

Biomedical Ethics Policy in Korea: Characteristics and Historical Development

Ki-Hyun Hahm¹ and Ilhak Lee²

¹Department of Medical Humanities Et Social Medicine, Ajou University School of Medicine, Suwon; ²Department of Medical Law and Ethics, Asian Institute for Bioethics and Health Law, Yonsei University College of Medicine, Seoul, Korea

Received: 16 June 2011

Accepted: 2 January 2012

Address for Correspondence:

Ilhak Lee, MD

Department of Medical Law and Ethics, Asian Institute for Bioethics and Health Law, #408 Administration B/D Yonsei University Health System, 50 Yonsei-ro, Seodaemun-gu, Seoul 120-752, Korea
Tel: +82.2-2228-2671, Fax: +82.2-2227-7728
E-mail: arete2@yuhs.ac

Ethical consideration is an inseparable part of policy-making in modern society. Biomedical ethics is an interdisciplinary study of ethical issues that result from advances in medical practices and research. Because these issues often arise at the bedside, society must provide solutions or judgments that are effective and applicable. Thus, the development and progress of biomedical ethics has been made possible via the cooperation of experts from diverse backgrounds. The biomedical ethics discourse should not be seen as a conflict between values but as a collective activity for problem-solving. To support this perspective on ethics discourse, a historical perspective on biomedical ethics in Korea was given emphasis on the participants and their perspectives. Major cases and the changes resulting therefrom were discussed with the agenda proposed. The Korean situation with respect to ethics development shows the interactions between groups participating in policy development and its collaborative nature.

Key Words: Biomedical Ethics; Medical Ethics; Korea; Policy

INTRODUCTION

Ethical consideration is an inseparable part of policy-making in modern society. What is ethics and how do ethical considerations affect decision-making? The Korean situation with respect to ethics development shows the interactions between groups participating in policy development and its collaborative nature.

Biomedical ethics (or bioethics and medical ethics) is an interdisciplinary study of the ethical issues that result from advances in medical practices and research. Its interdisciplinary character comes from the very fact that these issues are not only new to society but also radical and controversial. And because the issues actually arise at the bedside, society must provide solutions or judgments that are effective and applicable. Thus, the development and progress of biomedical ethics has been made possible via the cooperation of experts from diverse backgrounds, such as medicine, bioscience, ethics, theology, legal studies, and public policy.

This article will discuss the historical development of Korean biomedical ethics with current participants in biomedical ethics discourse and their perspectives, as well as the major cases and the changes they brought about in social and policy. This historical perspective will show that biomedical ethics is an interdisciplinary study that calls for more active participation and interest from the medical professional as well as other related fields of study.

DEVELOPMENT OF KOREAN BIOMEDICAL ETHICS: HISTORICAL PERSPECTIVES

Scope of biomedical ethics discourse

The work of biomedical ethics is focused on these goals: first to provide priority or process for deliberation in healthcare policy-making, and second to set up a standard of legitimate expectations for professional behavior by identifying basic attitudes and competence. But biomedical ethics is not a single discipline. The term "biomedical ethics" itself is a coinage of "bioethics" and "medical ethics". The subjects and methodologies in bioethics and medical ethics are usually the same, but the scope and goals are not identical. Medical ethics, more specifically, takes the role of providing ideals and standards of behaviors and attitudes to medical professional while protecting professional autonomy from societal intervention (1-3). Bioethics is mainly non-professional engagement in issues of medicine and medical research for the protection of human participants and society's values (4). This distinction is essential from the start to have a better understanding of the current discussion concerning biomedical ethics.

Ethics tradition of Korean medical professionals: ideals & education

The medical professional has a long tradition of ethics in Korea. Traditional Korean doctors of the Chosun dynasty (14c-19c) were under the influence of Confucianism, which emphasized social

positions and the mutual responsibilities of each person. The responsibilities of Confucian physicians can be found in *Ui-Bang-Yu-Chui* (醫方類聚; A Collection of Medical Procedures), which identified a physician's duty to treat sickness, to act in the patient's best interest, to promote philanthropy, and to refrain from undue financial gain. Although Korea's traditional biomedical ethics can be traced back at least to the 15th century, its scope and interests had been confined to the etiquette of physicians (5). Biomedical ethics was understood as a way of becoming a good doctor and taught to students of medicine in a form of ethical declaration.

