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The Right to Refuse Life-Sustaining Medical Treatment in South Korea: The Case of Ms. Kim*

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1. Introduction

The following passage, which comes from an editorial published in the *New England Journal of Medicine* 15 years ago, describes the legal and ethical consensus that has emerged in the past 30 years over a patient's right to refuse life-sustaining medical treatment:

> Beginning with the case of Karen Anne Quinlan in 1975, family members began to assert a right to discontinue life support for patients in a permanent vegetative state. These efforts have slowly led to an ethical and legal consensus that families or other proxies may authorize the discontinuation of life-sustaining treatment, including artificial feeding, for such patients. We owe Joseph and Julia Quinlan, Karen's parents, our gratitude for turning their personal calamity into a public benefit by launching the right-to-die movement. Without this movement we would not have our present right to prepare advance directives or living wills that permit us to name a proxy decision maker to authorize discontinuation of treatment under specified circumstances.[1]

While the above passage is perfectly correct, it must be understood in its proper cultural context. In speaking of "our present right" to prepare advance directives or living wills that permit "us" to name a proxy decision maker to authorize the discontinuation of life-sustaining treatment the author of the passage is clearly speaking to an American audience. While the ethical and legal consensus that is described in the above

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[1] Angell M. After Quinlan: the dilemma of the persistent vegetative state. *N Engl J Med* 1994 ; 330 : 1524-1525.

passage may be true of the US and many other countries, it is not true universally. One country that lacks such a consensus is South Korea.

Though there are no specific laws in Korea governing passive euthanasia it is often said, and widely believed, that physicians are bound by law to exhaust all means necessary to prolong a patient's life and can be prosecuted for discontinuing life-sustaining treatment even if a patient has signed a do-not-resuscitate form or given tacit consent.[2] This belief stems in part from certain misconceptions about a well-known case at Boramae Hospital in Seoul in which a physician and a resident received jail terms in 2004 for disconnecting a patient from a respirator and discharging him at the request of his wife. However, the incident at Boramae Hospital was more of an example of negligence than of passive euthanasia, since the patient who died after being discharged in that case was not terminally ill. Nevertheless, as there are no specific laws governing passive euthanasia or advanced directives in South Korea, it is true 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. In an attempt to clarify matters and standardize treatment for terminally-ill patients, the Korean Medical Association (KMA) in 2001 issued a set of ethics guidelines that included a proposal that physicians should be allowed to discontinue life-sustaining treatment on terminally ill patients in certain circumstances. However, when the guidelines were first circulated, the Korean Ministry of Health and Welfare responded to the KMA's proposal on passive euthanasia by claiming that "it violated the nation's criminal law."[3] Since then the legality of passive euthanasia in Korea has remained unclear.

However, the situation appears to be changing. Two recent court decisions in Korea concerning an elderly woman in a persistent vegetative state have both affirmed the patient' s right to have life-sustaining medical treatment discontinued and to "die with dignity."[4] The legal battle over the fate of this patient, whom we may call Ms. Kim,[5] has many parallels to the landmark cases in the right-to-die movement in the US, such as those concerning Karen Ann Quinlan and Nancy Cruzan And just as these last two cases were pivotal in the process of

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[2] The Chosun Ilbo. Appellate Court Rules for Passive Euthanasia [on the Internet]. February 11, 2009. http://english.chosun.com/w21data/html/news/200902/200902110032.html. Accessed February 13, 2009.

[3] Watts J. Korean Medical Association stirs up controversy. *Lancet* 2001 ; 358 : 1881.

[4] International Herald Tribune. South Korean high court upholds right to die ruling [on the Internet]. February 10, 2009. http://www.iht.com/articles/ap/2009/02/10/asia/AS-SKorea-Right-to-Die.php. Accessed February 16, 2009.

[5] Out of respect for the patient' s privacy, I will in what follows refer to the patient using only her family name, although her full name has already been disclosed by the Korean media.

establishing the ethical and legal consensus that now exists in the US and elsewhere concerning passive euthanasia, the case of Ms. Kim may be an important first step in establishing such a consensus in Korea. However, there is still along way to go, obstacles to overcome, and misconceptions to clear away, in order to bring about that consensus in Korea.

This paper makes a contribution to this consensus-building process in Korea by reviewing some of the landmarks cases in the international right-to-die movement, identifying the key legal and ethical lessons from those cases, and then applying those lessons to the case of Ms. Kim in order to evaluate the decisions that have been made in her case so far and to make further recommendations on what needs to be done. I begin, in section 2, by reviewing the Canadian case of Nancy B. and explaining the legal and ethical justification for granting competent patients the right to refuse life-sustaining medical care. I then consider, in section 3, the rights of incompetent patients to refuse life-sustaining medical care by reviewing the American cases of Karen Anne Quinlan and Nancy Cruzan. In section 4, I examine the decisions made in the Korean case of Ms. Kim within the context of these other landmark cases. Along the way I argue a) that any patient, whether competent or not, should have the legal and ethical right to refuse any medical treatment, whether life-sustaining or not, and b) that when patients cannot make medical decisions for themselves, their right to refuse should be transferred to surrogate decision-makers, which in most cases will be a family member or close friend.

