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The ICC Investigation in Afghanistan

Ahn Soo Min*

Abstract

The International Criminal Court's investigation in Afghanistan showcases the Court's attempt to expand its jurisdictional reach while targeting the United States, a powerful non-State Party. The investigation is significant for several reasons: i) the Suspect, the U.S., is a non-State Party with a history fraught with tension with the Court; ii) the Prosecution has initiated the investigation by *proprio motu*; and iii) after the Taliban takeover of the Afghanistan government, the *de facto* government in the territory where the alleged crimes took place has yet to be officially recognized by any State or international organization. Given recent developments in the relationship between the U.S. and the Court, it is of interest to the international community to observe whether the U.S. will shift its stance towards the Court's jurisdiction regarding this investigation.

Keywords *jurisdictional reach, jurisdiction of the ICC, Afghanistan*

* Ewha Law School. e-mail: smahn@ewhain.net

I. Introduction

On November 20, 2017, the Office of the Prosecutor (OTP) of the International Criminal Court (ICC), led by previous incumbent ICC prosecutor Fatou Bensouda, requested the authorization of a *proprio motu* investigation into alleged crimes against humanity and war crimes committed during the Afghanistan war (ICC, "Afghanistan").[1] On March 5, 2020, the Appeals Chamber of the ICC decided to unanimously authorize the Prosecutor to commence an investigation into the crimes committed in Afghanistan since May 1st, 2003, as well as other alleged linked crimes committed on the territory of states parties to the Rome Statute. As of April 2023, the Prosecution has been authorized by the Appeals Chamber to resume its investigation within the previously determined scope: on the alleged crimes committed in Afghanistan as well as other alleged crimes that have a nexus to and are sufficiently linked to the armed conflict in Afghanistan.

The United States, the primary target of this investigation and not a party to the Rome Statute, fiercely contested the ICC's jurisdiction. The Trump administration launched an economic and legal campaign against the ICC, imposing visa restrictions on ICC officials, opening a counter-investigation into the ICC, and denouncing it as "little more than a political tool employed by unaccountable international elites."(Borger) Although these measures were retracted by the Biden administration, the U.S. maintains that it is not subject to the ICC's jurisdiction. Perhaps as a result of this pressure, the incumbent prosecutor Karim Khan stated, to considerable criticism, that the resumed investigation would focus solely on the crimes committed by the Taliban and the Islamic State Khorasan Province.

In recent years, the ICC has sought to expand its jurisdiction to encompass powerful, non-party states as a response to criticism that without jurisdiction over those states, its decisions carry little weight. The Afghanistan investigation, targeting the United States, marked the beginning of that effort, leading the way to the 2021 investigation of the situation in Ukraine, which targets Russia. This reflects the current trend in international law that prioritizes universal jurisdiction over

state sovereignty in the spirit of the doctrine of *jus cogens*. Even with the investigation's shift away from the U.S., the Afghanistan investigation is significant in that it was the first case in which the ICC actively pursued this trend by targeting the United States. It also showcased how the ICC, as the only international court capable of criminally prosecuting individuals, could become a prominent actor in international conflicts.

In this paper, I will first outline the scope of the ICC's jurisdiction and its legal process, then examine three facets of the Afghanistan investigation: the suspects, the Prosecution, and the State in which the crimes were committed. Finally, I will explore the possibility of the ICC exercising and enforcing jurisdiction over the U.S. and other non-State Parties, such as Russia.

II. The Jurisdiction and Legal Process of the ICC

1. The Jurisdiction of the ICC[2]

(1) Subject-matter Jurisdiction

As per the Rome Statute upon which the Court is founded, the ICC has jurisdiction over four crimes: war crimes, crimes against humanity, genocide, and the crime of aggression.

(2) Territorial Jurisdiction

The ICC can exercise jurisdiction in the territory of State Parties, non-member States that consent to the Court's jurisdiction, or non-state parties that are referred to the Court by the UN Security Council (UNSC). As of July 2023, there are 123 States Parties to the Rome Statute. Notably, the United States, China, and Russia are not members.

(3) Personal Jurisdiction

The ICC can exercise jurisdiction over natural persons over the age of 18, not over governments, organizations, political parties, etc. Also, the person must be a national of a state within the Court's jurisdiction.

(4) Temporal Jurisdiction

The ICC can exercise jurisdiction over crimes committed after July 1, 2002, the date on which the Rome Statute was enforced.

2. The Legal Process of the ICC

The legal process of the ICC is largely divided into six steps: preliminary examination, investigation, arrest warrants and summons, confirmation of charges, trial and appeal, and sentencing and reparations.

The process begins i) when a State Party refers alleged crimes to the Court ii) when the UN Security Council refers the crimes to the Court, or iii) when the ICC Prosecutor initiates a preliminary examination into the crimes (*proprio motu*). Before transiting into a formal investigation called a situation, the ICC prosecutor must carry out a preliminary examination where four phases of analysis are required: i) initial, ii) jurisdictional, iii) admissibility, and iv) interest of justice assessments.

III. Three Facets of the Afghanistan Investigation

1. The Suspect: The United States

The Afghanistan investigation is notable in that it originally focused on the U.S., a non-member State with a history of tension with the Court.

The Court has previously opened formal investigations involving non-member States such as Myanmar (2019), Russia (2016), and Israel (2021). The Pre-Trial Chamber's decision regarding jurisdiction over Myanmar in the situation in Bangladesh/Myanmar is considered to have opened up new possibilities for the expansion of the Court's jurisdiction over non-state parties.

In its *Decision on the Authorization of an Investigation into the Situation in Bangladesh and Myanmar*,[3] the Pre-Trial Chamber stated that the Court may exercise jurisdiction when part of the criminal conduct takes place on the territory of a State Party. The Court applied the principle of ordinary territorial jurisdiction under customary international law to itself in its reasoning. For the crimes against humanity of deportation and persecution against the Rohingya population with which Myanmar was charged, the Court found the nature of the crime of deportation to be "inherently transboundary" (27) and so concluded that the requirements for jurisdiction under article 12(2)(a) of the Statute were met. The Court also stated that i) the Court may determine its own jurisdiction under the principle of *"la compétence de la competence*" and that ii) it would be against the principle of good faith and the intent of the drafters to read article 12(2)(a) as limiting the Court's territorial jurisdiction to crimes occurring exclusively in the territory of State Parties (27).

Following the Myanmar ruling, the Pre-Trial Chamber also authorized investigations into crimes committed on the territories of State Parties by nationals of two non-State Parties, Russia and Israel (IJRC).[4] As the Court appears to be actively expanding its jurisdictional reach, it seems highly possible that its rationale of ordinary territorial jurisdiction may also be applied to the Afghanistan investigation.

The strained relationship between the U.S. and the ICC further complicates the issue. Although the U.S. initially supported and played an active role in the founding of the ICC, it ultimately did not ratify the Statute and rescinded its signature in concern of the scope of the Court's jurisdiction and its independence from the UNSC. The U.S. stance toward the Court has since been varied, but even the Obama and Biden administrations, which maintained a generally positive relationship with the Court, sought greater U.S. influence over the Court and was vocally

critical of any perceived encroachment on U.S. sovereignty (Dutton).[5] The U.S.'s non-member status and subsequent non-compliance to the Court pose many limitations for the Court and other State Parties in carrying out its legal process.

The Afghanistan investigation is the first case in which an American national is directly involved as a suspect. It is also the first case in which the OTP has been authorized to launch a formal investigation into a democratic major-power state such as the U.S. Although the OTP has deprioritized the investigation into U.S. forces, it remains to be seen whether the U.S. will comply with the Prosecutor's investigations at all.

2. The Prosecution: *Proprio Motu* Investigation

A second facet of the Afghanistan investigation, the Prosecution, is notable in that the inquiry was initiated by *proprio motu*, the least common of the three triggers. This trigger is considered to be the strongest exercise of the Court's authority and was a matter of much controversy during the drafting of the Rome Statute. Unlike referrals, a *proprio motu* investigation requires judicial authorization for the investigation to proceed. As of present, only four investigations have been triggered by *proprio motu*.

During the drafting phase of the Rome Statute, the U.S. and a group of like-minded states opposed granting such power to the OTP and cited this as one of the reasons for its refusal to ratify the Statute. The U.S. especially expressed concern that the OTP would be politically motivated to indict U.S. forces or authorities. It argued for special protection of U.S. forces from the ICC for concern that the U.S. forces' international presence may lead to an American citizen being indicted despite the U.S. being a non-State Party. Its criticism of the Court in this regard has escalated with the Court's gradual expansion of its jurisdictional reach (Feinstein/Lindberg 40).[6]

The Afghanistan investigation is exactly the sort of overreach of which the U.S. has long been wary. John Bolton, the National Security Advisor to President Trump, criticized the ICC as "illegitimate," "superfluous," and "a threat to Amer-

ican sovereignty and U.S. national security." (BBC News)[7] However, as the Biden administration is vocally supportive of the ICC investigation into fellow non-State Party Russia over the situation in Ukraine, it remains to be seen whether the U.S. will take a more reconciliatory approach to the ICC and its investigation.

3. The Territory: The Uncertain Representation of Afghanistan

The third facet of the Afghanistan investigation, the State where the crimes were committed, is notable in that since the Taliban takeover of the Afghanistan government in August 2021, it is uncertain which government is internationally recognized as the rightful representative of Afghanistan.

After the takeover, the OTP requested the Court to authorize the resumption of the investigation under article 18(2) of the Statute, based on its belief that Afghanistan was not carrying out genuine investigations in a manner that would justify a deferral of the Court's investigations. In response, the Pre-Trial Chamber stated in *Decision Setting the Procedure* (2021)[8] that for the Court to make a decision, it needed reliable and updated information regarding the identifications of the authorities currently representing Afghanistan. It then requested the Secretary-General of the United Nations and the Bureau of the Assembly of States Parties of the International Criminal Court to submit relevant information on this matter.

In *Order Setting the Schedule* (2022),[9] the Court reported the Under-Secretary-General for Legal Affairs and United Nations Legal Counsel had responded that i) the Secretary-General does not engage in recognition of any government, ii) the Secretary-General, as depository, is guided by the decisions of Member States, and iii) since August 15, 2021, the General Assembly has not adopted any decision regarding the representation of Afghanistan at the UN. The Court then acknowledged that there was no decisive determination regarding the representation of Afghanistan. At the same time, it stated that this could not prevent the Court from making a ruling on the investigation. It also noted that i) changes of governments have no impact on the continuity of States ii) on proceedings before international

courts, and iii) while no official recognition of Afghanistan has been made by any State, the current group that has ousted the previous government has been referred to by international organizations and States as the '*de facto* government.' The Court then invited Afghanistan to provide observations on this matter to ensure "the continuity of judicial proceedings in the most rigorous way." (8)

In this Order, the Court is thought to have clarified that the determination of the representative of Afghanistan is not a necessary prerequisite to its legal proceedings, and that the OTP is capable of moving forward with its investigation without such determination. Despite the Court's stance on this matter, the issue of government recognition may cause issues in the investigation process, especially since members of the group considered the *de facto* representatives of Afghanistan are the very focus of the investigation. As of 2023, no State or international organization has officially recognized the Taliban government in Afghanistan, and the UN envoy to the country has stated that it would be "nearly impossible" for the Taliban government to be recognized by the international community and the UN (Al Jazeera).[10]

IV. ICC Jurisdiction over the U.S.

1. Jurisdiction over Non-State Parties

The U.S. has consistently maintained that the ICC has no jurisdiction over the U.S. under the principle of international law that a State is not bound by any treaty to which it has not consented. As i) the U.S. is a non-State Party and ii) has veto power as a permanent member of the UNSC, the ICC may not exercise jurisdiction over the U.S. by state referral or referral by the UNSC. However, the ICC may exercise jurisdiction over a non-State Party i) when a crime is committed on the territory of a State Party or ii) when a State Party requests extradition via a bilateral treaty with a non-State Party. The possibility of the former, ordinary territorial jurisdiction, has been discussed in the Myanmar investigation; the second possibili-

ty of extradition merits further discussion.