But the sustainable development of medical ethics was interrupted by the Japanese occupation (1910-1945) (6). Medical professionals were urged to take a role of medical police to maintain surveillance of Koreans (7). Korea's medical professionals, including the Korean Medical Association (KMA), struggled to restore the ethics tradition, but the result was not much to speak of. However, it is noteworthy that the importance of ethics was reiterated through several attempts to introduce ethics into medical education. In 1964, the Geneva Declaration of the World Medical Association was translated and adopted among medical schools. In the early 1980s, the works of bioethics were introduced to Korean academia, and medical schools adopted ethics into their curricula (8).

The KMA developed the Doctor's Code of Ethics, which was revised in 1961, 1965, 1979, 1997, and 2006. Through these revisions, biomedical ethics remained a matter for the physician, not of public concern. As the application of the Code was compelled by the authoritative regime during the 1960s and 1970s and related to the introduction of the National Health Insurance system in 1977, the social implications of medical practice became recognized among medical professionals.

Bioethics activists in Korea

There is bioethics activism on the other side of medical ethics. This organized bioethics activism came to exist in the 1990s and concerned the abortion and end-of-life care issues (9). Activists expressed concerns from conservative perspectives on several health policies and demanded revision of legislation and, as a result, integrated biomedical ethics into healthcare policy. Interestingly, many Korean bioethics academics held conservative perspectives on these issues, while researchers and medical practitioners represented the liberal position.

Participants and their relationship in biomedical ethics discourse

Medical professionals, researchers and engineers, biotechnology entrepreneurs, bioethicists, and policy makers are possible participants in a biomedical ethics discourse. They are connected in various ways: monitor and review each other, regulate and control, mediate or co-work on certain issues. The modes can

be passive and defensive or active and dominant. The major concerns for joining the bioethics discourse are preserving the identity of the groups, or realization of ideals shared among its members, sometimes promoting the interests.

Biomedical ethics as a collective activity

If we consider these two major participants of biomedical ethics, it seems persuasive that deliberations and building consensus are in conflict or negotiation between professionals and society, and regulators. This view could be named as "biopolitics", not "bioethics" (10). However, bioethics should be viewed as a collective activity between diverse perspectives to solve problems brought about during the struggle to improve human conditions by maintaining health and curing disease. Mistakes, understanding and rectifying previous errors, are ways to progress (11). This is a pragmatic understanding of bioethics and will enable us to better open discussion. How does collective activity in bioethics work? In the field of bioethics, if there happens to be an ethically controversial case, this case pushes ethical questions to the fore, and public interest works as a launching place for academic interests. After this issuing of a case, there follow professional responses that could be influenced by the decision made on that case: they appeal to the authority of traditional ethics or meaning and imperatives of their professional values. The initial responses from professionals and their arguments and reasons become the subject of academic interests for further development of argument. After this social discussion, or collective activity, a resolution finally is derived in a form of court decision or legislation (12). By this collective activity, society can arrive at a better position for its members to live their life in its fullest sense. The cases of ethical disputes are not, in this sense, matters of conflict but chances for healthcare systems to embrace the values of society in general and to reflect on inconsistency in framing and solving health problems. Now that we can say that ethics is integral to health policy, then policy makers and biomedical ethics expert should develop a mechanism to specify and reflect the ethical discourse into practice: systematic and cultural transformations and legislations are possible answers.

Healthcare policy and bioethics policy

Even a very short reflection on the history of healthcare policy identifies numerous policies charged with ethical debates. But not until the 1990s, when organ transplantation and defining brain death became social issues, did ethics become a major concern for policy developers. Biomedical ethics became reference points and then targets of policy in itself. For example, ethical principles (such as respect for autonomy) are expressed in the Framework Act on Health and Medical Services, and the government established public bodies like the Korean Network for Organ Sharing (KONOS) for ethical deliberations concerning the allocation of solid organs (13).

Events that shaped the field of biomedical ethics

Biomedical ethics in Korea developed through major cases with deep social implications that led discourse. The following are cases that contributed to the development of the current biomedical ethics framework in Korea.