Before proceeding, it will be best to note some distinctions relevant to the issues discussed below. Passive euthanasia, the general topic of this article, may be defined as the withholding or withdrawing of life-sustaining medical treatment; active euthanasia, on the other hand, is medical treatment designed to bring about a patient's death. Either form of euthanasia may be voluntary, involuntary, or non-voluntary. It is voluntary when it is explicitly requested by the patient, involuntary when it is explicitly refused by the patient, and non-voluntary when the patient is unable either to request or to refuse it. Furthermore, following a broad consensus among bioethicists,6) I see no ethical distinction between withholding and withdrawing life-sustaining treatment. When the patient's refusal of life-sustaining treatment is given prior to the initiation of treatment, the patient is requesting that treatment be withheld; when the patient's refusal is given after treatment has already commenced, the patient is requesting that treatment be withdrawn. Though there are differences between the two cases, there are

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6) Council on Ethical and Judicial Affairs, American Medical Association. Withholding and withdrawing life-sustaining treatment. In: Mappes TA, Degrazia D, eds. *Biomedical Ethics* (5th ed). New York, New York : McGraw-Hill, 2001 : 327-329.

no important ethical differences. Hence, in what follows, in speaking of a patient's right to *refuse* life-sustaining treatment I intend to refer to the patient's right to have life-sustaining treatment either withheld or withdrawn.

This article is concerned neither with involuntary euthanasia, which is widely and rightly condemned, nor (except in passing) with active euthanasia. The focus of this article is rather on voluntary and non-voluntary passive euthanasia. The specific case under discussion in what follows, the case of Ms. Kim, may be classified as an example of non-voluntary passive euthanasia, as it involves an *incompetent* patient, one who is unable to give or withhold consent to the discontinuation of her life-sustaining treatment. Cases of voluntary passive euthanasia, on the other hand, involve *competent* patients who give their consent to the termination of life-sustaining treatment. However, aside from the matter of patient competence, voluntary and non-voluntary passive euthanasia raise many of the same ethical issues. And since voluntary euthanasia is the less controversial and more tractable of the two forms, it is best to consider it before proceeding to a discussion of the issues involved in non-voluntary passive euthanasia.

2. Competent Patients and the Right to Refuse Life-Sustaining Treatment: The Case of Nancy B.

Nancy B. (a pseudonym) was a previously healthy Canadian woman in her early twenties when, in June 1989, she was diagnosed in with Guillain-Barre syndrome, resulting in a progressive motor paralysis that left her bedridden and dependant on a respirator for survival.[7] By January 1991, Nancy had suffered a complete loss of motor nerves and was informed that there was no cure for her condition. This medical prognosis was confirmed by her attending physician as well as two expert neurologists. Over the course of the next year, Nancy B. expressed a firm and fixed wish to have the ventilator removed and to be allowed to die. During that time, a psychologist met with her on four separate occasions and determined that she was in excellent mental health and that she was capable of making decisions and understanding the consequences of those decisions. Her attending physician sought judicial sanction to remove Nancy B. from the ventilator.

During the trial her mother testified that life was no longer livable for Nancy because of her total dependence on others, her

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[7] This description of the case of Nancy B. is based largely on that provided in Hebert P. *Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians*. Don Mills, Ontario : Oxford University Press, 1996.

confinement to a bed, and her loss of privacy. In its decision, the Superior Court of Quebec claimed that "What Nancy B. is seeking, relying on the principle of autonomy and her right of self-determination, is that the respiratory support treatment being given her cease so that nature may take its course; that she be freed from slavery to a machine as her life depends on it."[8] The court recognized that removing the ventilator from Nancy B. would require the assistance of her doctor, but this they permitted, claiming that removing the ventilator would not be culpable negligence or assisted suicide, but reasonable medical treatment.

From a legal point of view, the case of Nancy B. was relatively unproblematic. Nevertheless, the judgment helped to make clear that physicians have no right to impose medical treatment against a patient's will; in other words, the judgment made it clear that a patient's consent is necessary for any and all medical treatment, including life-sustaining treatment, and that this is required by the principle of autonomy. It may be thought that the judgment in this case is a uniquely Canadian decision or due to an arbitrary ranking of the principle of autonomy above that of beneficence, but neither suggestion would be correct. In 1992, the Council on Ethical and Judicial Affairs of the American Medical Association published a report in which it presented a series of clarifications related to the right of competent patients to refuse life-sustaining treatment. The report notes that while the patient's right to refuse life-sustaining treatment is required by the principle of autonomy, it is in no way inconsistent with the principles of beneficence or non-maleficence.

