a New Law for Palliative Care & LST in Korea

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Milestone Case (1)

• Boramae Hospital case
  – 58/M, Chronic alcoholics (1997)
  – Extensive SDH & EDH
  – Wife appeared later wanted DAMA
  – w/ DIC pattern, Discharge allowed
  – Surgeon; guilty for assistance of homicide (2004)
  – “Discontinuation of ventilator = Homicide”
Milestone Case (2)

• Severance Hospital case
  – 77/F, PVS after bronchoscopy (2008)
  – Pt’s family sued hospital for “forgoing the ventilator” on her presumed intention
  – Supreme Court admitted 2009
  – Survived 201 days after the judgement
  – Judicial precedent, guideline, law,,,,
KMA

- Korean Medical Association issued Guideline for Withdrawing of LST (Oct. 2009)
NBC* recommendations

• Medical condition
  – Irreversible, not responsive to active treatment & Imminent death

• Patient’s will
  – Clear intention of the competent
  – Presumed patient’s will
  – Best interests

* (Presidential) National Bioethics Committee
Medical Conditions

- Irreversible
- Not responsive to Active Treatment
- Imminent death
  - Excluded ALS and PVS
# Patient’s Will

<table>
<thead>
<tr>
<th>To Prove</th>
<th>Clear</th>
<th>Presumed</th>
<th>Best Interests</th>
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</thead>
<tbody>
<tr>
<td><strong>Clear</strong></td>
<td>● LST plan (like POLST)</td>
<td>● Previous AD (Advance Directives)</td>
<td>● Parents, Proxy, etc.</td>
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<td>● AD acknowledged by physicians</td>
<td>● Statements of 2 family members</td>
<td>● All family members</td>
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# Patient’s Will

<table>
<thead>
<tr>
<th>LST Plan (POLST)</th>
<th>Advance Directive</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>Registry Agencies for AD</td>
</tr>
<tr>
<td>Patient + Attending physician</td>
<td>Healthy person</td>
</tr>
<tr>
<td>Adult or Minor w/ legal representative</td>
<td>Adult</td>
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<tr>
<td>Adult Guardian is not approved</td>
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<tr>
<td>Digital registration to National Agency</td>
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<td>for LST</td>
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</table>
LST that could be discontinued

- CPR, Anti-cancer Chemotherapy, Hemodialysis, Mechanical Ventilator

- Not ordinary ones, e.g. pain-relief, or supply of nutrition, simple oxygen supply, hydration, etc.
Practical Process

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<tr>
<th>Healthy</th>
<th>Terminal</th>
<th>Dying</th>
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<tbody>
<tr>
<td>LST plan</td>
<td>LST plan</td>
<td>Forgo LST</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>Advance Directives</td>
<td>yes</td>
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<tr>
<td>Statements of family</td>
<td>yes</td>
<td></td>
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<tr>
<td>All family or Legal representative</td>
<td>yes</td>
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</table>

- Healthy: Advance Directives
- Terminal: LST plan
- Dying: LST plan, yes, yes, yes, no, no, yes, yes
Governance for LST

- Min. of Health and Welfare (Div. of Bioethics Policy)
National Committee for Hospice-Palliative Care and LST

- Major Role: Master plans (every 5 years) & implementation plans (every 1 years).
- Chairperson: Vice-Minister of Health and Welfare.
- 15 committee members
National Agency for the Management of LST

• Database for LST plans and Advance Directives
• Supervision of the registry agencies for AD
• Response to the request for LST plans and AD
• Research & Education
Hospice-Palliative Care

• Terminal Patient w/
  – Cancer, AIDS, COPD, Liver Cirrhosis and
  – Diseases that MoHW designated.

• Types of Palliative care
  – Admission, Home-visit, Consultation (PC team)
Governance for Palliative Care

• Min. of Health and Welfare (Div. of Disease Policy)
Dying is a Human and Communal Experience, Not a Medical Event.