Legislation of mother and child health act and anti-abortion campaign

Mother and Child Health Act of 1973 contained provisions that identified legal conditions for pregnancy termination (i.e. abortion), which had been provided as a part of family planning services by the public health sector. There rarely was any public debate about the legitimacy of such legislation, but the acts ordered mandatory sterilization and abortion for eugenic purposes. The act was revised to eliminate eugenic provisions, but the conditions for legitimate abortion remain with few changes. As a response to this legitimization of abortion, anti-abortion groups (mainly religious groups) formed organizations to protest against the law, lobbying for banning almost every abortion and strict criminal punishments for illegal abortion (14). The major target for pro-life activists was not public awareness but rather strict enforcement. Meanwhile, the voices for women's rights on self-determination and reproduction were relatively small, but obstetricians kept their understanding of abortion as a way to promote women's health, and the government was loose in enforcement.

But the policy on population turned around in 2000's, mainly due to rapid progression into an aging society, and the government changed its attitude toward abortion. A governmental task force was formed to provide recommendations for preventing abortion. In 2009, the so-called "pro-life doctor" group implemented a campaign against the government's population policy and asked for strict punishments for abortion doctors (15). It was sensational for several reasons: professional groups became voluntarily engaged in public debate, and they asked for punishment on their colleagues.

The abortion debate exemplifies the characteristic of Korean biomedical ethics discourse, that system such as legislation becomes target of criticism and change and that government's political decision influence further discourse. There are not many academic discussions on the permissibility of abortion; public campaigns and political activities from the conservatives are still very active.

Legislation of internal organs etc. transplant act (1999) and debate on brain death

As transplantation techniques develop and more patients can be benefited with transplants, but organ selling and resulting dehumanization is brought about. Concerns about organ black markets and unequal access to transplantation led to legislation of the transplantation act in 1999. KONOS was established by

law to ensure justice in allocation and monitoring and more rigorous monitoring for living organ donation was required on medical practices (16). At the same time, legislation was intended for legalizing organ donations from brain-dead patients, which was demanded from transplantation surgeons (17). The first brain-dead donor transplantation took place in 1979, and by the year 1998 reported cases of brain death numbered 125, but there was no legal recognition of brain death. So surgeons had to take the risk of being accused of murder when they received consent from the attorney of the brain-dead patient for organ donation because these patients were not dead legally. Because brain death was not familiar to Korean society, and there was hesitation for lessening the standard of death, introduction of the brain death concept was barely possible (18). There was adamant resistance that brain death could not be an alternative nor complementary concept for cardiac death. Legislators, who could not ignore the reality and necessity of donation from brain-dead patients, reached a compromise: brain death should be decided by strict process and standards and organ donation could be permitted only after declaration of brain death (19).

This dual recognition of brain death still remains in Korea and affects end-of-life care discourse. Because brain death does not constitute a standard of death, there exists a legal duty to care (usually life-sustaining treatment) for the brain-dead patient. When brain death is not recognized, other discussion about life-sustaining treatment is difficult, not impossible (20). If ethical discussion and medical reality could not change public attitudes on death, there may be other facts to be explored.

Boramae hospital case: medical convention not protected legally

It took more than a decade to reach an agreement on foregoing life-sustaining treatment. There had been a convention of discharging a patient with expectation of immediate death (so-called hopeless discharge) before the criminal case of Boramae Hospital (21). On December 4, 1997, a 58-yr-old-man fell on the floor at his house in a drunken state resulting in a massive intracranial hemorrhage requiring surgery followed by intensive care unit administration. The patient's wife learned from medical staff that the hematoma was removed through surgery and that her husband's condition would improve. However, with power-of-attorney, she insisted that her husband be discharged, citing financial burdens. Even though medical team told her that he would die without medical staff and a respirator, she signed a note, a form called discharge against medical advice (DAMA), and took her husband. In less than 5 min after leaving the hospital, the patient died. When the authorities learned about the situation, both the wife and the hospital staff in charge were charged with homicide as joint offenders.