> The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When the physician withholds or withdraws treatment on the request of a patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withholding is not a treatment, but the forgoing of a treatment.[9]

The above passage correctly characterizes the principles of beneficence and non-maleficence and clearly shows how neither principle is violated by a physician's withholding or withdrawing of life-sustaining medical treatment on a patient's request. Since the patient's right to refuse life-

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[8] Hebert P. 1996 : 175.

[9] Council on Ethical and Judicial Affairs, American Medical Association ; 2001 : 328.

sustaining treatment is required by the principle of autonomy and since it does not conflict with the other principles governing biomedical ethics, decisions concerning the discontinuation of life-sustaining treatment for competent patients are now properly regarded in most countries with any tradition of biomedical ethics as legally and ethically unproblematic. The idea that competent patients have the right to refuse life-sustaining treatment is a consequence, not of any cultural norm, but of a proper understanding of the four principles that are widely regarded as the foundation of biomedical ethics – the principles of autonomy, beneficence, non-maleficence, and justice.

It is sometimes supposed that accepting voluntary passive euthanasia leads one down a slippery slope to accepting voluntary active euthanasia. However, that supposition is incorrect. As the foregoing shows, the justification for voluntary passive euthanasia is based on the legal and ethical doctrine of informed consent, which grants patients the right to consent to any proposed treatment but not the right to receive any treatment they desire. The doctrine of informed consent places no obligation on physicians to provide treatment that they believe is medically unsound or contrary to the principle of non-maleficence. As such, the foregoing justification for voluntary passive euthanasia offers no support at all for voluntary active euthanasia. There may be indeed be other arguments in support of active euthanasia, but it is a mistake to think that accepting voluntary passive euthanasia on the basis of the doctrine of informed consent automatically forces one to accept voluntary active euthanasia as well.

3. Incompetent Patients and the Right to Refuse Life-Sustaining Treatment

3.1 The Case of Karen Ann Quinlan

Karen Ann Quinlan was 21 years old in April 1975 when she suffered brain damage and irreversible loss of all neocortical function after ingesting alcohol and tranquilizers.10) Sustained by a ventilator and feeding tubes, Karen remained in a persistent vegetative state for some seven months before her physicians indicated to the family that there was no realistic hope that she would ever regain consciousness and that she would likely die if the ventilator support were removed. Upon hearing this prognosis, the family requested that it be removed, claiming that Karen would not have wanted to live in this state. However, as she did not meet the

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10) The following description of the case of Karen Ann Quinlan is based largely on that provided by in Edge RS, Groves JR. Ethics of Health Care: A Guide for Clinical Practice. 3rd ed. Clifton Park, NY: Thomson; 1994.

criteria for brain death, the physicians refused to remove the ventilator and the family took the matter to court.

In a lower court ruling, the family was refused permission to have the ventilator removed, but the New Jersey Supreme Court later overturned the lower court decision and appointed Karen's father as her guardian for purposes of discontinuing treatment. The higher court ruled that when an individual has no chance of recovering consciousness, then the argument for the protection of life weakens and an individual' s right to privacy justifies the discontinuation of burdensome life-sustaining medical treatment, as requested by her guardian. However, the attending nurses weaned Karen from the ventilator in such a way that she was able to continue to breathe once it was fully removed. Karen then remained in a persistent vegetative state for an additional ten years before finally succumbing to acute pneumonia in 1985. During the final ten years of her life, Karen was sustained by feeding tubes and IV fluids. Had this additional support been removed when the ventilator was removed, Karen most likely would have died ten years earlier.

Unlike Nancy B., Karen Ann Quinlan was unable to make the decision to discontinue treatment herself. It was her parents who made the request to withdraw treatment, and while the court's decision to grant Karen's parents the right to make that decision on her behalf was controversial at the time, it has since been embraced by numerous medical societies, interdisciplinary bodies, and courts. One way of justifying this decision is by recourse to the principle of justice: the rights that are granted to competent patients to discontinue medical treatment should not be denied to other patients merely because they lose their ability to exercise that right themselves. And if incompetent patients are granted the right to discontinue life-sustaining treatment and cannot themselves exercise it, then someone else must be given the right to exercise it on their behalf. The question, then, is not whether someone else can exercise this right on their behalf, but rather who is the best position to do so.