2. Jurisdiction by Extradition between States

In 2002, the American Service-Members' Protection Act (ASPA) was signed into federal law by President Bush to prevent the criminal prosecution of U.S. authorities and military personnel by the ICC. The Act authorizes the President to "use all means necessary and appropriate to bring about the release of any U.S. or allied personnel being detained or imprisoned by, on behalf of, or at the request of the International Criminal Court." (ASPA)[11] The Act i) prevents cooperation with the ICC, ii) authorizes military action to release any United States or allied person detained by the ICC at the request of the ICC, and iii) refuses military aid to any State Party to the Rome Statute that refuses to sign a bilateral immunity agreement (BIA) with the U.S. that precludes American citizens from extradition to the ICC. As such, ASPA was enforced as a direct countermeasure against ICC jurisdiction. This led to the U.S. signing 102 BIAs, 46 of those with State Parties to the Rome Statute, but such efforts were concentrated during the Bush administration and no further BIAs have since been signed (Shim 10).[12]

Of the BIAs, 21 have been ratified by their respective parliaments and 18 agreements are legally valid (11). In theory, this means that the extradition of U.S. authorities and personnel by a State Party that has not entered into a BIA with the U.S. is possible. However, the steadfast determination of the U.S. to prevent criminal prosecution of its citizens by the ICC and the political backlash any State Party that attempts extradition may face make the realistic chances of such an event occurring very slim.

V. Conclusion

The ICC's investigation in Afghanistan is notable in that it i) directly in-

volves the U.S., ii) was initiated by *proprio motu*, and iii) is prefaced by the question of recognition of a government. It also faces many hurdles for those reasons, especially since it will be difficult for the OTP to proceed with its investigations on-the-ground without U.S. cooperation. The shift away from the U.S. in the investigations and the recent U.S. support of the ICC's investigation into Russia may possibly relieve tensions between the Court and the U.S. However, the U.S. supporting ICC jurisdiction over a hostile State is a different matter from accepting the Court's jurisdiction over itself. Whether the U.S. will cooperate with the OTP in the Afghanistan investigation in light of recent developments is still a matter to be observed as the investigation proceeds.

Notes

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Legal Parentage Determination in Surrogacy Cases Involving Gestational Surrogacy

Cho Eun Byul*

Abstract

The topic of surrogacy is intertwined with various issues of interests, values, and fundamental rights, such as the importance of kinship between parents and children, the welfare of the born child, bodily autonomy and self-determination of surrogates, the right to childbirth, the pursuit of happiness, the protection of motherhood, and the commodification of infants. Moreover, as the aging population becomes a global issue, the issue of childbirth varies in legislation and societal perceptions according to each country's circumstances, making it difficult to claim that the legislation of any specific country is the best. As discussions regarding surrogacy are expected to become more active in the future, it is worth noting that internal discussions on surrogacy within South Korea have not made much progress since the ruling in 2018. Consequently, discussions on surrogacy have not been actively conducted in society. Therefore, due to the continued legislative gap regarding surrogacy, the current legal framework in South Korea, including「the Civil Code」and「the Act on the Registration of Family Relationships」, has not adequately addressed the reality of surrogacy. In this context, this article aims to examine the factual background and key points of the Seoul Family Court's decision, which is the first precedent explicitly stating the position of our courts regarding the establishment of a

* Ewha Law School. e-mail: 222lal97@ewhain.net

child's legal parent-child relationship in cases involving surrogacy. By incorporating discussions on surrogacy since the release of that precedent in 2018, the article seeks to explore future responses and solutions.

Keywords *assisted reproductive technology, legal parenthood, surrogate mother, intended parents*

I. Introduction

1. The Importance of Parental Decision

Recently, the news is filled with crimes, particularly targeting infants and children. The reason that those cruel violence and neglect against newborn infants is even more heart-wrenching is because the perpetrators are none other than the parents of these children. Recently, a person in her 30s was arrested for purchasing children from unmarried mothers or financially struggling mothers and acting as a surrogate for infertile couples. The common thread among these incidents is that they involve crimes committed by parents against infants and young children.

While there can be various explanations for such crimes, the main reason lies in the overlooking of the weight of responsibility that comes with giving birth to and raising a child. In the realm of law, parents hold an absolute position in relation to their children. However, being the legal representative of a child and having numerous rights regarding the child also implies taking on numerous obligations. According to Article 913 of our Civil Code, parents have the duty to protect and nurture their minor children. The duty of childcare under civil law also serves as the foundation for the legal duty of guardianship under criminal law. Consequently, our society has the legitimacy to regulate and punish parental neglect and violence towards children.

In other words, decision making of who is, or should be the parent of a child caries a significant meaning as it determines the beginning and entirety of a child's welfare. However, since being a parent is not a qualification, from the perspective of the child and our society, decisions about one's parents cannot be arbitrarily made. Especially when it comes to the decision about parents immediately after birth, it might even seem awkward to even use the term "decision" since it naturally occurs based on biological factors. Nevertheless, in our society, there is currently one matter in which parents can be legally and legislatively determined. It is the decision about the parents of a child born through surrogacy.

Globally, there is an increasing trend of childbirth through surrogacy. With news of Hollywood stars opting for surrogacy becoming more frequent, there are opinions suggesting that surrogacy is now establishing itself not just as a form of Assisted Reproductive Technology (ART) primarily for infertile couples but as a type of childbirth. In the past, surrogacy through ART primarily targeted infertile couples, but recently, there has been a noticeable shift as more individuals choose surrogacy for personal reasons.

With advancements in science and technology allowing for the separation of conception and gestation, it has become possible for a biological mother and a genetic mother to exist separately, each contributing one individual. As a result, our society's long-standing standards of determining parentage based on gestational and marital relationships are being challenged.

2. Types of Surrogacies

In traditional surrogacy, which involves direct sexual intercourse with the intended father, the surrogate mother provides both the egg and carries the pregnancy to term. However, with advancements in ART, modern surrogacy differs from traditional surrogacy as it is now possible to transfer embryos created from sperm and eggs without the need for direct sexual intercourse.

The types of surrogacy arrangements can be classified based on whether there

is direct sexual intercourse between the intended father and the surrogate mother and whether the surrogate's eggs are used.[1] While gestational surrogacy is commonly associated with in vitro fertilization, there are cases where direct sexual contact or artificial insemination without medical intervention is used to establish a contract with a third party for the purpose of having a child. Traditional surrogacy refers to the combination of the father and surrogate mother. On the other hand, modern surrogacy involves only the act of gestation by the surrogate mother, while biologically utilizing the intended parents' or donors' DNA. And depending on whether monetary compensation is received for such surrogacy roles, surrogates can be classified as either "commercial surrogacy" or "altruistic surrogacy."

This article will focus on cases where the child receives genes from the intended parents and is born through a surrogate mother. In this case, the resulting child only has a biological connection to the surrogate through the process of pregnancy and childbirth, while the genetic connection is established with the intended mother who provided her own eggs. Therefore, the surrogate only provides the function of her uterus, hence referred to as "gestational surrogacy" or "birth surrogacy."

II. Precedent Analysis on Seoul Family Court Decision on 2018V15 Decided on May 9, 2018

The subject ruling is the first explicit judgment by our courts regarding the legal parents of a child born through surrogacy. Although it is a decision at the lower court level, it holds significant meaning as it was the first and direct judgment in South Korea regarding the effectiveness of surrogacy contracts and the criteria for determining the legal parents of surrogacy-born children. It continues to have influence as a major precedent that sets the standards for discussions on surrogacy.

Prior to this ruling, there had not been any direct legal disputes in South Korea specifically concerning surrogacy pregnancies and childbirth. Most of the related legal cases involved surrogacy where the surrogate and the intended father had

direct sexual intercourse, resulting in a child with a genetic connection to the surrogate. However, in the 2018 ruling, there was a significant difference as the surrogacy only involved the surrogate carrying the pregnancy and giving birth on behalf of the intended parents without a genetic connection to the child.

1. Factual Background

The factual background of the precedent is as follows:

The male and female parties involved are legally married and desired to have a child. However, due to medical opinions stating that natural conception and maintaining pregnancy were difficult for them, the couple sought to have a child using their own reproductive cells for embryo creation and having a surrogate mother carry the pregnancy and give birth on their behalf.

On July 26, 2016, the infertile couple had an embryo created using their reproductive cells and implanted it into the surrogate mother. The surrogate mother gave birth to the child on March 26, 2017, at a hospital in Los Angeles, USA, and her name was listed as the mother on the birth certificate issued by the hospital.

On December 22, 2017, the couple attempted to register the child's birth at the Jongno District Office in Seoul, listing the wife as the mother and the husband as the father on the birth report. However, the family relationship registration official at the district office rejected the birth registration because the personal information of the intended parents listed on the birth report submitted by the couple did not match the information provided on the birth certificate.

The Seoul Family Court Decision on 2018HoGi13 Decided on February 14, 2018

The couple appealed the rejection of their birth registration by the district office, and the first-instance court dismissed the appeal.

The Seoul Family Court Decision on 2018V15 Decided on May 9, 2018

In response, the couple filed a second appeal, arguing that: ① They had submitted the birth report and birth certificate in accordance with the procedures and format prescribed by the Act on the Registration of Family Relationships, ② Their agreement with the surrogate was valid as it was not a commercial surrogacy contract which violated the Act on Bioethics and Safety since it was not for profit, ③ The surrogacy arrangement, where the surrogate only carried the pregnancy and gave birth without providing her own eggs, did not violate the Act on Bioethics and Safety. However, the second-instance court rejected their appeal.

The Supreme Court Decision on 2018Su37

The couple filed a final appeal with the Supreme Court, but on August 8, 2019, they withdrew the final appeal, and the previous decision was fixed.

2. Key Points of the Ruling

In fact, the subject ruling focused on the legality of the administrative decision rejecting the birth registration. Therefore, the main issue for direct judgment was whether the district official's refusal of the birth registration due to the discrepancy between the surrogate information on the birth report and the birth certificate violated the law. In the process of making this judgment, the validity of the surrogacy agreement and the criteria for determining the legal parents of a child born through surrogacy were also discussed.