On June 24, 2004, the Supreme Court sentenced the doctor to 1 yr and 6 month in prison and 2 yr probation. The Court, while

acknowledging that the doctor had followed the demands of the guardian, asserted that he had permitted the patient to be discharged although he knew that he would die without a respirator (22). This judgment imposed the responsibility on the doctor. This judgment came as a shock to most Korean doctors, as decisions of a patient's family were generally accepted as an important ground for doctors in making difficult decisions regarding treatment termination (23). With this judgment, doctors were reminded of their duties to treat patients as autonomous individuals and the patients' best interest should be considered under any circumstances. This led to the publication of the medical ethics guidelines but no explicit written provisions in laws, causing confusion, which became a social issue again in 2008 (24).

This shows a lack of communication between medical professionals and society.

Separation of dispensing function for prescribing

Conflicts among doctors, pharmacists and the government regarding the separation of the dispensing function from prescribing provoked the doctors' general strike of 2000 nationwide and became a national issue that roused much conflict and interest. Beginning with a one-day strike, it went on for five rounds, in addition to the nearly 4-month-long specialists' strike.

Doctors focused on banning alternative filling of prescriptions by pharmacists. However, under the circumstances in the medical field back then, it was hardly possible and they were determined to block the implementation of the system itself.

Despite doctors' strong opposition, the government announced its stance to implement the system in September of 1998, with an exception for hospital in-patients, and passed the bill in the following year. This brought forth another strike among primary care physicians first and expanded into general strikes by doctors thereafter.

This event stemmed from the different views between the professionals' interests and the government's role over implementation of new policy. The fact that physicians, who stand conservative towards social issues, initiated a strong action like a general strike came to many people as a shock.

It still remains to be seen whether this event will be seen by society as a fair protest for the justifiable rights of doctors or as an improper exercise of power. This provided a good opportunity to debate society's values regarding medicine and the medical workers' roles. However, doctors could not receive sympathy from the public and failed to adhere to Article 8 of in the Declaration of Medical Ethics, thus bringing down the level of trust invested in them by the society.

Doctors tried to divert the source of public mistrust to the National Health Insurance System, not in the loss of professionalism among them. After 10 yr of the strike, public interruption and monitoring became more pervasive and less understanding, such as stricter enforcement of anti-kickback provisions

and introduction of license renewal (25). Ethics as a strategy to preserve professional autonomy is now facing serious mistrust from society, and other ethics is required.

WS Hwang research fraud

WS Hwang's renowned nuclear transfer stem cells (NTSC) was published in the Science. His method of NTSC was criticized that this technique could be used for human cloning, but Hwang evaded the debate by emphasizing the possible benefits from future NTSC applications. But in the year 2005, suspicions on his research practices, like his treatment of research assistants, as well as fabrications of 2004, 2005 research papers, exploded. He was found to have fabricated research results and deprived of his professor position from his university, and the aftermath of this scandal was huge (26).

Hwang's research scandal vividly reminded Korean society of the ethical nuances in scientific research, leading to establishing ethics reviewing systems. Legislation of Bioethics and Safety Act (2005) was initiated by the debate about the ethics of Hwang's research. The Korea National Bioethics Board and institutional bioethics boards are grounded on this act, and stem cell researches, human genetic research and other research using human embryo are under the regulation of this act (27).

But the most important lesson from this case was the seriousness of research integrity among Korean researchers. The Ministry of Education, for example, issued a directive that every institution benefitting from governmental R&D funds should install a body to review research integrity (28).

Severance hospital case

In February 2008, a 77-yr-old female suffered hypoxic brain damage due to severe bleeding from a pulmonary artery during a bronchoscope biopsy. Soon thereafter, she was diagnosed as persistent vegetative state (PVS) and could not breathe by herself. Her family wanted to withdraw the life-sustaining treatment (artificial ventilator) and let her die in a dignified way as she had expressed before, but medical staff argued that she could survive quite a significant period of time and that the treatment should continue. A lawsuit to stop medical treatment was instituted and the so-called severance hospital case began. The trial process was quick, and the Supreme Court ruled:

"when it is recognized that a patient who reached a state of irreversible stage of death exercise her right to self determination on the ground of constitutional rights of human dignity and right to pursue happiness, it is permissible to withdraw life-sustaining treatment" (29).