Brock provides helpful guidance on this point.[11] In many states now in the US, it is possible for a patient legally to designate a surrogate for making medical decisions for them by executing a Durable Power of Attorney for Health Care (DPOA). When a patient has not designated a surrogate, the reasonable and common presumption is that a family member of the patient is an appropriate surrogate. In some states family members can become surrogates for incompetent patients without having to go

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[11] Brock D. Surrogate decision making for incompetent adults: an ethical framework. In: Mappes TA, Degrazia D, eds. *Biomedical Ethics* (5th ed). New York, New York : McGraw-Hill, 2001 : 350-356.

through guardianship proceedings. Brock lists three reasons in support of the presumption that a family member is the most appropriate surrogate. First, in most cases a family member is the person a patient would have wanted to act as surrogate for him or her. Second, in most cases a family member will know the patient best and be most concerned with his or her welfare. Third, in most societies the family is the central social and moral unit assigned responsibility to care for its dependent members. When no family member is available to serve as surrogate, then a close friend is typically the next best alternative for similar reasons to those given in support of designating a family member as surrogate.

There is, however, at least one complication to the idea of granting family members decision-making authority with respect to the life-sustaining treatment of an incompetent patient, namely, those same family members may be the ones paying for the costs of the patient's medical treatment. If so, the family members may have a conflict of interest. Guardians or surrogate decision makers have an ethical obligation to make decisions either in the patient's best interest or according to his or her instructions if given in advance. But if the medical costs of keeping the patient alive are born by family members, then this fact can compromise their ability to make decisions in the patient's best interest. According to one report, for instance, the cost of keeping Karen Ann Quinlan alive in 1975 was $450 per day, although in her case the costs were absorbed by Medicare since she was an adult without income.12) Had she been under twentyone, the parents would have been responsible for the costs of her care. Given the increases in the costs of advance medical care that have occurred since 1975, the price of providing a patient with life-sustaining medical treatment over an extended period of time can easily overwhelm the family members who are required to pay for it. Thus, it is reasonable to expect that, at least in some cases, the financial costs of the life-sustaining treatment will influence and affect a family's ability to make decisions that are purely in the patient's best interests. Nevertheless, as I will argue below, these kinds of conflicts are commonplace in all areas of family decision-making and should not be seen as obstacles to family members serving as surrogate decision makers.

3.2 The Case of Nancy Cruzan

In 1983, at the age of 25, Nancy Cruzan lost consciousness in a car accident.13) She was

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12) Munson R. *Interventions and Reflections: Basic Issues in Medical Ethics* (5th ed). Belmont, CA: Wadsworth, 1996 : 158.

13) The following description of the case of Nancy Cruz is based on that provided by in Edge RS, Groves JR. 1994 and on the Supreme Court Syllabus of Cruzan v. Director, Missouri Department of Health, (88-1503), 497 U.S. 261 (1990) [on the Internet]. http://supct.law.cornell.edu/supct/html/88-1503.ZS.html. Accessed February 20, 2009.

resuscitated at the scene of the accident but never regained consciousness and was later diagnosed as being in a persistent vegetative state. She had a feeding tube installed to keep her alive, and her doctors estimated that she could live for another 30 years with the support of the feeding tube. The State of Missouri bore the cost of her care.

After it had become apparent that Nancy had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures, knowing that this would hasten her death. When the employees of the Missouri Rehabilitation Center refused to honor this request, the parents then sought authorization from the state trial court for termination of treatment. The court ruled in favor of the Cruzans claiming that Nancy had a fundamental right under the State and Federal Constitutions to refuse death-prolonging procedures. As evidence that Nancy herself would have wanted to discontinue treatment, the court accepted remarks she had earlier made in a somewhat serious conversation on a related subject with a friend.

The State Supreme Court later reversed this decision, arguing that while the common-law doctrine of informed consent does entail a right to refuse treatment, it is doubtful that the doctrine can be applied in this case. The court decided that Nancy's statements to her friend were unreliable for the purpose of determining her intent. It also rejected the argument that her parents were entitled to order the termination of her medical treatment, concluding that no person can assume that choice for an incompetent in the absence of the formalities required by the State of Missouri living will statute or clear and convincing evidence of the patient's wishes.

The U.S. Supreme Court later affirmed the decision of the State Supreme Court, claiming that not even the family should make choices for an incompetent patient in the absence of clear and convincing evidence of the patient's wishes. In a five-four split decision, the court ruled that states do have these rights because the state does have a right to assert an unqualified interest in the preservation of human life and because abuse can occur when patients do not have loved ones to serve as surrogate decision makers. The family later attempted to provide clear and convincing evidence by having three of Nancy's friends testify. Following this, the State of Missouri no longer opposed and the feeding tube was removed. Nancy died 11 days later.