(1) Validity of the Surrogacy Agreement

Regarding surrogacy agreements, there is no explicit provision in our law. Article 23, paragraph 3 of the Act on Bioethics and Safety states that "No one shall

provide or use eggs, sperm, or embryos or induce or arrange such provision or use in return for monetary or property benefits or other opposite obligations." However, since the law does not specifically include provisions regarding the uterus, it cannot be considered as a basis for declaring surrogacy contracts for childbirth as invalid.

The court stated that if the legal criterion for determining maternal relationships, the 'fact of childbirth,' is to be applied equally to surrogacy births, a person who provides eggs can establish a legal parent-child relationship through adoption or other means under the Civil Code. Based on this perspective, the court deemed contracts involving childbirth through surrogacy as invalid under Article 103 of the Civil Code as they violated good customs and social order.

According to the ruling, it said:

> Since **the legal criterion for determining maternal relationships is based on the 'fact of childbirth,**' and according to the Act on the Registration of Family Relationships, the fact of childbirth must be proven through the birth certificate attached to the birth report, **considering the legislative purpose of the Act on Bioethics and Safety to prevent violations of human dignity and values, ensure bioethics and safety, and contribute to the health and quality of life of the people, both traditional surrogacy and 'gestational surrogacy' like the present case are not permitted under our legal interpretation**. Such contracts involving childbirth through surrogacy are considered **invalid under Article 103 of the Civil Code as they violate good customs and social order.**

(2) Criteria for Determining Legal Parenthood

In this case, the issue of determining legal parenthood arose because the child shared genetic material with the intended parents. Since the embryo created using the couple's gametes was used for pregnancy, genetic testing confirmed that the

child born had a genetic relationship with the couple. In other words, scientifically speaking, the intended parents were the child's biological parents. This raised the question of whether our society should follow scientific criteria or separate legal criteria in determining parenthood.

In Korea, there is no explicit provision regarding the determination of maternal relationships. However, it is generally interpreted, based on consistent precedents (such as the Supreme Court ruling on October 4, 1967, case number 67da1791), that even if the birth mother's intention is absent, a legal familial relationship is automatically established through "childbirth." Thus, the criterion for determining parents based on childbirth reflects the principle of "maternity" in Roman law,[1] where the woman who gives birth is considered the mother.

Accordingly, the woman who gives birth is regarded as the child's mother, and if she is married, her husband is presumed to be the father (Civil Code Article 844, paragraph 2). In the absence of a husband presumed to be the father, the father can be determined through a paternity confirmation lawsuit (Civil Code Article 845). Unlike the determination of paternity, there is no explicit provision for the determination of maternity, but if the birth mother can be identified for births outside of marriage (Civil Code Article 855, paragraph 1), such identification is allowed only in exceptional cases where maternity is unclear, such as cases involving abandoned children. This identification request has a legal nature different from that of a paternity confirmation lawsuit (a formative lawsuit) and falls under a "confirmation lawsuit."

Under the Act on the Registration of Family Relationships, the birth report must include the "mother's" name, the place of birth, the registration standard location, and the resident registration number (Article 44, Paragraph 2, Subparagraph 4). The birth certificate, prepared by a doctor or a certified midwife, must be attached to the birth report, or if not available, a written document substantiating the fact

1) mater semper certa est, pater is est quem nuptias demonstrant ("The mother is always certain, the father is whom the marriage points to.")

of childbirth, such as medical records of pregnancy or childbirth, must be attached (Article 44, Paragraph 4). If it is not possible to attach a birth certificate or similar document, the confirmation of birth must be obtained from a family court (Article 44-2, Paragraph 1). Furthermore, according to the Regulations on Family Relationship Registration, the birth certificate must include the date and place of birth, as well as the mother's name and date of birth (Rule 38, Paragraph 2, Subparagraph 4). A written document prepared by someone involved in the childbirth must be attached, containing materials that can prove the fact of childbirth by the mother, such as a copy of the mother's medical records during pregnancy or the child's birth (Rule 38-2). In addition, for a child born outside of marriage, the "mother" must make the birth report (Article 46, Paragraph 2). Therefore, in principle, the surrogate mother of the born child becomes the child's legal mother, and the intended parents can become parents using the Civil Code's provisions on adopting blood-related children.

In determining the motherhood of the child, the court's logic based on the natural fact of "childbirth" relied on four main justifications. First, childbirth is a natural fact that is clear and straightforward compared to other criteria. Second, protecting the emotional bond formed between the surrogate and the child during the approximately 40-week pregnancy period, childbirth process, and breastfeeding is ultimately for the child's welfare. Third, it aims to protect the surrogate mother. Fourth, intended parents can become the child's legal parents through adoption as blood-related parents under the Civil Code.

> *Regarding the criteria for determining parents under our Civil Code, there may be opinions suggesting that the criteria should be based on genetic commonality or the intent of the gamete provider and the birth mother, rather than the natural fact of 'giving birth,' in line with the advancements in science and technology, such as artificial insemination. However, there are reasons why* ***the natural fact of 'giving birth' serves as*** ***① a clear and easy criterion compared***

> ***to other standards***. *Furthermore,* ②***the concept of maternity*** *involves not only a legal relationship, but also emotional aspects formed through gestation, the process of childbirth, and the approximately 40 weeks of pregnancy, and it* ***is valid to protect such emotional bonds as 'motherhood' under the law***. *However, if parents are determined based on genetic commonality or the intent of related parties, such maternity may not receive legal protection, which* ***can ultimately undermine the welfare of the child.*** *Moreover, if the genetic commonality or the gamete provider is considered the parent,* ③ ***it may result in women being used to mere birthing services or suppressing the formation of maternity,*** *which contradicts the values and emotions of our society. Additionally, considering that the person providing the sperm or egg* ④ ***can obtain a legal status equivalent to the biological parent of the child through adoption, especially relative adoption***, *it is determined that the existing criteria for determining parents under our Civil Code should be maintained."*

III. Trends and Related Legislation in Various Countries

1. Legalization of Surrogacy Contracts

In surrogacy contracts, the surrogate mother is responsible solely for the act of giving birth to the child, while the ultimate goal of the surrogacy contract is for the intending parents, who are the commissioning party, to establish a legal parental relationship with the child. Regarding the legal validity of surrogacy contracts, there are conflicting views.

The main justification for recognizing the validity of surrogacy contracts is understood as a constitutional protection of personal autonomy or reproductive freedom, which is seen as a form of privacy right. It argues that even infertile cou-

ples who cannot naturally conceive or give birth should have the right to pursue alternative means, and they should not be criticized for seeking the assistance of others in the process of having a baby. However, even from this perspective, many people believe that commercial surrogacy should be banned due to the presence of public elements within these agreements and the potential issues of commodification of human beings.

On the other hand, the invalidity theory asserts that surrogacy contracts are void due to the exploitation of the surrogate's body and the fact that laws regulating parental relationships cannot delegate the abandonment of parental rights and the establishment of legal parental relationships to private autonomy. It argues that surrogacy contracts contradict public morals and are deemed invalid because they impede the independent objectives of child welfare, clarity, and stability in status relationships governed by parental rights.

Legislation regarding the validity of surrogacy contracts can be broadly classified into two legal systems: the Continental legal system and the Anglo-American legal system. In the United Kingdom, limited acceptance of surrogacy is allowed under the Human Fertilization and Embryology Act of 1990. In the United States, the permissibility of surrogacy contracts varies by state, but it can generally be seen that surrogacy contracts are allowed in most states. In contrast, countries within the Continental legal system, including Germany, Japan, and South Korea, generally consider surrogacy contracts as acts contrary to social norms and deem them void.

Countries that Allow Surrogacy:

The United States is the country most frequently mentioned in our media regarding surrogacy, particularly with celebrities at the center. It is difficult to provide a comprehensive explanation due to varying legislation at the state level, but it is generally understood that surrogacy contracts are allowed in the majority of states.

The United Kingdom has one of the most well-defined legal frameworks globally concerning assisted reproduction and surrogacy. While commercial surrogacy is prohibited, non-commercial surrogacy arrangements are not penalized. Instead, the

country actively intervenes in the entire process of surrogacy through the Surrogacy Arrangements Act 1985 (SAA) and the Human Fertilization and Embryology Act 2008 (HFEA).

While commercial surrogacy is prohibited in Thailand, it is allowed for married couples who have been married for more than three years, with one spouse being a Thai national and the surrogate being the sister of the commissioning woman. Similarly, in Vietnam, commercial surrogacy is prohibited, but if the commissioning couple has no genetic children and a qualified medical institution confirms the commissioning woman's infertility, the surrogate must be a relative of the commissioning couple with previous childbirth experience. Both the commissioning couple and the surrogate must receive medical, legal, and psychological consultations.

In Israel, surrogacy contracts are allowed if approved by a committee established by law, under the premise that there is free agreement between married or unmarried couples in lawful relationships and no risk to the health or rights of the surrogate or the child.

In Greece, surrogacy contracts are allowed when there is a written agreement between a woman who is medically unable to conceive and carry a pregnancy and another woman who is suitable for pregnancy and childbirth. The court's approval is required for such contracts.

Countries Do Not Allow Surrogacy:

In Germany, surrogacy contracts are generally prohibited. However, in cases where surrogacy is performed, the performers (usually the hospital) other than the commissioning couple or the surrogate are subject to punishment. The Embryo Protection Act (Embryonen - schutzgesetz) Article 1, Paragraph 1, Item 7 establishes penalties for those who perform artificial insemination or implant embryos in surrogates, and the Adoption Mediation Act (Adoptionsvermittlungs - gesetz) Article 13c prohibits surrogacy arrangements and has provisions for punitive measures in Article 14b. Moreover, regarding the determination of parental relationships for the born child, German Civil Law Article 1591 follows the principle of maternal

birth, making the surrogate the legal mother.

2. Parental Determination:

In legal systems that invalidate surrogacy contracts, the surrogate is recognized as the legal mother of the child, and intended parents must acquire the status of legal parents through adoption or other methods.

In Germany, the 1998 Law on Parental Relationships added provisions establishing the birth mother as the legal mother (German Civil Law Article 1591), and in Japan, through a Supreme Court ruling, surrogates are recognized as the legal mothers of the children but are resolved through the adoption of the surrogate by the commissioning mother.

Regarding the determination of the legal mother of a child born through surrogacy, countries that allow surrogacy differ in recognizing the surrogate mother as the legal mother while granting the intended parents the right of custody or designating the commissioning parents as the child's legal parents.

In the United States, the Johnson v. Calvert case is the most famous precedent related to parental determination. In this case, the surrogate who acted on behalf of the intended mother for pregnancy and childbirth refused to surrender the child. The court determined that although the surrogate had a biological connection as she directly carried the pregnancy and gave birth, the intended mother, who intended to raise the child as her own and had the intention to become a parent, should be recognized as the legal mother in the formation of the legal parental relationship. The surrogate, who had agreed to relinquish all rights regarding the child to the intended parents, was deemed to have no rights over the child.

In the United Kingdom, the Human Fertilization and Embryology Act of 1990 legalized non-commercial surrogacy pregnancies and births, explicitly specifying the criteria for determining the child's parents and their legal status. In 2023, the UK concluded through legislative amendments that the commissioning parents should become the child's legal parents from the moment of birth.

