

## Role of Hospital Ethics Committee on the Consultation of Near the End-of-Life Care in a Korean University Hospital

KOH Youn-Suk\*, KANG Jeong-Min\*\*, John D. Armstrong ||\*\*\*

Together with medical advances over a broad area of diseases, patients have also developed improved skills in managing incurable illnesses. However, maintaining patients on life sustaining therapy has increasingly raised ethical dilemmas regarding end-of-life care and quality-of-life assessments by the patient's family and medical caregivers.<sup>1,2)</sup> A discrepancy between the patient's family and caregiver's views regarding the value of life-sustaining treatment, provided to a critically ill patient, occasionally creates a serious dispute. This is particularly true when family and caregivers depend upon personal values to determine the meaning of therapy for the critically ill patient. This sort of dispute may be very difficult to resolve in

terms of medical ethical principles. Moreover, the discrepancy of perception between family and caregiver regarding the value of therapy may be further widened if the family faces financial difficulty with the expense of providing such therapy. A well-functioned hospital ethics committee(HEC) can make an important contribution to resolving these ethical dilemmas that are experienced by a patient's family and medical personnel. In fact, ethics consultations were useful in resolving conflicts that may have prolonged non-beneficial or unwanted treatments in the ICU.<sup>3)</sup> An interest in creating a HEC in Korea is heightened after so called the Boramae Hospital case in 1997. In this case, physicians, who unable to

\* Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, Asan Medical Center

\*\* University of Ulsan College of Medicine, Seoul, Korea

\*\*\* Department of Radiology, University of Colorado Health Sciences Center, CO., USA

Correspondence: Dr. Youn-Suck KOH, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, Asan Medical Center, 388-1, Pungnap-dong, Songpa-gu, Seoul 138-736, Korea. 82-2-3010-3134. yskoh@amc.seoul.kr

- 1) Koh Y. Residents' preparation for and ability to manage ethical conflicts in Korean residency programs, *Academic Medicine* 2001 ; 76(3) : 297-300
- 2) Anonymous, Medical futility in end-of-life care: report of the Council on Ethical and Judicial Affairs.[see comment]. *Jama* 1999 ; 281(10) : 937-41
- 3) Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial.[see comment]. *Jama* 2003 ; 290(9) : 1166-72

persuade the patient's wife to keep required therapies, were charged and found guilty for discharging to home a postoperative patient after discontinuing life-sustained therapy. Prior to this case, physicians have been to withdraw life-sustaining therapy with the consent of the patient's delegate in Korea. Since the verdict in this case, physicians are understandably reluctant to withdraw life-sustaining therapy from a critically ill patient, and the likelihood of conflict between the patient's family and physicians has increased. Although the number of HECs has increased in Korean hospitals since the 1997 case, the activity of HECs has been disappointingly small even at university hospitals.<sup>4)</sup> Moreover, advance directives, including do-not-resuscitate orders, are not well accepted to critically ill patients in Korea.

Asan Medical Center's HEC has been functioning well since it was organized on 1992. We retrospectively reviewed treatment withdrawal requests to the Asan Medical Center's HEC from January 1998 to December 2003. Asan Medical Center, a 2,205 bed university hospital, has 178 intensive care beds divided into 8 different units including a 40 bed neonatal intensive care unit(NICU). The HEC is composed of fourteen persons; nine clinical specialists including psychiatry and neurology, two hospital administration workers, a medical ethics professor, a nurse, and a lawyer. The HEC received twenty-

seven consultation requests during the period. The case request rate was 0.05% based on the number of ICU patients during the period. Considering that care-providers frequently experience a dilemma regarding a decision to continue or withhold/withdraw treatment from a critically ill patient, the usual method for resolving ethical conflicts in our hospital seems to depend on personal discussions between physicians and patients and/or their families or clinical colleagues. That is, the ethical decision-making process has been largely dependent on a physician's personal values, attitudes, and behaviors.<sup>5)</sup> End-of-life questions are mostly resolved in the private sphere within legal bounds in western countries too.<sup>6)</sup> The main barriers to having an active and consistent HEC include time shortages of the members and inadequate knowledge of medical law or medical ethics in addition to physicians' suspicion about the HEC's role. Physicians' ignorance or insensitivity to relevant ethical precedent regarding discontinuation of life sustaining therapy might be another barrier to the HEC's activity.