Despite the serious ethical discourse about end-of-life care following the Boramae Hospital case in 1997, mechanisms such as advance directive, durable power of attorney, and clinical ethics consultation had not been implemented properly. So, many professional bodies like the KMA and Korean Hospital

Association were quick to develop legitimate guidelines to realize the spirit of the court decision (30). A citizens' campaign for writing advance directives was launched to mobilize and revitalize preparing end-of-life care planning. Meanwhile, the medical professional's recognition or participation does not reach the expectation. There can be several reasons, but they seem to demand more secure basis for following patient's will, like exemption from liability (31). The controversies may continue before reasonable conditions or processes for withdrawing be given.

DISCUSSION AND SUGGESTIONS

Biomedical ethics is not a single way of communication. It is between conflicting perspectives of the liberal and the conservative, ethical specialists and policy makers, and even between disciplines. The communication is not to defeat the other side with political tactics, but a collective way of reaching common understanding and solutions to a problem.

Medical science and healthcare are dealing human life and health, which are the very foundation of all human activities and closely connected with values. Values are to the subject of ethical discourse, which is to bring up an applicable and reasonable solution to current ethical problems. Ethical discourse is collaborative in its nature, which means every participant contributes to generation of applicable solution. Governmental policies are developed as a result of social measure to problems and also means for society to sustain its common ground between different values. But the policies sometimes bring about another tension rather than cooperation when they are not based on sufficient communication. We can see it in the case of the abortion debate. When participants do not focus on practicable solution but repeat their own agenda, the solution would be too far to reach. We equipped, by legitimate process, the legislation about abortion but participants of the debate do not respect it. Why? The legislation is only temporary remedy without social acceptance.

Legislation or policy initiative gives effectiveness and continuation that secure the product of ethical discourse. Ethical solutions can take various forms like guidelines or position statements, but sometimes discussion itself is sufficient even without any products. Ethics works through exchanging and understanding the perspectives of other persons toward a common understanding and consensus. Legislation could be abused as a bypass to avoid social discussion and consensus. And if we become too dependent on any law, some issues placed in the blind spot of law are readily neglected.

Following will be necessary for Korean society to adjust itself to the ethical changes. First, we must make it anew the understanding that medical ethics is collaboration, not conflict. Participation, expressing of the concerns, developing common understanding, and resourceful identification of solution is key to

the collaboration. Second, the field for sustainable and productive debate/discussion should be provided. Governmental supporting for ethics research institutes needs to be increased especially to educating medical ethics experts who is knowledgeable to medicine and ethical-legal discipline. And the institutes can provide the experiences of successful debate and win-win solution. They will deepen the commitment to joint activity, but it will take time to have this kind of experiences. In the example of biomedical ethics discourse of other countries, biomedical ethics institutions are taking the role of communication linkage. For example, Singapore and United States have national bioethics committees appropriate for their culture and current problems, and while US developed independent, but institution-based ethics bodies (i.e. IRB) as basic units of ethical review, other nations such as the United Kingdom or Australia have installed public ethical review bodies. Third, in the organizational level, legally designated committees should be revitalized and efficient in its deliberation with more discretion. It needs providing the well-trained personnel who understand the interdisciplinary character of ethics, and have experiences of running a committee. Policy initiatives from government, research funding organizations and national health insurance can affect its development. Finally vigorous communication and educating the public on biomedical issues and its ethical implications is imperative, for common understanding of social and scientific fact is basis for any consensus (32).