IV. Opinion

1. Opinions on the Validity of Surrogacy Agreements

In light of the widespread acceptance of surrogacy agreements worldwide, refusing to recognize surrogacy births can lead to even greater problems of abuse due to legal loopholes as will be mentioned later. Given that surrogacy births are already taking place in reality due to advancements in science and medical technology, preventing surrogacy through invalidation by certain countries is ineffective. Considering the numerous ethical dilemmas and the significance involved in surrogacy, it is believed that establishing detailed regulations to prevent its misuse through a systematic framework would be more helpful in avoiding potential issues.

A similar case is the organ transplantation. Like surrogacy, organ donation also raises ethical discussions concerning human instrumentalization and violation of human dignity. However, a complete ban on organ transplantation could potentially lead to an increase in illegal organ trading, so countries strictly govern organ donation through comprehensive regulations.

In fact, instances of private surrogacy agreements being made through personal contacts on the internet have been frequently observed. Even in recent cases where baby trafficking and illegal activities were exposed, it has been reported that surrogacy contracts were conducted anonymously through the internet. When surrogacy agreements are deemed illegal, they cannot be arranged through hospitals, making it difficult for both the intended parents and the surrogate to share accurate information about each other. This creates an environment prone to fraudulent activities exploiting the lack of fact-checking. In South Korea, surrogacy agreements have become even more clandestine following the aforementioned legal precedent.

However, even in cases where surrogacy contracts are legalized, it is believed that commercial surrogacy should be prohibited, considering that it fundamentally objectifies a woman's uterus as a mere tool. Additionally, the perspective that allows surrogacy contracts requires a strict regulatory framework and a properly estab-

lished administrative system as a prerequisite.

2. The criteria for determining the parentage of a child should prioritize the best interests of the child born through surrogacy.

In the past, when genetic testing technology was not yet available or sophisticated, the act of giving birth served as a clear and error-free means of determining parentage. However, with the advancements in assisted reproductive technologies (ART), particularly in vitro fertilization, and the widespread practice of surrogacy, the act of giving birth no longer guarantees genetic similarity between the birth-mother and the child. As a result, the expression used in previous legal precedents, claiming that the standard for parentage determination is "clear," is no longer correct. Furthermore, unlike the past when genetic identification technology was not well developed, it is now easy to determine the genetic parents of a child. Therefore, the first basis of the previous legal precedent, which relied on birth by the surrogate mother, is no longer valid.

So, what should be the criterion for determining legal parentage? The act of having a child goes beyond pregnancy and childbirth; it entails long-term responsibilities and obligations associated with raising the child. In this regard, the primary consideration should be the "well-being of the child born".

If we prioritize the well-being of the child born, the intended parents should be considered the legal parents. This is because, without such recognition, the child born through surrogacy would be placed in an unstable position, even if the surrogate mother hands over the child to the intended parents as agreed or refuses to do it.

[CASE 1] When the surrogate mother hands over the child to the intended parents without any issues:

In this case, for the intended parents to have full legal parental status over the child, they would need to go through the process of adoption. During the period

from the child's birth until the completion of the adoption process, the child would be in a state where they do not receive the full protection of a guardian who is emotionally and financially prepared to ultimately raise the child. While there may be criminal penalties if the parents fail to fulfill their parental duties during this period, regardless of the punishment, it is important to prevent such situations from occurring and to move the child to a secure environment under the protection of someone who is ready to raise the child as soon as possible.

In countries where surrogacy is legalized and well-regulated, the concerns mentioned above may not be significant since the management of post-surrogacy birth is likely to be detailed in the contract. However, even in countries where surrogacy is not legally recognized, there is still a possibility of children being born through surrogacy. In such cases, where commercial surrogacy is strictly prohibited, it can be presumed that most instances of surrogacy involve the surrogate receiving financial compensation from the intended parents in exchange for handing over the child. Realistically, expecting such commercial surrogacy, driven by the urgent need for money due to the physical burden of pregnancy and childbirth, to provide adequate support for the child soon to be handed over is preposterous.

In cases where surrogacy agreements are deemed illegal, due to the lack of regulation, there may be inadequate management, especially in private surrogacy agreements. Since it would be difficult for intended parents as individuals to establish a systematic monitoring system, they would have virtually no influence or protection over the child until the surrogate mother hands over the child. In other words, during this period, the intended parents would have no legal rights or obligations regarding the child, regardless of any issues that may arise.

Particularly under the current interpretation, if the surrogate mother is considered the mother of the child, as is often the case when the parties are unmarried, can we expect the biological father, presumed to be the surrogate mother's spouse, to fulfill the role of a legal parent? It is also worth questioning whether imposing such responsibility on the surrogate mother's partner is appropriate. In cases where surrogacy is not accompanied by marriage, if one parent is absent, it is doubtful

whether it is in the child's best interest to have only one parent.

Moreover, this raises issues related to inheritance. If an unexpected incident occurs and the intended parents pass away before going through the process of stepchild adoption, the child would not be legally recognized as having any blood relationship with the intended parents and would not be able to claim inheritance from their estate. Particularly in Type 5 surrogacy cases, where the child is genetically related to the intended parents, the child would still be unable to inherit due to the lack of legal status.

[CASE 2] When the surrogate mother refuses to hand over the child:

In a situation where the surrogate mother is considered the legal parent of the child, the intended parents have no rights over the child and can only claim transfer rights based on the private contract of the surrogacy agreement. As intended parents, if the surrogate mother fails to fulfill the contract, they can assert their rights over the child through legal proceedings, but it comes with the burden of publicly revealing that the child was born through surrogacy. Considering that there have been cases in the past where some surrogates have made threats or extorted money from intended parents by threatening to disclose the fact of birth through surrogacy, disclosure of the fact of birth through surrogacy can be a significant burden for intended parents, as well as for the child born through surrogacy.

[CASE 3] When the intended parents refuse to accept the child from the surrogate:

In the case of a surrogacy agreement, while the contract usually contains detailed provisions regarding the surrogate's breach of obligations, the clauses related to the intended parents' performance of obligations are often inadequate. For example, the surrogacy agreement stipulates that the surrogate has an obligation to protect the conceived embryo after conception and cannot voluntarily abandon the pregnancy or harm the conceived embryo. However, conversely, there is generally no provision preventing the intended parents from abandoning the childbirth mid-

way or demanding the surrogate to terminate the pregnancy.

For example, there was a case in Thailand where the commissioning couple refused to take custody of a child with Down syndrome born through surrogacy. In such cases, under the principle that the surrogate mother becomes the legal parent, there is an issue where the couple bears no legal responsibility for the child they made, but refuse.

V. The Limitations of Existing Standards and Points for Improvement

1. Protection for The Surrogate mother

In the case of a surrogate who determined to donate her reproductive cells or the function of her womb for the sake of someone else's parenthood without intending to become the parent of the child, there is a high possibility that she is not adequately prepared for raising the child until after the pregnancy. In that aspect, the intended parents, who planned and executed the pregnancy and childbirth to become the parents of the child, should be prioritized in determing the parentage.

However, if we consider the intended parents as the legal parents from the moment of the child's birth, there may be inadequate protection for the surrogate mother. As mentioned in the previous legal precedent, surrogacy involves a long period of approximately 40 weeks of pregnancy, childbirth pain, and breastfeeding, during which the surrogate forms an emotional bond with the child, known as "maternity," which has been socially and culturally protected. Voluntary consent should be based on sufficient explanation and understanding, but in the case of maternity, we cannot expect the surrogate to be fully aware of maternity until she actually goes through the process.

In order to protect the surrogates and ensure their well-being, legislative measures can be put in place to guarantee visitation rights between the surrogate and the child or to allow intended parents to have parental rights immediately after

birth but provide a legal process for surrogates who wish to obtain parental rights for the child by requesting a judicial decision. Similarly, in the UK, a surrogate has the right to withdraw consent to the surrogacy agreement within the first six weeks after birth, and in such cases, the commissioning parents are advised to apply for a parental order from the court. According to current law, if the surrogate does not consent, the court cannot issue a parental order, but the judge can do so if they deem it necessary for the welfare of the child.

Furthermore, some argue that recognizing the surrogate as the child's legal mother immediately after birth can be helpful when the child wants to know their birth mother in the future. However, it is not appropriate to prioritize the child's right to know their birth parents over the surrogate's right to choose whether or not to disclose their identity as a surrogate. The child has the right to know their parents, but they should also have the right to decide whether or not to disclose the identity of their surrogate.

2. Strengthening the Role of the Father in Parental Determination

Furthermore, there's a problem of the Korean legal system overlooking the parental determination of the child born.

In Korean Civil Law, when a husband and wife are in a marital relationship, if the wife becomes pregnant, the child is legally presumed to be the biological child of the husband (Article 844, Paragraph 1), and the revocation of such presumption can only be done through a lawsuit by the wife (Articles 846 and 847). If a child is born when a marital relationship is not presumed, the mother can acknowledge the child as her own biological child (Article 855). Thus, in most cases, the determination of paternity follows as a secondary decision after the determination of maternity. Particularly, in cases where a child is born without the prerequisite of a marital relationship, only the mother can fulfill the obligation of reporting the birth (Article 46, Paragraph 2).

While maternity is determined based on the abstract concept of "maternity,"

Korean civil law relies on genetic relatedness as the criterion for paternity determination, leading to a discrepancy in the criteria for determining paternity and maternity. According to the provisions of the Civil Law, if a child is born within 300 days from the termination of a marital relationship, it is presumed that the child was conceived during the terminated marital relationship, and the biological father can request permission from the family court to establish a legal parent-child relationship with the child (Article 844, Paragraph 3, and Article 855-2, Paragraph 1). In such cases, the family court decides on the permission based on scientific methods such as blood type tests, genetic tests, or other factors such as long-term separation, and if the father granted permission by the family court submits a birth report for the child as a child born out of wedlock, it not only generates legal recognition (Article 57, Paragraph 1 of the Family Relationship Registration Act), but also even if the woman who conceived and gave birth to the child (the biological mother) remarries and has a husband in a legal marital relationship, the child is not presumed to be the child of the remarried woman's husband based on the legal marital relationship (Article 855-2, Paragraph 3). Ultimately, this is based on the scientific proof of genetic relatedness.

With the evolution and widespread adoption of assisted reproductive technologies, the act of having a child entails not only pregnancy and childbirth but also the long-term responsibility and obligation of childcare. The importance of the person who wishes to become the father in establishing the legal parent-child relationship is as significant as that of the woman who undergoes pregnancy and childbirth as the mother. If maternity in surrogacy has cultural value worth protecting, why isn't paternity considered important as much as maternity?

VI. Conclusion

Recently, there seems to be a tendency in South Korea to view assisted reproductive technologies as a potential solution to the declining population and

low birth rate issues. Of course, from a policy perspective, we cannot ignore the potential of using assisted reproductive technologies as one solution to the growing problem of low birth rates. However, simply allowing assisted reproductive and surrogacy childbirth without sufficient discussion about the process, and only focusing on increasing the population, is a one-dimensional approach which cannot escape criticism that it views women merely as instrumental beings for the nation's population reproduction.