As the first case of passive euthanasia to reach the US Supreme Court, the case of Nancy Cruz was significant in several respects. In its ruling, the court upheld the decision that competent patients can refuse life-sustaining treatment on the basis of the common-law right to informed consent, which follows from the principle of autonomy. Second, the court made no legal distinction between tube feeding and other life-sustaining measures, thereby diminishing the significance of the ordinary/extraordinary distinction that played such an important role in the case of Karen Ann Quinlan, keeping her alive unnecessarily for an additional ten years. Third, while the court recognized that the state is bound to follow the requests of a patient-appointed surrogate, it upheld the clear and convincing evidence standard and rejected the family's right to refuse treatment for Nancy in the absence of that evidence. This directly led to an increased interest in the US in advance directives and durable powers of attorney (DPOAs). Most US States have at this point passed some form of living will, right-to-die, or death-with-dignity statute.[14] Fourth, it is important to note that the state paid for the costs of Nancy's medical care (estimated to be $130,000 per year),[15] thus removing any conflict of interest from Nancy's parents in requesting to terminate treatment.

The most important feature though of the court's ruling in the case of Nancy Cruzan was the decision not to allow Nancy's parents to serve as surrogate decision makers. The rational given on this point by the majority is worth noting.

> A competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. … However, the question whether that constitutional right has been violated must be determined by balancing the liberty interest against relevant state interests. For purposes of this case, it is assumed that a competent person would have a constitutionally protected right to refuse lifesaving hydration and nutrition. This does not mean that an incompetent person should possess the same right, since such a person is unable to make an informed and voluntary choice to exercise that hypothetical right or any other right. While Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to withdraw hydration and nutrition and thus cause death, it has established a procedural safeguard to assure that the surrogate's action conforms as best it may to the wishes expressed by the patient while competent.[16]

However, this crucial argument was one that the dissenting justices rejected. They argued that the right to be free from medical attention without consent is a fundamental right and explicitly stated that the fact that Nancy Cruzan had become incompetent does not deprive her of her fundamental rights. The dissenting justices would have given families the constitutional right to serve

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[14] Edge RS & Groves JR. 1994 : 209.

[15] Munson R. 1996 : 154.

[16] Supreme Court Syllabus of Cruzan v. Director, Missouri Department of Health ; 1990.

as surrogate decision makers for incompetent patients who had not made their treatment preferences known. In particular, they rejected a state right to require that patients formalize their intentions in living wills or DPOAs as unnece-ssarily burdensome. In contrast to the majority opinion, the dissenting justices would have excluded the state from participating in termination of treatment decisions, finding families better judges of the patient's best interests.17)

4. The Case of Ms. Kim

In February 2008, while undergoing an endoscopic lung examination for pneumonia at Severance Hospital in Seoul, a 76-year-old patient, Ms. Kim, sustained severe brain damage leaving her in a persistent vegetative state and dependant on feeding tubes and a ventilator. Three months later, family members of the patient filed a court petition after the hospital refused the family's request that she be removed from the ventilator and allowed to die. During the trial several doctors testified that Ms. Kim had no reasonable chance of recovering from her vegetative state; the patient's children testified that their mother had always opposed keeping people alive when there was no hope of recovery. In November 2008, the Seoul Western District Court ruled in favour of Ms. Kim's family and ordered Severance Hospital to discontinue life-sustaining treatment for Ms. Kim.

The court judgment was based in part on the medical opinion that there was no hope for recovery or improvement in the patient's condition and, hence, that the treatment was medically meaningless. The judgment stated that "according to the individual's personal rights and right to the pursuit of happiness as guaranteed by Article 10 of the Constitution, when life-support treatment imposes physical and/or mental pain and harms a person's dignity and individual values, the patient can refuse … treatment, and the hospital is obligated to comply with this."18) The court also stated that "even if the plaintiff did not express her wishes explicitly, her right of claim can be recognized" and that "only the patient herself has the right to demand cessation of treatment."19) Thus, the court did not recognize the right of Ms. Kim's children to refuse treatment for their mother, even though Ms. Kim is alleged to have designated her daughter as a special proxy.20)

The court's decision is widely regarded

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17) Richards EP, Rathbun KC. Medical Care Law. Boston : Jones & Bartlett Publishers, 1999 :239.

18) Bioethics Policy Research Center. Court grants right to die with dignity in landmark ruling [on the Internet]. November 29, 2008. http://eng.bprc.re.kr/gz05.htm?number=7. Accessed January 12, 2009.

19) Bioethics Policy Research Center. November 29, 2008.

20) Bioethics Policy Research Center. November 29, 2008.

as a landmark ruling in Korea since it is the first time a court has recognized a patient's right to have life-sustaining medical treatment withdrawn. The decision was also welcomed by the KMA, which insists that doctors should be allowed, in certain circumstances, to discontinue life-sustaining treatment on terminally-ill patients.[21] Nevertheless, Severance Hospital decided to appeal the decision. An official with the hospital said "the appeal was submitted because of worries that the district court's decision could lead to an unfavorable precedent which could encourage more terminally ill patients or their guardians to reject life support."[22] Other reports suggest that Severance Hospital appealed the decision seeking more specific guidelines for terminating life-support.

