Korean Experience of Withholding and Withdrawing of Life-Sustaining Therapy in Intensive Care Units

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ARTICLES

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Introduction

Patients should be treated with dignity and respect at the end of their lives, and unnecessary and painful life-sustaining therapy (LST) should be avoided. A painful end-of life (EOL) experience of a loved one remains in the memories of the relatives. Family members of critically ill patients often ask physicians about withholding or withdrawing (WH/WD) of LST. Open communication of physicians and patients or their surrogates could allow physicians to develop plans for better EOL care. In the present report, we describe the current status of WH/WD of LST in intensive care units (ICUs) in Korea.

Withholding (WH) and Withdrawing (WD) of Life-Sustaining Therapy (LST) in Korea: Past and Present

The Korean medical society did not have much attention to advance care planning for EOL care until recently. EOL care should be individualised based on socially agreed-upon guidelines that meet a patient's and family's wishes about LST. Physicians should identify, document, and respect patients' needs, priorities, and preferences for EOL care. However, there is no generally accepted consensus regarding EOL care decision-making in Korean society at large, or even the Korean medical community.

EOL care has been dependent on a physician's individual perceptions and preferences. In 2007, a questionnaire survey (Kim, Kang, Koh, and Koh 2009) of 100 members of the Korean Society of Critical Care Medicine evaluated

the attitudes and practices of critical care physicians in Korean ICUs regarding EOL care decisions. There were 88 responses from individuals in 53 different institutions. The results indicated significant differences between perceptions and actual practices regarding WH/WD of LST. Attitudes and practices varied according to the respondents' clinical experience years of service as a critical care professional, and medical specialty. Physicians with relatively short careers as critical care specialists tended not to agree to the WH/WD of LST. However, even among young physicians, there was a discrepancy between their attitudes and actual practices depending on the consent of patients and families, or the competence of patients, and the request for a surrogate. That reflected the current level of perception of Korean critical care physicians on the WH/WD of LST. These results suggest a need to provide consensus guidelines and continued medical education on LST for Korean physicians and healthcare workers in ICUs.

Among all EOL decision-making processes, a do-not-resuscitate (DNR) order in the event of cardiac arrest is the most common discussion between a patient's family and physicians. A previous study (Lee, Jang, Hong, Lim, and Koh 2008) of ICU patients with DNR orders in one medical centre reported that families are accepting of DNR orders proposed by attending physicians. However, most DNR orders are not initiated by clinicians till a patient's death is imminent.

The above study (Kim *et al.* 2009) reported that 75% of respondents considered that more than three discussions were needed to communicate with patients or families about the WH/WD of LST. However, only 60.8% of all respondents actually had three or more discussions on this topic. Regarding informed consent, 89.7% of ICU physicians endorsed the need for Advance Directives (AD). However, this policy is not yet institutionalised in most Korean ICUs. A total of 93.8% of respondents recognised the need for ethics committees and a multidisciplinary team approach to resolve the decisions regarding EOL decisions, and 96.6% agreed on the need for standardised guidelines.

There are recent movements to establish a "death with dignity act" in the Korean National Congress, following a legal case (*2009Da17417 Decided*, May 2009) by the family of a patient in a persistent vegetative state which requested withdrawal of mechanical ventilator support. A set of consensus guidelines (published in 13 October 2009) prepared by a task force team for withdrawal of LST has been endorsed by the Korean Medical Association, the Korean Academy of Medical Science, and the Korean Hospital Association.

However, in our own survey on the 2009 consensus guidelines regarding the WH/WD of LST, 26 respondents of 81 Korean critical care physicians

were unaware of the existence of these guidelines and 68% said that they had difficulties in applying that in ICUs (unpublished data).

Consultation for WH/WD of LST: A University Hospital Ethics Committee's Experience

An ethics committee's main role is an advisory service. In Korea, the hospital ethics committee's suggestion has been considered as a review process to examine the appropriateness of EOL decisions. It has been recommended by the Supreme Court to undergo a review process by the hospital ethics committee when there is a dispute or uncertainty about the EOL decision.

Almost all university hospitals in Korea have a hospital ethics committee (HEC) to handle ethics problems and mediate conflicts between patients and caregivers, or doctors after the "Boramae-hospital" incident in 1997, in which the attending physician was found guilty of allowing the discharge of a post-operative neuro-trauma patient following the patient's wife's request.