As technology advances to assist human childbirth, the criteria for establishing legal parenthood are expected to undergo further changes. For example, if the technology of artificial uterus, currently under development, becomes commercialized, surrogate childbirth can no longer serve as a criterion for determining parenthood. It is not entirely unrealistic to anticipate that in the future, artificial uterus technology could handle the entire process from conception to childbirth. However, even in such cases, the ultimate determination of legal parenthood should be based on who is intended and prepared for the child's birth and who can provide the child with the best interests of upbringing.

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The Issues and Challenges of the Current "Advance Statement on Life-Sustaining Treatment" from the Perspective of Minors' Right to Self-Determination

- Focusing on the Commentary on the Supreme Court Decision 2020Da218925 Decided on March 9, 2023 -

Jeon Jun Ha*

Abstract

Recently, the Supreme Court of South Korea delineated the obligations of physicians to elucidate medical treatments or procedures to minors. The ruling firmly posits that, contrary to conventional medical practices, minors too possess the capacity to provide informed consent. It underscores that for minors to effectively exercise their consent capacity in medical contexts, it should be complemented by the analogous capacity of those holding parental authority or legal representation. Concurrently, the judgment outlines circumstances where a minor's capacity to consent can be sought independently, detailing specific thresholds and overarching criteria for such determinations. This paves the way for acknowledging minors' capacity to consent, especially in end-of-life medical decisions. This article underscores the Supreme Court's affirmation of minors' consent capacity. Given the identified legislative voids in the current "Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life," the paper endeavors to probe avenues to fortify the right to self-determination for individuals below the age of 19.

* Ewha Law School. e-mail: tillwehavefaces@ewhain.net

Keywords *informed consent, minor's right, self-determination, end-of-life decisions*

I. Introduction

Since the introduction of the "Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life" (hereafter, "Life-Sustaining Treatment Decision Act") in 2016 and its subsequent enforcement in 2017, we now mark its seventh year in 2023. Post-implementation, the Act has been the focal point of myriad discussions and proposals. These discourses, spanning legal, medical, and philosophical domains, pivot on the Act's foundational ethos: to honor patients' autonomy and uphold their inherent dignity and worth. This is achieved by codifying the decision-making process concerning life-sustaining treatments, grounded in the core tenets of advance statements on such treatments, the governance of these declarations, and the essential considerations for determining and executing life-sustaining interventions.

Of particular note, questions surrounding patients' right to self-determination, the ideological bedrock of the system, have emerged. Central to these debates is the query of whether the extant law mandates "surrogate decision-making" when discontinuing life-sustaining treatments. For example, scholarly inquiries have scrutinized the very model of substitute decision-making autonomy, suggesting the "relational-autonomy" paradigm as a fitting alternative within the prevailing legal structure. Others have championed an overhaul of the system, grounding their arguments in the "pure autonomy standard" principle.[1]

Moreover, concerns have been raised regarding certain demographics, including minors, those without legal representation, or elderly individuals estranged from family, who are perceived to lack decision-making capacity and consequently are deprived of autonomous decision-making opportunities. Various scholarly works have labeled these groups as "decisionally vulnerable" or "decisionally inca-

pacitated," highlighting and critiquing the oversight in the existing system."[2]

Recently, instead of relying solely on the patient's right to self-determination based on "the pure autonomy standard", there have been proposals to actively reflect the medical practice where decision-making is predominantly carried out by family members. These proposals include the introduction of medical decision surrogacy, as seen in the United States' Uniform Health Care Decisions Act. They suggest including a system of designating representatives during the stage of advance statement on life-sustaining treatments and expanding the range of surrogate decision-makers in cases where the patient's intention is unknown during the end-of-life phase or when it cannot be ascertained.[3]

The discourse to date presents a tapestry of multifaceted viewpoints and intricate frameworks, challenging any attempt to distill them into a singular narrative. Yet, a consensus seems to emerge, advocating for a scenario where "each individual can confront death on their own terms." In this vein, my focus shifts to examining potential avenues to fortify the right to self-determination for those under 19 years of age (hereafter, "minors") within the context of decisions regarding the cessation of life-sustaining treatments. This is one of the foundational elements of the prevailing system governing the termination of such treatments. My inquiry is predicated on the belief that invigorating this system is paramount to ensuring a more direct realization of the right to self-determination.

In terms of minors' right to self-determination in medical situations, the recent Supreme Court judgement (Case No. 2020Da218925, hereinafter referred to as the "subject judgement") delivered in March of this year is noteworthy. This ruling grappled with the question of whether healthcare practitioners bear a direct responsibility to elucidate procedures to minor patients. To safeguard the minor's right to self-determination by ensuring the comprehensive discharge of the duty to provide explanations, the ruling delineated scenarios contingent upon the intended recipient of such explanations: (1) the minor patient directly, (2) the parent in their capacity as the legal guardian (and holder of parental authority), or (3) both entities. Particularly, regarding the question of whether the object of the duty to provide

explanations is the minor patient themselves, the judgement emphasized the need to assess the decision-making capacity of the minor on a case-by-case basis, taking into account the age and understanding of the minor patient. This aspect of the judgement is significant as the Supreme Court acknowledged the decision-making capacity of minors in medical situations and explicitly called for the individual assessment of decision-making capacity for each minor.

In this paper, I will commence by dissecting the ruling's content, its interpretative nuances, and the legal quandaries it surfaces (Part II). Subsequently, drawing from this analysis, I will delve into the assurance of minors' right to self-determination, viewing it through the lens of their paramount interests within the ambit of the "advance medical directive" paradigm (Part III). Throughout this exploration, the article will reference international legislative precedents, probing potential methodologies to fortify minors' right to self-determination and culminating in proposed directions for future consideration (Part IV).

II. Content of the Subject Judgement

1. Facts

On June 14, 2016, plaintiff 1, then aged 11 years and 7 months, sought medical attention at X University Hospital due to a suspected case of 'Moyamoya disease', a disorder marked by abrupt occlusions of cerebral arteries. Merely three days later, on June 17, the first plaintiff was transferred to Y University Hospital (hereafter termed the "defendant hospital") to undergo cerebral angiography (henceforth, the "subject procedure") as a preliminary step before an indirect revascularization surgery for the diagnosed ailment. Roughly a fortnight thereafter, on June 30 at precisely 9:34 AM, the first plaintiff was once again admitted to the defendant hospital.

The attending physician for plaintiff 1 and a pediatric urologist at the defen-

dant hospital, explained the procedure and presented the consent form regarding the procedure, including the following sections: "I. Explanation of the Diagnosis, II. Prognosis in Case of Non-Treatment, III. Types of Treatment Methods, IV. Reasons, Objectives, and Necessity of the Procedure, V. Procedure Method and Details, VI. Potential Complications and Side Effects, VII. Actions in Case of Problems, VIII. Post-Procedure Precautions, IX. Additional Explanations." Sequentially, he provided the explanation while presenting the consent form to plaintiff 2, who was the mother of the plaintiff 1, and plaintiff 2 signed it as the legal representative or guardian of plaintiff 1.

The subsequent day, on July 1, 2016, plaintiff 1 underwent cerebral angiography between approximately 9:00 AM and 10:20 AM, and by 10:37 AM, was relocated to the general ward. Regrettably, plaintiff 1 suffered two seizure episodes, and an MRI scan revealed an acute brain infarction in the territory of the left middle cerebral artery. Consequently, plaintiff 1 was promptly moved to the intensive care unit for specialized care.

Roughly two weeks later, on July 13, 2016, plaintiff 1 received the indirect revascularization surgery and was released from the defendant hospital a week thereafter. Tragically, the aftermath left plaintiff 1 with enduring right-sided hemiplegia and compromised linguistic abilities. In light of these outcomes, the plaintiffs initiated a medical negligence lawsuit against the defendant hospital, seeking compensation.

The main arguments of the allegation were twofold: first, there was negligence in the performance of the procedure in this case, and second, there was a violation of the duty to provide explanations. Specifically, it was claimed that the medical staff only explained the risks to plaintiff 2 and failed to provide direct explanations to plaintiff 1, thereby infringing upon plaintiff 1's right to self-determination and violating the obligation to provide explanations, which led to the filing of the medical malpractice lawsuit seeking damages against the defendant hospital.

2. Court Decisions

The legal proceedings advanced sequentially from the trial court to the appellate court, culminating at the Supreme Court. Across these three judicial phases, concerning the duo of pivotal issues, all courts concurred in dismissing the merits of the initial contention. Yet, they diverged on the matter of whether the defendant hospital's omission to directly elucidate the procedure in question to the first plaintiff amounted to a breach of the duty to provide explanations. Hence, in this segment, a scrutiny will be confined to the latter contention.

(1) First Instance: Seoul Central District Court, Decision 2019Ga-Hap505956 on June 11, 2019.

The first instance court ruled against the plaintiff. In other words, based solely on the recognized facts, the court determined that the defendant hospital had fulfilled its legal duty to provide explanations.

(2) Appellate Court: Seoul High Court, Decision 2019Na2028025 on January 23, 2020.

However, the appellate court's judgment differed from the first instance court. The appellate court found that there were violations of the duty to provide explanations by the medical staff of the defendant hospital and that the self-determination right of plaintiff 1 had been infringed. The court acknowledged that plaintiff 2, as the legal representative or guardian of plaintiff 1, had signed the consent form. However, despite the fact that ① the invasive procedure such as the procedure in this case was performed on a young child with suspected 'Moyamoya disease', which carried a high risk of cerebral infarction, and efforts should have been made to explain the procedure to the child to ensure they do not feel anxious (except when the child is pre-school age and communication is difficult, in which case the procedure should be performed under general anesthesia to ensure a calm state), ② there was no direct confirmation that the pediatric neurosurgeon at the defendant

hospital, who was responsible for the procedure in this case, directly explained to plaintiff 1, who was 12 years old at the time, the reasons for the procedure and the potential side effects such as cerebral infarction, and ③ considering the blank spaces in the section surrounding "I. Explanation of the Diagnosis" in the consent form, it can be inferred that the attending physician responsible for the procedure should have provided more specific explanations about the procedure process and the risks associated with potential side effects such as cerebral infarction so that the child and their guardian could make a well-informed decision. Based on these findings, the court concluded that the defendant hospital's violation of the duty to provide explanations infringed upon plaintiff 1's self-determination right and ordered the payment of damages.

(3) Supreme Court

Conversely, the Supreme Court deviated from the determinations of the subordinate courts. The jurisprudential tenets articulated in the referenced ruling can be encapsulated as follows.

1) Minors Are Generally Subject to the Duty of Explanation

Firstly, the subject decision recognized that even if a patient is a minor, as long as they possess decision-making capacity, they have the right to make decisions regarding medical procedures that may pose risks to their own bodies. Therefore, the court held that, in principle, healthcare providers have an obligation to explain medical procedures to minor patients.