In February 2009, the appellate court upheld the decision of the lower court and went on to provide guidelines that could be applied in other cases. In its ruling the Seoul High Court claimed that the ventilator should be removed on the basis of the patient's presumed desire. Furthermore, it provided the following guidelines for withdrawing life-support systems: 1) there must be no realistic possibility that the patient will recover from his or her terminal illness; 2) the patient must have expressed a sincere and rational decision not to remain on a life-support system if there is no hope of recovery; 3) only life-support treatment can be stopped; palliative care must be continued; and 4) only doctors can terminate life-sustaining treatment.[23] The court also emphasized the need for a law on a person's right to die with dignity, claiming that society's opinion should be sought and reflected in standards for terminating life-sustaining treatment.

There are at least three aspects of the court decisions on the fate of Ms. Kim that deserve close attention. They are as follows: 1) the landmark decision to grant patients the right to discontinue life-sustaining treatment under certain conditions; 2) the specific condition that the patient must have expressed a sincere and rational decision not to remain on a life-support system if there is no hope of medical recovery; and 3) the courts' decision not to grant the right to discontinue life-sustaining medical treatment to the family members of the incompetent patient. I will comment on each of these in turn.

The Seoul High Court's decision to recognize the right of patients to refuse life-

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[21] Korea Times. Respirator allowed to be removed from comatose grandmother [on the Internet]. February 10, 2009. http://www.koreatimes.co.kr/www/news/include/print.asp?newsIdx=39296. Accessed February 18, 2009.

[22] Arirang News. Hospital files appeal with Supreme Court to overturn euthanasia decision [on the Internet]. December 18, 2008. http://www.arirang.co.kr/News/News_View.asp?code=Ne2&nseq=85659. Accessed February 2, 2009.

[23] JoongAng Daily. High Court issues guidelines for the unplugging of an artificial respirator [on the Internet]. February 11, 2009. http://joongangdaily.joins.com/article/view.asp?aid=2900894. Accessed February 17, 2009.

sustaining treatment is an important and very positive development in Korea. As noted above, this right is a consequence of the legal and ethical doctrine of informed consent, which in turn is a requirement of the principle of autonomy. This right in no way conflicts with the bioethical principles of beneficence or non-maleficence, when properly understood. Furthermore, the court properly noted that the right to refuse life-sustaining treatment applies, not only to competent patients, but also to incompetent patients under certain conditions.

However, the conditions under which the court is prepared to allow incompetent patients to refuse life-sustaining treatment are troubling. The requirement that an incompetent patient must have expressed a sincere and rational decision not to remain on a life-support system if there is no hope of medical recovery is objectionable on the basis of the principle of justice. Imagine two incompetent patients, A and B, both of whom are in a persistent vegetative state and on life-support. Imagine that A and B are alike in almost every respect, including the fact that they both have for long periods of time been opposed to the idea of medically meaningless life-support treatment. Suppose that the only difference between A and B is that A has on some prior occasion expressed her views on medically meaningless life-support treatment to her spouse while B has never had such a conversation. According to the court's judgment, in this hypothetical scenario, A should be granted the right to refuse life-support treatment, while B should not. But this is an arbitrary and unfair violation of B's right to consent. If the right to consent is a fundamental right, as justices in the case of Nancy Cruzan argued, then it cannot be based on something as arbitrary as whether or not the patient in question is lucky enough to have had a certain conversation previously in his or her life.

Worse still, imagine that patient B in the above scenario did express her views regarding medically meaningless treatment to her spouse on several occasions earlier in her life. But suppose now that B's spouse is no longer alive to testify on her behalf. Scenarios such as this one show that even patients who do in fact satisfy the court's requirement of having expressed a sincere and rational decision not to remain on a life-support system if there is no hope of recovery may be unable to exercise their right to have treatment discontinued merely in virtue of the fact that some third party is no longer alive to testify. Clearly, patient's rights should not be made to depend on contingencies such as these; if they are made to depend on such contingencies, then problems of justice arise.

There is, of course, some justification for the court' s requirement that an incompetent patient must have expressed a sincere and rational decision not to remain on a life-support system if there is no hope of medical recovery. It is somewhat similar to the clear and convincing evidence standard that the majority justices of the US Supreme Court demanded in their ruling in the case of Nancy Cruzan. Both safeguards are designed to ensure that the decisions made for an incompetent patient conform as closely as possible to the patient's own values and beliefs. However, the question can and should be raised as to why the burden of proof is on those who wish to remove the life-support treatment rather than on those who seek to maintain it.