Age distribution was bimodal: thirteen(48%) were newborns less than 1 month old; six(22%) were infants(more than 1 month and less than 1 year old); one(4%) was an adult under 60 years of age; seven(26%) were adults over 60 years. All requests to the attending physician for withdrawal of treatment came from a patient's family.

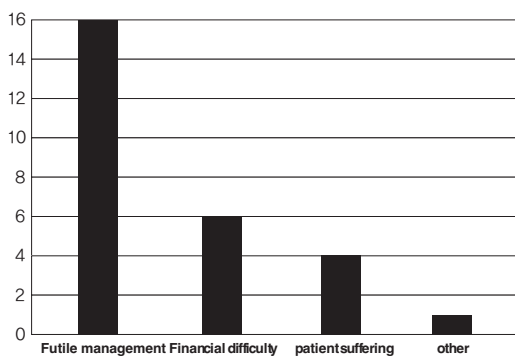
4) Koh Y, Meng KG, Koo YM, Sohn M, Hwang SI, Hong CD. Hospital ethics committee in Korea. *Medicine, Ethics, Education* 1999 ; 7 : 63-78

5) Koh Y, Koo YM, Min Wk, Kim YS, Lee JD, Han OS. A survey for Professors' opinions of medical ethics subjects in Korean University Hospitals located in Seoul and Gyeonggi Province. *Medicine, Ethics, Education* 2004 ; 7(2) : 130-140

6) Bloche MG. Managing conflict at the end of life. *New England Journal of Medicine* 2005 ; 352(23) : 2371-3

Attending physicians, unable to persuade the family to continue life-sustaining therapies or who desired HEC concurrence before the final decision, requested HEC consultation in all cases. Treatment withdrawal was requested under three circumstances(Figure 1): “futile” or non-beneficial

Fig 1. The major reason of treatment withdrawal request



treatment in sixteen cases(59.3%); family financial difficulty with continuation of non-beneficial treatment in six cases(22.2%);and inability to ameliorate patient suffering in 4 cases(14.8%). When all reasons for family requests to discontinue treatment are included: twenty cases(74%) cited “futile” or non-beneficial treatment; fifteen cases(55%) related to family financial difficulty; six cases(22.2%) involved anticipated difficulty with post-discharge care of patients in poor health; four cases(14.8%) involved substituted judgment that the patient would not want continued treatment; and two cases(7.4%) involved unacceptable quality of life assessment.

Overall, the HEC recommended continuation of treatment in 7 cases(25.9%); treatment withdrawal in 11 cases(40.7%); withholding new treatment in 8 cases(29.6%); and transfer to another hospital in 1 case(3.8%)<Table 1>. The HEC was unanimous in its recommendation in twenty-one cases(77%) and

<Table 1> Recommendation of the Committee and Compliance of Patients for the Cases

Recommendation of committee	Treatment withdrawal	Treatment withhold	Continuation of treatment
Acceptance of recommendation	11	7	3
Refusal of recommendation	0	1	4
Compliance	100%	87.5%	42.9%*

\*The compliance for the decision of continuation of treatment is significantly lower than the other decision (p value < 0.05)

required a majority vote to reach a decision in six cases(23%). Family requests for HEC recommendation were accepted by family in 22 cases(81.5%) and rejected in five cases(18.5%). Regarding the authority of the committee, our HEC has been purely consultative, rather than prescriptive, and recommendations are not binding.<sup>7)</sup> The committee’s recommendations to continue the life-sustaining therapy were not well accepted by patients’ families. In fact, of seven recommendations to continue life-sustaining treatment, only three accepted the recommendation. In the remaining four cases, when family refused the HEC recommendation for