2) Explanation Provided by the Physician to the Guardian or Legal Representative of the Minor Patient Can Be as Fulfilling the Duty of Explanation to the Minor Patient

The subject decision also recognized that in practice, when a physician explains medical procedures to a minor patient, it is considered acceptable for the ex-

planation to be conveyed to the minor patient through their guardian or legal representative. This is applicable in situations involving general circumstances where a physician explains medical procedures to a minor patient, as well as in accordance with Article 24-2.1. and 24-2.2. of the Medical Service Act: "(1) Where a medical doctor, dentist or Korean medicine doctor performs a surgery, blood transfusion or general anesthesia (hereafter in this Article referred to as "surgery, etc.") that might cause serious harm to a life or body, he or she shall explain the matters set forth in paragraph (2) to the patient (referring to a legal representative, where the patient lacks decision-making capacity; hereafter in this Article the same shall apply) and obtain a written consent (including an electronic document; hereafter in this Article the same shall apply) from the patient: Provided, That this shall not apply where the patient's life might fall into danger or the patient might fall into serious mental incapacity due to the delay of surgery, etc. caused by taking the procedures for explanation and obtaining consent."

This also applies to relevant laws such as Article 9.1. and 9.2. of the Emergency Medical Service Act, which stipulates that if an emergency medical practitioner needs to provide emergency medical treatment to an emergency patient lacking decision-making capacity, they must explain the treatment to the patient's legal representative who accompanies them, and if no legal representative accompanies the patient, they must explain the treatment to the person who accompanies the patient before providing emergency care.

Furthermore, Article 16.1. and 16.2. of the Bioethics and Safety Act state that in research involving human subjects, the researcher must obtain written consent, and in the case of research involving minors under 18 years of age, who are deemed to lack or have incomplete decision-making capacity, the consent of the legal representative or others must be obtained, but such consent should not contradict the intentions of the research subject.

Considering the purpose, the Supreme Court concluded that it is also permissible for the physician to explain medical procedures to a minor patient through their guardian or legal representative. In other words, it is common for "a minor

patient, under the protection of their guardian or legal representative, to visit a hospital, listen to the physician's explanation, and choose and consent to medical procedures. In the case of a minor who is not yet mentally or physically mature, it may be more desirable for the explanation to be conveyed and accepted by the guardian or legal representative, who has a relationship with the minor patient, rather than allowing the minor patient to directly receive the explanation and make decisions regarding medical procedures."

3) In Specific Situations, the Physician Must Explain Medical Procedures Directly to the Minor Patient, Taking into Account the Minor Patient's Age and the Level of Understanding of the Illness on a Case-by-case Basis

Yet, the Supreme Court posited that in scenarios where, despite the guardian or legal representatives receiving the explanation, it remains uncommunicated to the minor patient, thereby overtly sidelining the minor's consent in the decision-making and execution of the medical intervention, or when the minor patient actively manifests a resistance to the procedure, there exist "exceptional circumstances necessitating a direct elucidation of the medical procedure to the minor by the physician." Under such circumstances, the onus is on the physician to directly convey the details of the procedure to the minor, factoring in the minor's age and comprehension of their medical condition.

Based on the above legal principles, the Supreme Court clarified that the error in the lower court's decision does *not* lie in the result of the judgment itself, which concluded that the healthcare professionals at the defendant hospital infringed upon the plaintiff's right to self-determination. Rather, the lower court *should have* examined whether there were circumstances indicating that even if the defendant hospital explained the nature of the medical procedure to the plaintiff (1) and determined that the plaintiff had the capacity to understand and make decisions regarding the procedure (2), whether there were special circumstances that required the defendant hospital to directly explain the surgical procedure related to this case

to the plaintiff, even if the explanation had been given to the legal representative or guardian of the plaintiff. Unfortunately, the lower court failed to conduct such an examination.

3. Interpretation

(1) The Capacity to Provide Medical Consent, Which Forms the Basis of a Minor Patient's Right to Self-Determination, is Separate from Legal Capacity under the Civil Act.

The subject decision states that even minor patients are generally subject to the obligation of explanation, and it implies that they have rights to medical consent. The "right to medical consent" refers to the patient's right to receive medical procedures, which requires the patient to listen to the healthcare provider's explanation of their current health status, diagnosis, purpose of the medical procedure, treatment methods and duration, risks associated with the treatment, expected results, and potential sequelae or side effects. The patient must sufficiently understand the meaning of such medical procedures and give consent to receive them. The underlying capacity necessary for this is referred to as capacity to provide medical consent.

The right of a patient to consent to medical procedures is essentially an act of deciding whether to receive specific treatment, which falls within the exercise of the patient's right to self-determination in medical matters. The capacity to provide medical consent serves as a prerequisite for the exercise of a patient's right to self-determination in medical matters.

However, the Civil Act does not provide specific regulations on how to determine and regulate the exercise of self-determination rights by minors, including the criteria and methods for exercising capacity. Instead, in academic discussions, the capacity of minors is generally considered in terms of (1) cognitive capacity, (2) legal capacity, and the (3) liability capacity.

1) Cognitive Capacity

Cognitive capacity refers to the mental ability of an individual to rationally assess the meaning and consequences of their actions based on normal comprehension and foresight. Especially in cases where certain legal actions have specific legal meanings and effects that are not easily understandable from everyday perspectives, cognitive capacity is required to comprehend not only the everyday significance but also the legal significance and effects of such actions. Therefore, it may be difficult to expect cognitive capacity from young children or individuals with severe mental illnesses. According to precedent, cognitive capacity is typically evaluated based on the mental abilities of children aged 7 to 10 years old (See Supreme Court Decision 2001Da10013, decided on October 11, 2002). However, this is not an absolute criterion, and there is no objective or uniform standard for determining cognitive capacity. Hence, the determination of cognitive capacity should be made on a case-by-case basis, especially in relation to specific legal actions (See Supreme Court Decision 2019Da213344, decided on May 26, 2022).

2) Legal Capacity

Legal capacity is the ability to independently engage in legal actions, and distinct from cognitive capacity. Legal capacity is determined by age and is uniformly differentiated. In other words, minors who have not reached the age of 19 are recognized as "the Person with Limited Capacity" under the Civil Act(See Article 4, and 5.1. on the same law). This is because the system is generally applied to legal actions related *to property rights*. The basis of the system lies in the difficulty of individually assessing cognitive capacity for minors. Therefore, to protect the safety of transaction partners and the interests of limited capacity individuals, the legal system allows the cancellation of legal actions undertaken by minors who have not reached a certain age, regardless of their cognitive capacity.

3) Liability Capacity

Liability capacity, under the Civil Act, refers to the intellectual ability of an

individual to understand that their actions may unlawfully infringe upon the legal interests of others, and it involves the ability to assume legal responsibility for their actions. Similar to cognitive capacity, liability capacity is judged individually concerning each action.

Now, which of these three capacities does the capacity to provide medical consent correspond to? Regarding this question, the research by Choi, Ah-reum; Kim, Seong-eun; and Baek, Kyung-hee (2023) suggests that while it is difficult to conclude that the capacity to provide medical consent is entirely identical to any of these three capacities, it is closely related to two of them: cognitive capacity and liability capacity.[4]

For cognitive capacity, it is considered essential for minor patients to understand complex and intricate medical procedures, make decisions that respect their human dignity, and reach decisions that serve their best interests. Meanwhile, liability capacity involves a preliminary understanding and acceptance of various possible outcomes, including uncertain and hypothetical results, in interactions with oneself and others, particularly in cases of "medical acts with good intentions (beneficent intrusion)." In this context, it is important to consider the notion of "self-responsibility," encompassing an understanding of potential risks to oneself. This should be viewed in a light similar to legal liability capacity, even if full legal liability is not mandated.[5]

Yet, given that the exercise of the right to medical consent does *not* constitute a legal action but rather an *endorsement* or *permission* for a tangible act, the question of legal capacity becomes inconsequential. Hence, when deliberating on the essence of capacity for medical consent, it is deemed primary to set this aspect aside.

In both medical practice and legal precedents, how do we *rationalize* parents or legal guardians acting on behalf of a minor patient's right to give medical consent? This practice stems from the common procedure where hospitals enter into medical agreements with the legal guardians of minor patients, treating it as a property-related legal action, before obtaining consent from the minor. Since a medical contract is a legal action, minors can also enter into medical contracts with

the consent of their legal representatives. If a minor patient is recognized to have the capacity to provide medical consent, they can independently give consent for individual medical procedures, regardless of the consent of their legal representative. However, for medical procedures involving longer treatment periods or major invasive surgeries, the medical expenses may be beyond what a minor can afford. As a result, it is common for legal representatives to be involved from the stage of entering into a medical contract, and for medical practitioners to prioritize explaining the procedures to them. Therefore, in medical practice, the exercise of the right to medical consent for minor patients typically *appears as* an act of parental authority in addition to or separate from the cognitive capacity of the minor patient.[6]

(2) Generally the Support of Their Parents or Legal Representatives Is Necessary When Minor Patient Exercises Their Medical Consent Right, and the Rationale for This Requirement Lies in the Welfare of the Minor Patient

The subject judgment also states that it is permissible for the minor patient's parent or legal representative to provide the explanation on their behalf. In this context, one perspective is that this allows the parents to act as a legal representative and exercise their rights to consent. Another perspective is that it *assists* the partial consent capacity of the minor, which is a natural consent capacity separate from the minor's legal capacity, but may not be fully matured, depending on individual developmental levels.

While there may be differing opinions on this matter, the judgment emphasizes that the explanation given by the healthcare provider to the parents can be considered as fulfilling the explanation obligation to the minor patient. However, to make this explanation legally valid, it must be "*conveyed*" to the minor patient, indicating that they should *not* be excluded as the subject of the explanation obligation. The rationale for providing the explanation to the parent is based on the spirit of Article 912 of the Civil Act, which states that in exercising parental authority, the welfare of the child should be prioritized. This emphasizes the parental aspect as a

form of "parental authority," separate from the minor patient's capacity for self-determination, regardless of whether the minor patient has cognitive capacity.

(3) However, in Special Circumstances, the Minor Patient's Medical Consent Capacity Is Considered to Be Intact

The Subject judgment also suggests that the minor patient's decision takes precedence over that of their parents or legal representatives when there is *clear* conflict of interest between them or when the patient *explicitly* refuses medical treatment. Furthermore, the subject judgment indicates that the determination of whether the minor patient has medical consent ability relies on the development level and the nature of the situation that requires the minor's consent, based on the principle of the "Gillick Competence" or "Gillick Rule" established in the UK. This principle allows minors to make decisions about their treatment without parental consent if they have reached a sufficient level of maturity.

While the significance of providing criteria for judging whether a minor patient has full capacity to consent is noteworthy, in the absence of legal standards or guidelines for assessing whether they have the capacity, it may be challenging to evaluate the capacity of each individual minor patient in medical practice. There may be a tendency to defer the evaluation to the court in retrospective legal disputes. However, according to the subject judgement, if a minor patient is deemed to have met the criteria for "special circumstances," healthcare providers who fail to fulfill the explanation obligation to the minor patient before treatment may face increased responsibility. Therefore, while considering the legal significance of the specific judgment, it is essential to address the necessary measures to protect the self-determination rights of minor patients.

These measures could include: (A) Setting separate guidelines for minors categorized by age group, encompassing infants aged 1 to 6, children aged 7 to 13, and adolescents aged 14 to 18, based on relevant laws and references, (B) Establishing objective indicators for measuring the development of capacity to consent, taking

into account the reality of family policies and medical practices in Korea, while preserving the fundamental purpose of ensuring minors' self-determination rights through exercising their rights to consent.

