education level were significantly associated with approval of active euthanasia and physician-assisted suicide.

Even though other surveys demonstrated similar results, patient autonomy and withdrawal of futile life-sustaining treatment are not respected in the real situation.

Surrogate decision

In relation to do not resuscitate (DNR) decisions in Korean cancer patients, proxy decision-making is overwhelming and issu-

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ance of DNR discussion is raised at a late stage.

One study showed that the DNR directive was implemented in 143 patients of the enrolled 165 patients (86.7%). All discussions about DNR took place between physician and family members, except in only one case. DNR directives were enacted at a median of 8.0 days (range 0-79, mean 12.15) before death. For 18 patients, the DNR directive was formally taken on the day of admission. In contrast, 14 cases (9.8%) were agreed on the day of death, 18.8% within 48 h of death, and 46.8% (67 of 143) within 1 week before death, 62% before 10 days, and 71.3% within 2 weeks (6).

The other study demonstrated that an order of DNR consent was obtained from 296 patients (76%) of a total of 387 patients. All DNR consents were made between the physician and family, without involving the patient. Terminal cardiopulmonary resuscitation (CPR) was performed on 29 (7%) patients. DNR discussion was made within 7 days of the day of death on 228 (77%) patient among the 296 DNR consenting patients (7).

Surrogate decision-making was frequently observed among Korean cancer patients, especially when the patient's death was imminent, and for decisions related to end-of-life care. Surrogates were also frequently involved in decisions for elderly or rapidly deteriorating patients (8).

Withdrawal vs withholding of life-sustaining medical treatment

It is generally accepted that there is no ethical or legal distinction between withdrawing and withholding life-sustaining treatment. However, in Korea, 68% of general population and 71% of medical professionals think there should be ethical and legal difference between withdrawing and withholding life-sustaining treatment (1). Withholding is acceptable, but withdrawing of mechanical ventilator is not.

This situation is very similar to Israel. The Jewish legal system or *Halacha*, developed from the Bible (Tanach), Talmud and rabbinic responsa, differentiates between active and passive actions and between withholding and withdrawing life-sustaining therapies. *Halacha* does not allow the hastening of death even in the terminally ill, but there is no obligation to actively prolong the pain and suffering of a dying patient or to lengthen such a patient's life. Therefore, *Halacha* allows the withholding of a life-prolonging treatment, provided that it pertains to the dying process, but forbids the withdrawing of life-sustaining therapy, if it is a continuous form of treatment (9).

Guidelines to withdrawing life-sustaining therapies endorsed by the Korean Medical Association, the Korean Academy of Medical Science, and the Korean Hospital Association, were published on October 13, 2009 (10). However, physicians are not utilizing the guidelines and have asked legislation to defend legal charges. Many hospitals have their own guidelines and recommend advance care planning by utilizing advance directives.

One of the obstacles to social consensus on the issue is confusion over terminology. Various terms are translated into different Korean words regarding euthanasia, death with dignity, natural death, etc. It brought difficulties to get public support on the guidelines suggested by medical groups.

Bigger issue is cultural. The importance of patient autonomy in the Western (Christian) world is not necessarily an issue among other ethnic and religious groups. One joint study done on Korean, Chinese and Japanese patients demonstrated importance of family values. Only a quarter of them preferred making end-of-life care decisions by themselves, while many respondents favoured a 'joint decision' with their family members. The most favored proxy decision maker was the spouse, followed by the children. Most admitted the necessity of 'advance directives' and agreed with artificial ventilation withdrawal in irreversible conditions (11).

Although patient self-determination with advance directives is important in this issue, discussion is needed for the role of family members in end-of-life decisions for the best interests of the terminal patients. In addition, hospice-palliative care program should be expanded in Korea.

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