7) Rosner F. Hospital medical ethics committees: a review of their development. JAMA 1985 ; 253(18) : 2693-7

continued life support, the patients died in the ICU. These data reinforce the observation that patients and surrogate family have the right to refuse any and all treatment in Korea, including life-sustaining therapy, despite a physician's claim to the contrary and regardless of support by the HEC. One of the most important roles for the HEC is to facilitate communication between patient surrogate and the patient's caregivers and to help establish realistic goals for treatment. The HEC helps to inform patient surrogates about the availability of resources to provide their patient with the best possible future.<sup>8,9)</sup>

In our requests, a conflict regarding the value of intensive therapy provided for a patient was resolved after a HEC meeting where the patient's family was able to fully ask questions of the attending physician and a common understanding evolved. The discrepancy of perception regarding the value of intensive therapy may be further widened if the family faces financial difficulty with the expense of providing such therapy. Requests for treatment withdrawal were associated with family financial difficulty in 55% of our cases. Almost all of patients have medical insurance in Korea. However, the insurance usually covers about 60-70% of total medical expense in ICU patients. Because there is no other practical way to support the financial problem of patients' families in our society, this circumstance places an undue burden on the patient, the family and the physician. The burden facing the physician is the experience of a

withdrawal of life-sustaining treatment from such a patient in Korea.<sup>1)</sup> Moreover, this situation becomes untenable because of the precedent created by the Boramae Hospital ruling of 1997. A family is coerced, by necessity of financial ruin, to request withdrawal of life-sustaining treatment. The physician may be coerced, by fear of litigation for premature withdrawal of such treatment, to decline the family's request; moreover, based on the precedent-setting Boramae case, the physician may be coerced to continue non-beneficial life-sustaining treatment. Neither family nor physician can easily accept this situation. Thus, conflict is heightened at a time of illness near the end-of-life and the accompanying stresses for all parties. Considering this, any guidelines for the end-of life care could not be functional without the consensus of lay publics to the guidelines.

In summary, the case referral rate to a HEC was low in our hospital. Patient families requested the HEC consultation in all cases. We experienced that the role of HEC to help resolve the ethical conflicts between care-givers and patients family will be limited without social systems to support the medical expense and nursing after discharge from the hospital for critically ill patients. Moreover, prevailing law significantly constrains the ethical decision-making process for patients, families and caregivers. **ME**

**key words** : Hospital Ethic Committee, End-of-Life Care.

8) La Puma J, Toulmin SE. Ethics consultants and ethics committees. *Archives of Internal Medicine* 1989 ; 149(5) : 1109-12

9) Sexson WR, Thigpen J. Organization and function of a hospital ethics committee. *Clinics in Perinatology* 1996 ; 23(3) : 429-36

## 연명치료 중단 자문에 대한 대학병원 의료윤리위원회의 역할

고 윤 석\*, 강 정 민\*\*, John D. Armstrong II\*\*\*

최근의 집중치료의 발전은 치유는 되지 않은 채 사망에 이르는 시간만 연장시키는 경우들을 초래하여 연명치료의 지속여부와 관련한 윤리적 갈등을 야기하고 있다. 의료인들은 흔히 의료윤리 문제를 개개인의 의료윤리 지식이나 가치관 혹은 동료의사의 의견을 참고하여 해결하여 왔으나 사회는 의료인들이 보다 전문적이고 체계적으로 의료윤리 문제들에 접근 할 것을 요구하고 있다. 연명치료의 중단과 관련된 의료윤리 문제의 해결에 병원윤리위원회가 중요한 역할을 수행할 수 있으나 국내의 현실은 그렇지 않은 것으로 추정된다. 이에 한 병원윤리위원회에서 연명치료 중단에 연관된 윤리 문제를 다룬 경험을 통하여 국내 병원윤리위원회와 연관된 문제점들을 고찰하고자 한다.

**색인어** : 병원윤리위원회, 연명치료 중단

---

\* 서울아산병원 내과

\*\* 울산대학교 의과대학

\*\*\* Department of Radiology, University of Colorado Health Sciences Center, USA

교신저자 : 고윤석, 서울아산병원 내과, 02-3010-3134, yskoh@amc.seoul.kr