III. Issues and Challenges in Relation to the Current Advance Statement on Life-Sustaining Treatment System and the Right to Self-Determination

1. Relationship Between the Right to Medical Consent and the Right to Self-Determination under Life-Sustaining Treatment Decision Act

(1) Implications of the Subject Judgement

The subject judgement indicates the following points:

A. The right to consent is fundamentally distinct from the current legal capacity under the Civil Act, and thus the assessment of the level of development is not confined to the statutory age of 19 for legal capacity.
B. However, the preference for parental consent, if not the exclusive consideration, can be attributed to practical considerations such as medical contract obligations, including medical expenses.
C. In accordance with the legal principles of the judgement, when the consent ability of a minor is not fully developed, it aims to ensure the best interest of the child.
D. The degree of consent ability of a minor should be assessed based on their unique knowledge and experiences, emphasizing the need for individual guidelines corresponding to the age group of the minor to enable case-by-case evaluations.

Nonetheless, for these implications to strengthen the protection of the right to self-determination of minors under the Life-Sustaining Treatment Decisions Act, it is crucial to elucidate the relationship between the medical consent ability of minors and the underlying principles of the Act. Especially, the correlation between the right to self-determination in the Life-Sustaining Treatment Decisions Act and its justifications for capacity needs to be clarified before bolstering the persuasiveness of these implications in safeguarding the right to self-determination of minors.

2. Legal Nature of the Act of Drafting "Advance Statement on Life-Sustaining Treatment" and "Life-Sustaining Treatment Plan"

Firstly, the capacity to consent to medical procedures refers to a person's ability to assess whether to permit or refuse medical interventions concerning oneself after being informed of their current health status or diagnosis, the purpose of the medical treatment, the treatment methods and duration, potential risks, anticipated results, and possible after-effects or side effects of the treatment. In essence, it requires the individual to comprehend the significance of the medical intervention and make a judgment accordingly.

Conversely, when an individual creates an "Advance Statement on Life-Sustaining Treatment" (hereafter "Advance Statement") or a "Life-Sustaining Treatment Plan," it represents their decision to decline futile life-sustaining medical interventions. This decision is made for situations where they are at the end-of-life stage, with no hope of recovery despite medical treatment, and are on the brink of death due to rapidly worsening symptoms. This act can be regarded as a part of exercising their medical consent rights concerning invasive medical procedures on their own body.

However, the act of exercising the right to consent of a minor in withholding or terminating the life-sustaining treatment requires more distinctive protection due to its specific nature. Firstly, regarding the capacity for assuming responsibility, it could be argued that the same degree of responsibility shift ability required for

medical consent is demanded in exercising right to consent to withhold life-sustaining treatment. However, the extent of this requirement may be *alleviated* instead.

The reason for this lies in the emphasis of the patient's reliability capacity in the Medical Service Act, where the consideration is based on whether the patient can understand and accept the potential consequences of the physician's invasive medical intervention in good faith during treatment. On the other hand, in the case of a patient at the 'end-of-life' phase, considering withholding life-sustaining treatment as an invasive procedure, it is an act that would *only* prolong the process of dying, increasing suffering and harm to the patient, rather than a decision that may potentially shorten their life(See Article 2.2. of the Life-Sustaining Treatment Decision Act). Therefore, the act of refusing such invasive treatment is *closer* to accepting the protection of one's own dignity and value rather than harboring the possibility of shortening their life. Moreover, the demand for this responsibility shift ability would be alleviated further when the accuracy and objectivity of the diagnosis of the end-of-life are guaranteed. For the same reasons, the requirement for the capacity of the child's welfare for the minor to be exercised by the consent of the parent or legal representative would also be relaxed.

In summary, while the exercise of the consent ability of a minor in the circumstances of withholding or terminating the life-sustaining treatment shares similarities with general medical procedures in terms of the purpose of treatment and the exercise of right to consent, the act of withholding or terminating the treatment, and its nature of decision-making, necessitates less intervention from parents or legal representatives compared to general medical procedures. It can be considered as an independent decision in such cases.

However, it is essential to note that the premise of the 'right to consent' is the 'capacity to consent,' which has characteristics of legal capacity. Thus, in exercising consent rights for withholding or terminating of life-sustaining treatment, the capacity for consent that minors can exercise, just like the capacity for medical consent, should be recognized regardless of age. However, to ensure full exercise of this capacity, individual judgment based on the level of understanding should be taken

into account.

In conclusion, the inferred transformation of the capacity to consent in the context of the Life-Sustaining Treatment Decision Act would be as follows:

A. The capacity to make decisions regarding the termination of life-sustaining medical treatment is fundamentally distinct from the legal capacity for acts under the current Civil Act. Therefore, it is not restricted to the statutory age of 19 for assessing the level of development.

B. However, the reason why the consent of the legal guardian is given priority or solely considered in practice is due to the practical consideration of medical contractual obligations, including the responsibility for medical expenses.

C. If we follow the legal principles of the subject case, when the capacity to make decisions is not fully developed, the aim is to maximize the best interests of the child by ensuring their welfare. Moreover, the termination of futile treatments can be an option to remove harm to the patient, in line with the constitutional intent of Life-Sustaining Treatment Decision Act.

D. The degree of capacity of a minor in making decisions on the termination of life-sustaining treatment should be assessed individually based on the minor's unique knowledge and experiences. To ensure individualized assessments, specific guidelines corresponding to the age range of minors should be established.

3. Limitations of Minors' Exercise of Self-Determination under Current Law

The importance of considering the aforementioned perspectives lies in the fact that the current law limits the self-determination of minors. Given that only

individuals aged 19 or older can participate in the Advance Statement system (See Article 2 of the same act), the most direct scenario where a minor patient can genuinely express their intent is when they, at the end-of-life stage, acknowledge the explanation given by their attending physician and, under the guidance of their parents or legal guardians and the overseeing doctor, draft a Life-Sustaining Treatment Plan (See Article 10.3 of the same Act). Even in such a case, confirmation by a legal representative is *required* simultaneously.

On the other hand, the Act allows for decision-making on behalf of the minor, albeit not directly reflecting their personal wishes, in cases where the medical condition of the patient prevents the verification of their intention or when the patient cannot express their intentions. In such circumstances, the legal guardian of the minor patient can make the decision regarding the termination of life-sustaining treatment, and it requires confirmation by the attending doctor in charge and another specialist (See Article 18.1. of the same act).

The challenges of making decisions on behalf of a minor encompass not just the indirect representation of the patient's wishes but also (1) the procedural issue arising when parents jointly exercise parental authority but have conflicting intentions, and (2) the absence of clear guidelines to safeguard the best interests and well-being of the minor patient. In cases where the patient's legal guardians are with several different interests, the absence of clear guidelines to prioritize the minor patient's welfare might lead to decisions influenced by the personal interests of the legal representatives, potentially infringing on the patient's right to self-determination.

4. Ensuring the Self-Determination Rights of Minors in Decisions to Withholding or Terminating the Life-Sustaining Treatment: A Comparison with the Uniform Health-Care Decisions Act

Various strategies have been proposed to address the complexities of safeguarding minors' rights to self-determination in decisions concerning the cessation

of life-sustaining medical interventions. Within this spectrum of solutions, this article will predominantly focus on the extant Advance Statement system and the Life-sustaining Treatment Plan system, using them as foundational reference points for comparison.

(1) Lowering the Age Criteria for the "Advance Statement of Life-Sustaining Treatment"

The United States adopts the concepts of "*mature minor*" and "*emancipated minor*" in this regard. Recognizing that the capacity of minors to comprehend medical decisions increases with maturity, legal, ethical, and scientific considerations have led to the enhancement of minors' role in the decision-making process. Notably, research has highlighted that adolescents can independently make medical decisions despite parental influences.[7]

The concept of a "mature minor" has been established through legal precedents,[8] while an individual considered as an "emancipated minor" is defined under state law: Emancipation of minors. The latter encompasses minors who, according to age criteria set by state law, can live independently without parental or guardian supervision. Notably, they are permitted to provide oral or written Advance Directives in accordance with the Uniform Health-Care Decisions Act, which is a federal medical decision unification law.

To be officially recognized as an "emancipated minor", the following conditions are required: ① Parental loss of custody due to child abuse or similar circumstances, ② Sufficient proof of financial independence or maturity to make medical decisions, and ③ Comprehensive evaluation of whether the minor's interests are served, with court judgement as necessary. Generally, a minimum age of 16 years is required.[9]

(2) Introducing the Representative Designation System to the Advance Statement System

As described, an emancipated minor under the Uniform Health-Care Decisions Act has the authority to delegate their decision-making powers in writing to an agent, granting them the power to make decisions that the minor could have made themselves if they had the capacity. This could be done through either oral or written advance medical directives (See Section 2. Advanced Health-care Directives (a), (b)).

(3) Expanding the Scope of Surrogate Decision-Makers Authorized to Draft a Life-Sustaining Treatment Plan

According to the Uniform Health-Care Decisions Act, an emancipated minor can appoint an individual as their surrogate decision-maker for drafting a Physician Orders for Life-Sustaining Treatment (POLST) by directly notifying their doctors in charge. The scope of agents authorized to draft a POLST has been expanded to include individuals in the following order: (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; or (4) an adult brother or sister. (See the section 5 (b) of UHCDA). It is possible to interpret this as broadening the range of lawful agents who can act on behalf of the individual for the draft of the Life-sustaining treatment Plan.[10]

However, it should be noted that the Uniform Health-Care Decisions Act does not establish a set of criteria to determine what is in the best interest of the patient for decision-making. Instead, it allows proxies, representatives, or agents to make medical decisions based on the patient's explicit expressions of their wishes and interests within the scope of what the agent knows.

5. Review

It is worth considering a reduction in the age requirement for the Advance Statement system or introducing the option for advanced agent designation. While there is a focus on enhancing the Advance Statement system, broadening the range

of surrogate decision-makers, and promoting presumptive decision-making under strict conditions in the Life-Sustaining Treatment Plan system, each method has its advantages and disadvantages. Notably, the latter strategy provides significant advantages in terms of time and cost savings, especially when avoiding court-appointed guardianship for a minor patient at the end-of-life stage who is not able to make decisions due to a lack of agreement among legal guardians. In my opinion, based on the following reasons, the former approach should take precedence.

(1) The Advance Statement System Directly Guarantees the Exercise of Self-Determination Rights

It is evident that the core philosophy behind the Advance Statement system centers on the patient's right to self-determination, aiming to prevent unnecessary prolongation of natural death and to preserve human dignity. The direct exercise of self-determination rights is realized through the draft and registration of the Advance Statements and the Life-sustaining treatment Plan. While both documents aim to ascertain the patient's preferences and intentions about withholding or discontinuing life-sustaining treatment under the same legal framework, their legal characteristics are distinct.

The Advance Statement is a legal document of *disposition* directly constituted by the patient, while the latter is a document *reported* by the attending physician based on their observations, hearing, feelings, and judgments. Especially concerning decisions regarding end-of-life circumstances, the self-determination must be the patient's own decision in situations with existential limitations.[11] Therefore, it is reasonable to improve the protection of minors' rights to self-determination by focusing on the Advance Statement system, as evidenced by decisions and legislative examples in the United States where the capacity to make decisions is individually determined.