REFERENCES

1. Jonsen AR, Toulmin S. *The abuse of casuistry: a history of moral reasoning*. Berkeley CA: University of California Press, 1987, p172.
2. Fox R. *The sociology of medicine: a participant observer's view*. Seoul: Nanam, 1994, p 120-4.
3. Kultgen J. *Ethics and Professionalsim*. Philadelphia: University of Pennsylvania Press, 1988, p 112.
4. Veatch RM. *The birth of bioethics: autobiographical reflections of a patient person*. *Camb Q Healthc Ethics* 2002; 11: 344-52.
5. Shin DW. *History of medical ethics in Korea: focused on analysis of medical codes and covenants*. *Korean J Med Hist* 2000; 9: 163-204.
6. Shin DC, Lee I. *The development of medical ethics in Korea*. *Jpn Med Assoc J* 2007; 50: 218-25.
7. Kang S. *A history and philosophy of bio-medical ethics seen from a dentist's point of view*. *Korean J Med Hist* 2002; 11: 117-36.
8. Yeo IS, Park YJ, Lee KL, Park HW. *A history of medical license in Korea*. *Korean J Med Hist* 2002; 11: 137-53.
9. Choi EK, Chang KH, Kim SY, Kwon I, Kim O. *Ethics education in medical schools in Korea: current status and problems concerning teachers, materials, and methodologies*. *Korean J Med Ethics Educ* 2006; 9: 44-59.
10. Bishop JP, Jotterand F. *Bioethics as biopolitics*. *J Med Philos* 2006; 31: 205-12.
11. Dewey J. *Human nature and conduct: an introduction to social psychology*. New York: Prometheus Books, 1922.
12. Sulmasy DP. *Research in medical ethics: physician-assisted suicide*. In:

- Sugarman J, Sulmasy DP, editor. *Methods in medical ethics*. Washington DC: Georgetown University Press, 2001, p 247-66.
13. Korea. *Framework act on health and medical services*. Article 6.
 14. Korea Prolife. *Will liberalizing abortion make women happy?* Available at <http://www.prolife.or.kr>. [accessed on 4 December 2011].
 15. The Korean Doctors Weekly. *Prolife doctors complaint 3 medical facilities for illegal abortion*. Available at <http://doc3.koreahealthlog.com/36086> [accessed 27 May 2011].
 16. Korea Network for Organ Sharing. *Introduction to KONOS*. Available at <http://www.konos.go.kr> [accessed on 1 June 2011].
 17. Korea. *Internal Organ ETC. Transplant Act*. Article 9.
 18. Kim MG, Jeong JC, Cho EJ, Huh KH, Yang J, Byeon NI, Yu JS, Bang KT, Chung HS, Ha JW, et al. *Operational and regulatory system requirements for pursuing self-sufficiency in deceased donor organ transplantation program in Korea*. *J Korean Soc Transplant* 2010; 24: 147-58.
 19. Joo HN. *Comparative study of Korean and German transplantation Act. Korean Criminal Law Association*. In: *Proceeding for 2006 Biannual Symposium for KCLA*. Seoul: KCLA, 2006.
 20. Korea. *Internal Organ ETC. Transplant Act*. Article 14 to 19.
 21. Korea Supreme Court Decision 2002Do995. *Decided 24 June 2004*.
 22. Kim JH. *Legal considerations on discharge against medical advice: the case at Boramae Hospital*. In: *Proceeding book of 2005 International Congress on Medical Law*. 2005, p 1035-42.
 23. Kim KY. *The medico-legal and ethical problems of withholding/withdrawing of futile life-sustaining mechanical respirator treatment*. *Tuberc Respir Dis* 2005; 58: 213-29.
 24. Korea Association of Medical Sciences. *Medical ethics guideline on foregoing life-sustaining treatment of dying patient*. Seoul: KAMS, 2002.
 25. Korea. *Medical Service Act*. Article 23-2.
 26. Korea National Board of Bioethics. *Reports on bioethical issues of WS Hwang's research*. Seoul: KNBB, 2006.
 27. Korea. *Bioethics and Safety Act*.
 28. Ministry of Education, Science and Technology. *Directive on securing research integrity*. 2008.
 29. Korea Supreme Court Decision 2009Da17417. *Decided 21 May 2009*.
 30. Ad Hoc Committee of Korean Medical Association. *Guideline for withdrawing life-sustaining treatment*. Seoul, 2009.
 31. Bioethics Policy Research Center. *Intensive care specialists' perspectives on life-sustaining treatment. Annual report of BPRC for 2010*. Available at <http://bprc.re.kr>.
 32. Murraroy TH, White RS. *Public engagement and bioethics commissions*. In: *Elliott JM, Ho WC, Lim SS, editor. Bioethics in Singapore: the ethical microsm*. Singapore: World Scientific, 2010, p 165-85.