Once we call into question the presumption in favour of continuing life-sustaining medical treatment on incompetent patients with no hope of recovery, then an interesting alternative may be appreciated. Consider, thus, the following proposal from Angell:

> We should instead presume that patients in a persistent vegetative state would not want to be kept alive indefinitely - a presumption buttressed by public opinion polls. On this basis we could establish a standard of care that included routinely stopping treatment after a specified time in a persistent vegetative state. The time would vary with the medical circumstances, but would be sufficiently long to establish irreversibility with virtual certainty. If particular families objected to discontinuing treatment at that time, they would have to justify their position, perhaps by documenting the wishes of the patient expressed earlier. The crucial points are that the matter be dealt with in a principled and general way, and that the burden of proof be shifted to those holding the idiosyncratic view.[24]

The foregoing proposal is a reasonable one that solves many problems, but as the author herself acknowledges, a great deal of public debate and a greater understanding of the issues is needed before such a proposal could be seriously entertained.

In the meantime, the best proposal for dealing with incompetent patients for whom there is no documented evidence of their views on life-sustaining treatment is to allow family members to function as surrogate decision-makers. This brings us to the third and final point concerning the ruling by the Seoul High Court. It is on this point, more than any other, that the court's ruling is problematic. For the Seoul High Court would not grant the patient's family members the right to serve as surrogate decision-maker for Ms. Kim even though she herself had allegedly designated her daughter to serve as a surrogate. From a legal point of view, this decision may have been inevitable, as there currently are no laws in Korea concerning advanced directives or DPOAs. From an ethical point of view, however, the decision is highly objectionable.

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[24] Angell M. 1994;330:1525.

There are two related problems with this decision that need to be distinguished. One problem relates to the court's refusal to recognize the right of a *patient-appointed* surrogate decision maker. If the paramount issue is to ensure that an incompetent patient's wishes are respected, the best way of doing so would be to follow the decision of the person whom the patient earlier appointed to serve as a surrogate decision maker. Indeed, in not granting this right to the patient's family members, the court is in effect giving itself the right to determine what the patient would have requested had she been able to make any requests. But it is highly unlikely that the court would be in a better position to know the patient's wishes than a family member appointed by the patient to serve as a surrogate decision maker. The second problem is the implication of this decision for other cases. How are decisions to be made when the incompetent patient has not earlier expressed his or her views to others or appointed a surrogate decision-maker - or when those to whom the patient has expressed his or her views are unable to testify? The best approach, it would seem, is to allow family members in these cases to act as surrogate decision makers.

As we saw above, the American ethicist Brock finds several reasons in support of family members being the most suitable surrogates. One of those reasons relates to the importance of family in the lives of most people and the fact that the family is the main moral unit assigned responsibility to care for its dependant members. But it is clear that the family has an even greater social and moral significance in Korean society than it has in the west, and so one would expect there to be an even stronger presumption in favour of family members as surrogate decision makers in Korea than in the US. It is therefore odd to find the opposite to be true in Korea - that family members in Korea do not have the legal right to act as surrogate decision makers for incompetent patients. In refusing to grant family members the right to function as surrogate decision makers, the Seoul High Court's ruling is not only out of line with some of the developments in other countries with stronger traditions in medical ethics but is also out of line with its own cultural norms concerning the importance of family as a social unit.

One may justify the Seoul High Court's decision on the grounds that it is necessary to prevent cases of abuse, in which family members might request the discontinuation of life-sustaining treatment for a patient, not out of respect for the patient's autonomy, but rather for financial reasons - because they either cannot or do not want to bear the costs of the life-sustaining medical treatment. But this is a rather weak justification. In Korea, where patients are required to bear a large part of the costs of their medical care, and where advanced medical care can be extremely expensive, families necessarily and routinely make decisions regarding medical care partly on economic grounds. It is commonplace in Korea for families to forego certain medical treatments that they would otherwise choose to undergo - even those that are medically necessary - because they cannot afford to pay the costs of the treatment. Why then should families not be allowed to let financial considerations play a role in their decisions concerning the termination of expensive life-sustaining treatment? Conversely, what justification is there for the state to impose financial burdens on families if they cannot afford to them?

Following the decision of the Seoul High Court, Severance Hospital decided once again to appeal, sending the case to the Supreme Court of Korea, where it now awaits a final ruling. According to one newspaper report, the president of Severance Hospital, Park Chang-Il, said the hospital's decision to appeal was based in part on "the dignity of human life based on … Christianity" as well as a "doctor's duty of taking care of a patient until … death.[25] These remarks are troubling. While doctors are bound by the professional duties of beneficence and non-maleficence nothing but a misunderstanding of these principles can justify the view that doctors have a duty to keep their patients alive at all costs, which is what the statement made by the hospital president seems to imply. Second, Park Chang-Il's remarks also suggest that religious convictions are playing a role in this case. This is a point that is in need of further clarification and elaboration, as it has significant implications for the practice of medicine and medical ethics in Korea. Furthermore, the president of Severance Hospital said that while he was aware of the necessity of introducing passive euthanasia, "life is not something to be taken for practical reasons" and that the purpose of the hospital's appeal is to "warn against the prevailing social atmosphere that takes life too lightly."[26] However, the reasons for allowing passive euthanasia, whether voluntary or non-voluntary, are not merely practical, but also principled. And it is both misleading and misguided to suggest that those who argue for the legalization of passive euthanasia in Korea simply fail to take life seriously enough. As the foregoing discussion indicates, the issue has little to do with the seriousness with which one regards life, and everything to do with a proper understanding and application of the principles of medical ethics.