(2) Expanding the Scope of Surrogate Decision-Makers Excessively May Reinforce the Existing Practice of Prioritizing Intentions of Paying Parties, Inconsistent with the Underlying Spirit of the Life-Sustaining Treatment Decision Law

This apprehension becomes pronounced when one contemplates enhancing the latter approach without rectifying the issues inherent in the Advance Statement system. As previously delineated, while the medical consent of minors is not categorically negated, the prevailing emphasis on the consent of legal guardians in medical practices is inextricably linked to pragmatic considerations surrounding medical contracts and associated fiscal responsibilities. Broadening the spectrum of surrogate decision-makers—even if restricted within familial bounds—under the "family autonomy model" appears congruent with the emotive ethos of Korean society. Yet, this also necessitates a contemplation on the relative prevalence of 'functional families' versus 'dysfunctional families' in the Korean societal context.

Unlike the Korean societal context, the ethos of individual autonomy has been deeply embedded in the historical fabric of the United States. Consequently, even when a modicum of autonomy is vested in family members, there have been advocacies for the institution of safeguards that mandate a "substituted judgment standard", hinging exclusively on unequivocal evidence of the patient's personal values, desires, and intentions. Absent such measures, there looms a considerable peril that familial autonomy might inadvertently pivot towards delineating what the patient's preferences ought to be in the family's interest, rather than ardently championing the patient's interests and endeavoring to discern or extrapolate them.[12] Thus, foregrounding such a perspective, especially when the inherent risks are palpable and the prevailing system already potentially curtails minors' rights to self-determination, appears misaligned.

(3) Expectation of Mutual Complementation between Two Systems

Moreover, as highlighted in Ahn, Dongin's 2020 article exploring methods to

enhance the legal standing and implementation of the Advance Statement system, it is imperative to not solely focus on the application of the Life-Sustaining Treatment Plan system, akin to POLST, but also to recognize the foundational role of the Advance Statement system in upholding patients' rights to self-determination.

As opposed to denying the inherent self-determination rights of minors and their capacity to consent and make decisions, it is understood that certain age groups may possess abilities similar to adults. Therefore, as described below, not only adults but also minors whose capacity to consent is recognized through individual assessment should be encouraged to draft advance statements for end-of-life treatments. Subsequently, a system can be established where they can develop and update their advance statements based on changes in their health conditions. By implementing such measures within the system, it is expected to systematically safeguard the minors' rights to self-determination more effectively.

IV. Conclusion

In conclusion, the subject decision explicitly states that despite the prevailing medical practice, minors can also be the subjects of capacity to consent. Although it acknowledges that, in some cases, the consent ability of minors in medical procedures may be complemented by the ability of a person with parental authority or a legal representative, it opens the possibility of extending the capacity to consent of minors in situations where their independent capacity is required, specifying the extent and general criteria for such judgments for making decisions against meaningless life-sustaining treatments.

This legal argument put forward by the Supreme Court is not entirely unnatural. Some might perceive minors merely as young children and find it disconcerting that such individuals are at the helm of decisions concerning life's culmination. Yet, just as life's inception and cessation are *natural* progressions for all, acknowledging that minors too possess the right to reflect upon and envision their final mo-

ments, and the overarching trajectory of their existence, and to determine its course, is inherently logical. Furthermore, if their genuine aspirations and desires are given due weight, eschewing artificial life prolongation at another's bidding, it could even serve as a poignant affirmation of their *life's* worth.

In light of this perspective, I posit that incorporating minors as rights-bearing entities within the Life-Sustaining Treatment Decision Act, as consistently advocated in this paper, holds significant merit. Nonetheless, as we navigate this inclusion, anticipated complexities tied to the implications of the aforementioned decision will emerge, which I will address as I draw this article to its conclusion.

A. Establishing Guidelines for Individual Assessment of Minors' Capacity to Consent

The determination of a minor's capacity to consent, similar to legal reasoning in the decision of the Supreme Court, should be made on an individual basis. In this regard, the criteria for assessing a minor's capacity to consent regarding 'the decision to discontinue life-sustaining treatment' need to be carefully considered to avoid excessive individualization, which could cause practical difficulties in the field. While merely illustrative, a phased approach to tackle these challenges might entail refining the criteria for capacity assessment. For example, individuals should grasp the implications of their consent to discontinue treatment, encompassing potential unforeseen outcomes—even in rare circumstances like unanticipated life extension during the end-of-life phase.

On the other hand, to prevent confusion in medical practice and simplify the counseling process in the Advance Statement system, for instance, implementing an age restriction (e.g., over 16 years old) or referencing relevant legal regulations concerning the definition of minors in the Criminal Act, the Organ Transplant Act, or the age required to make wills to segment the age groups. Here are some examples regarding age segmentation:[13]

- Children under 10 years old: Capacity to consent is excluded as a

principle due to the likelihood of not having general decision-making capacity.

• Children aged 11 to 15: While they may have the capacity, it is acknowledged that a significant portion of this age group is likely to have a low level of it. Thus, as a principle, the involvement of the patient's parents or legal guardian, or discussions with them, should precede the draft of Advance Statement. Furthermore, it may be permitted under the condition that the outcomes of the counseling are shared with their parents or legal guardians.

• Adolescents aged 16 to 18: Considering their capacity in most cases, the principle is to allow the draft of the Advance Statements. However, to ensure validity, it should be confirmed that counseling outcomes have been shared with their parents or legal guardians. In exceptional circumstances, if it is determined that the minor, as the author, is experiencing psychological distress or lacks full decision-making capacity, a provision for post-revocation may be considered.

B. Providing Educational Programs for "Advance Statement of Life-Sustaining Treatment" and Obtaining Detailed Statistical Data

As mentioned earlier, since determining the capacity to consent for minors in the context of discontinuing life-sustaining treatment requires contemplation and comprehensive thinking about the future outcome, i.e., 'death,' it is necessary to *incorporate* the education as part of the life ethics. This would help minors at different developmental stages to gain insights into death, establish their own value system, and prepare for future situations. For instance, for children below the age of 10, one might employ non-verbal or symbolic pedagogical techniques. Alternatively, literary methodologies can be introduced to facilitate exercises that allow them to resonate with future scenarios that transcend temporal boundaries.

Furthermore, it is essential to further elaborate on the items in the current sta-

tistics available on the website of the National Agency for Management of Life-Sustaining Treatment,[14] which analyze the number of the usage status or the age group of the registers in the system. Despite the fact that the minimum age to utilize the system is 19 years old, the minimum criterion for age classification in the table is set at 30 years old. It would be beneficial to add an age category of "19 years and above but below 30 years" to align the criteria with the usage of the current system in aim to gain insights into the usage patterns of minors in the future. This preliminary analysis would be vital for considering the practical benefits of system regulation.

C. Strict Examination of the Diagnosing-Records for End-of-Life Stage

As previously noted, given that the "end-of-life" phase implies that any subsequent medical interventions or efforts are futile, it is imperative that this stage be diagnosed with relative precision. According to the Article 16.1. of the current Act: Before terminating, etc. life-sustaining treatment, a doctor in charge shall diagnose, in cooperation with one medical specialist, whether his or her patient is at the end-of-life stage and shall keep records (including records in electronic form) of the outcome thereof as prescribed by Ordinance of the Ministry of Health and Welfare. While recognizing the challenges of making a discretionary judgment in such instances, rigorous oversight, including regular reviews of the records, is essential.

D. Seeking Approaches to Ensure Self-Determination through Surrogate Decision-Making

In conclusion, while the primary emphasis of this article has been on the enhancement of Advance Statements, especially centering on the direct articulation of intent, it remains vital to engage in dialogues and explore alternative solutions that ensure the effective protection of minors' rights to self-determination. Given the challenges highlighted in "Section III.2.", such as instances where a minor's intent remains ambiguous or potential system misuse due to conflicting interests among guardians, a systematic consideration of preventive strategies is paramount.

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1 *See e.g.* Song, Yoon Jin, *Limitations and Alternatives of Autonomy Competence Model in Medical Decision-Making*, Korean Journal of Medical Ethics, Vol.19 Issue3, 45-88(2016) & Kim, Claire Junga, *Two Conceptions of Autonomy in Surrogate Decision-Making for Life-Sustaining Treatment: An Examination of Article 18 of the Hospice, Palliative Care, and Life-Sustaining Treatment Decision-Making Act*, Korean Journal of Medical Ethics, Vol.20 Issue1, 56-77 (2017).

2 *See e.g.* Lee, Seok-Bae, *Incapacitated Patients and Their Right to Self-Determination*, Korean Journal of Medicine and Law, Vol.18 Issue1, 7-28 (2010) & Choi, Hye Young, *A Legal Study on Self-Determination Right to Life of Vulnerable Persons in Decision-Making–Focused on Life-Sustaining Treatment Determination Act–*, Doctoral Dissertation, Korea National Open University (2022).

3 *See e.g.* Lee, Jieun, *Surrogates Decision Making on Life-Sustaining Treatment*, Soongsil Law Review, Vol.50, 217-247 (2021).

4 Choe, A-Reum, Kim, Sung-Eun & Baek, Kyoung-Hee, *A study on the Physician's Obligation to Explain to Minors Patients –With a Focus on the Commentary on the Supreme Court Decision 2020Da218925 Decided March 9, 2023–*, Sogang Law Journal, Vol.12 Issue2, 153, 162-166 (2023).

5 *Id.* at 166.

6 *Id.* at 167.

7 Bruce Ambruel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, Law & Hum. Behav, Vol.16, 129, 148 (1993), cited in Eom, Ju-hee, *Decision making of Withholding or Withdrawal of Life-Sustaining Treatment for Minors in the U.S*, Soongsil Law Review, Vol.41, 121, 129 (2018).

8 Although Canadian provinces have varying provisions, they share the principle that "legal age of majority does not carry significance" in medical decision-making. Consequently, like the United States, they adopt the principle

of a "mature minor." However, Canada has specifically enacted legislation to acknowledge the medical decision-making capacity of minors and permits individuals aged 16 years and above to create Advance Directives based on substantive law, distinguishing it from the United States. *See i.g.* Sohng, Chai-Woo, *Minor's Right to Making Decision in Medical Care – Focused on the Legislation of Canada–*, Pusan Law Review, Vol. 63 Issue 2, 31-59 (2022).

9 *Supra* note 7, at 124.

10 *Supra* note 3, at 226.

11 Ahn, Dongin, *Searching for a Methodology for the Developmental Progress of the System of Decisions on Life-Sustaining Treatment: The Need to Strengthen the Legal Status and Role of the Advance Statement on Life-Sustaining Treatment*, Administrative Law Journal, Vol. 65, 175, 193 (2021).

12 Kim, Claire Junga, *supra* note 1, at 66-67.

13 *Supra* note 4, at 180.

14 Monthly Statistics, Korea National Institute For Bioethics Policy, last modified 2023.07., https://www.lst.go.kr/comm/monthlyStatistics.do

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