However, not all hospitals have active HECs. According to a mail survey (Koh *et al.* 1999) of the chairs of 76 major residents training hospitals in Korea, HECs were present in 48 of 58 responding hospitals, but only five HECs have had meetings more than once per month. Consultation with HECs is infrequent in Korea. A previous Korean study (Kang and Koh 2005) reported that from January 1998 to December 2003, only 27 cases for the discontinuation of patient care were referred to the HEC of a university hospital that had 2,200 patient beds. Based on the number of admitted ICU patients during the study period, the case request rate was 0.05%. The 27 cases referred to the HECs included 13 neonates (48%), six infants (22%), and eight adults (30%). The major causes of treatment withdrawal were futile management, financial difficulty, and patient suffering. The HEC recommended the continuation of treatment in seven cases (25.9%), treatment withdrawal in 11 cases (40.7%), treatment withholding in eight cases (29.6%), and transfer to another hospital in one case (3.8%). For the seven cases recommended for treatment continuation, only three of these decisions were accepted by the families, and these three patients were eventually discharged. For the 11 cases recommended for treatment withdrawal, treatment was withdrawn within one week in all 11 cases. For the eight cases recommended for treatment withholding, treatment was withheld in seven cases. In another questionnaire survey (Koh 2001) given to 2,000 resident physicians which had a 47% response rate, it indicated that 96.3% of respondents had an experience of discontinuing LST for a patient due to financial difficulties in meeting medical expenses. When faced with a family's insistence on the withdrawal of LST in a critically ill patient, 71.2%

of respondents accepted the family's request. Only two of 905 respondents had consulted the HEC in making decisions about EOL care. Thus, we consider that developing functioning hospital ethics committees in general hospitals is the key step for making the best EOL care decisions in Korea.

Differences in the WH/WD of LST between Korea and Other Countries

Since a decade before, Western countries have advocated that competent patients express the right of self-determination on EOL care through AD, tools that express patient's autonomy and facilitate EOL care based on a patient's best benefit.

However, there are currently barriers in adopting AD in Korean society, and even discussion of EOL care with critically ill patients is often considered taboo. Korea has been influenced by unique Asian culture and Confucianism for a long time; hence, patients are not treated as individuals but as a member of the family. The previously mentioned questionnaire survey (Koh 2001) of resident physicians reported that most residents were uncomfortable disclosing "bad news" directly to patients, and only 4.8% of residents reported routine disclosure of truthful information directly to patients. This survey also found that disclosure of information by residents to patients was guided by attending physicians (33.7%) or performed by request of surrogates (49.9%). Korean reports indicate that patients with a terminal illness would not be involved in the decision-making process for a DNR order (Heo 2009). In addition, the Korean healthcare system has incomplete legal support regarding the WH/WD of LST, and Korean physicians seek to avoid unnecessary disputes or legal troubles with the patient's family.

Among Asian countries, the Medical Law in Taiwan permits natural death, and the new law entitled Hospice Palliative Act was passed on 23 May 2000. The DNR order gained its legal basis for medical practice (Chao 2002). Taiwan has actively encouraged people to get AD. In traditional Asian family-centred decision-making, the Taiwan family makes important medical decisions. A recent study in Taiwan showed that their preferences for EOL care and attitudes towards executing AD varied depending on the knowledge of the Hospice-Palliative Care Act (Yang, Chiu, Hsiung, and Hu 2011).

The AD is not prevalent enough in Japan. Under such a situation, they have confessed it is difficult to do WH/WD of LST (Minooka 2008). Several types of the proposal for terminal care have been published by the Medical Association and Ministry of Health, but there are no acts and, specific provisions or official guidelines on "death with dignity" in Japanese law. Recently, the issues are seriously discussed in Japan (Aruga 2011; Kai 2010).

In Korea, the first step needed to promote patient autonomy would be to engage the patient in an open, respectful, and compassionate discussion providing full disclosure of the truth. One report (Yun *et al.* 2004) of the attitudes of cancer patients indicated that 78.3% of patients thought that the doctor in charge should openly inform the patient of his or her condition and possible need for AD for the WH/WD of LST. Second, our society including medical and legal communities needs to accept the need for the EOL decision-making process as the principle of medical ethics. Finally, physicians who best understand the treatments delivered to a terminally ill patient should play a central role in delegating decisions of EOL care, as suggested by the 2009 consensus guidelines.

Conclusion

There has been increasing attention given to the need for AD for the WH/WD of LST. This is becoming an increasingly important issue for individuals, health professionals, legal experts, and policymakers in Korea. However, Korean physicians do not seem well prepared to perform advance care planning of EOL.

Korean physicians should follow the 2009 consensus guidelines for LST in their ICUs to keep a patient's beneficence and enhance a patient's autonomy. Moreover, concerted actions to improve EOL care by education of the general public, medical professionals, others involved in EOL care, and governmental organisations are needed to address this ongoing social need.

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