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[25] Korea Times. Top court to rule on death with dignity [on the Internet]. February 24, 2009. http://www.koreatimes.co.kr/www/news/nation/2009/02/117_40173.html. Accessed March 10, 2009.

[26] Korea Times. Top court to rule on death with dignity [on the Internet]. February 24, 2009.

5. Conclusion

I began this paper by describing the legal and ethical consensus that exists in North America and elsewhere concerning the discontinuation of life-sustaining medical treatment. Hebert notes that there have been virtually no malpractice actions related to stopping life-sustaining treatment in the US and that the courts invariably find that the laws related to suicide or homicide do not apply to such treatment decisions when they are made in good faith.27) In support of this point, he cites Glantz, who writes that “Almost everything else physicians do (or do not do) puts them at greater risk of legal liability than withdrawing or withholding treatment in appropriate cases.”28)

Up until the present, this has certainly not been true for physicians working in South Korea. But the situation appears to be changing The judicial decisions made in the recent trials over the fate of Ms. Kim are positive developments insofar as they have affirmed the legal right of patients to refuse life-sustaining medical treatment in certain circumstances. The courts’ affirmation of this right will surely help to clarify some of the legal and ethical ambiguity that exists in Korea concerning the termination of life-sustaining treatment.

At the same time, there is room for improvement on the judicial decisions made in the case of Ms. Kim and a long way to go to achieve the level of understanding and consensus that exists on the issue in many other countries. Particularly problematic is the courts’ decision not to recognize a right of Ms. Kim’s family members - including one who was allegedly appointed by the patient to serve as her surrogate decision maker - to make decisions on her behalf. To its credit, the Seoul High Court seems to be aware of the problems with this decision, which is why it emphasized the need for a law concerning a person’s right to die with dignity. What is needed, in the first instance, is something akin to the US Patient Self-Determination Act of 1990, which requires health care providers in the US to counsel patients on the use of living wills, advanced directives, and powers of attorney to consent to medical care. Beyond this, there is also a need for a law specifying the conditions under which family members or others can serve as surrogate decision-makers for incompetent patients in making decisions concerning the termination of life-sustaining treatment. If patients in Korea were encouraged to make advance directives or appoint surrogate decision-makers upon admission to hospitals, and if such documents and decisions were regarded as legally valid,

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27) Hebert P. 1996 : 175.

28) Quoted in Snider G. Withholding and withdrawing life-sustaining therapy. *Am J Respir Care Med* 1995 ; 151 : 279.

costly and unfortunate incidents such as the one Ms. Kim and her family have recently undergone would simply not arise.

Finally, the legislation that is needed in Korea concerning an incompetent patient's right to refuse life-sustaining medical treatment should be crafted in such a way as to maximize consistency between relevant policies at different hospitals. And insofar as the law allows for variation between policies, hospitals in Korea should be compelled to make explicit their own internal guidelines or policies on the discontinuation of life-sustaining treatment and to make patients aware of these policies upon admission. This is especially true in Korea, where the religious convictions of individual doctors or institutions can play an important but obscured role in the decisions they take regarding requests to terminate life-sustaining treatment. ME

Keywords:
Passive euthanasia, Voluntary euthanasia, Non-voluntary euthanasia, Advanced directives, Durable power of attorney, South Korea

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The Right to Refuse Life-Sustaining Medical Treatment in South Korea: The Case of Ms. Kim

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Abstract

In North America and elsewhere there exists a legal and ethical consensus concerning the right of patients to refuse life-sustaining treatment and the right of families or other proxies to make such decisions for patients who are themselves unable to do so. This consensus emerged gradually and through several landmark legal rulings, such as those made in the cases of Karen Ann Quinlan and Nancy Cruzan. In South Korea, on the other hand, there is no consensus on the rights of families to make decisions concerning the refusal of life-sustaining treatment on behalf of incompetent patients and, until recently, there was no legal recognition of a patient's right to refuse life-sustaining treatment. However, the situation in Korea seems to be changing with the recent court rulings in the case of Ms. Kim, a case which may do for medical practice in Korea what the case of Karen Ann Quinlan did for the practice of medicine in the US. This paper makes a contribution to the much-needed consensus-building process in Korea by reviewing some of the landmarks cases in the international right-to-die movement, identifying the key legal and ethical lessons from those cases, and then applying those lessons to the case of Ms. Kim in order to evaluate the decisions that have been made in her case so far and to make further recommendations on what else needs to be done.

keywords

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