

Euthanasia and Death with Dignity in Japanese Law

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1. Introduction

In Japan, there are no acts and, specific provisions or official guidelines on euthanasia, but recently, as I will mention below, an official guideline on “death with dignity” has been made. Nevertheless in fact, this guideline provides only a few rules of process on terminal care. Therefore the problems of euthanasia and “death with dignity” are mainly left to the legal interpretation by literatures and judicial precedents of homicide (Article 199 of the Criminal Code; where there is no distinction between murder and manslaughter) and of homicide with consent (Article 202 of the Criminal Code). Furthermore, there are several cases on euthanasia or “death with dignity” as well as borderline cases in Japan. I have already published an article on Euthanasia in Japanese Law in English, which was written as a Japanese Report for the XVIIth International Congress of Comparative Law (Utrecht, 16–22 July 2006)¹. Following it, in this paper I will present the situation of the latest discussions on euthanasia and “death with dignity” in Japan from the viewpoint of medical law. Especially, “death with dignity” is seriously discussed in Japan, therefore I focus on it².

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¹ See Katsunori Kai, Euthanasia in Japanese Law, in Marc Groenhuijsen/Floris van Laanen (ed.), *Euthanasia and Comparative Perspective*. 2006 (Wolf Legal Publishers. The Netherlands), pp. 187–194. This book is very useful to understand on world discussions about the euthanasia and “death with dignity”. See also Katsunori Kai, Euthanasia in Japanese Law, in *Japanese Reports for the XVIIth International Congress of Comparative Law*, International Center for Comparative Law and Politics, the University of Tokyo, 2007, pp. 275–284.

² This paper is one that I have reported in the 4th Conference of the International Society of Clinical Bioethics, and the 3rd French-Japanese

2. Definition and classification of euthanasia in Japan

In Japan, there is no official definition of euthanasia, due to the absence of statutes, regulations and official guidelines on euthanasia. However, in literatures there are several definitions of euthanasia. I define euthanasia as “an act to relieve or remove an acute physical pain of the patient, whose time of death is imminent, on his/her sincere request and to make the patient meet his/her own peaceful death”³. This definition, which gains supporters to some extent, includes three fundamental requirements. First, an imminence of the time of death. Second, the existence of an acute physical pain, and third is the patient’s sincere request. In a judicial precedent, however, the definition is slightly different.

Euthanasia is normally classified into five categories in Japan. And mercy killing, which is actively made without the patient’s wish, is excluded from euthanasia. This conduct is considered as a homicide in Japan. Furthermore also “death with dignity” is distinguished from euthanasia.

Five categories of euthanasia are the following. (1) Pure euthanasia; this is a type that the act of doctor doesn’t make the time of death of the patient sooner by removing suitably the pain from the patient. This act is a sort of medical treatment or palliative care and therefore lawful in Japan. (2) Indirect euthanasia; this is a type that giving an analgesic drug hastens incidentally the time of death of the patient. Also this act is lawful in Japan, but the reasons of justification are various. (3) Active euthanasia; this is a type that doctor or close relatives removes the physical pain by means of active killing with lethal drugs and so on by complying with a request of the patient. This has been discussed as a typical euthanasia for a long time in Japan. And it is now disputable whether the act is lawful or unlawful, and if unlawful, whether it is excusable or not. (4) Passive euthanasia; this is a type that doctor does not perform active life-prolonging measures (e.g.

Bioethics Seminar (Seminaire Franco-Japonais de Bioethique) in Aix en Provence (France) 14–15 September 2007.

³ See Katsunori Kai, Anrakushi To Keihō (Euthanasia and Criminal Law), 2003, Seibundō, Tokyo, p. 2.

an intravenous drip injection or an injection of Ringer's solution) by complying with a request of the patient. This omission is generally lawful in Japan, because no one can compel the patient to receive life-prolonging measures against his/her wish will. (5) Physician assisted suicide; this is a new type that the physician assists the suicide of the patient by providing so called suicide machine or lethal drug. This type derives from USA, especially the States of Oregon and Michigan. However this act (especially, active assisted suicide) is generally unlawful in Japan, because aiding suicide is punishable in Japanese Criminal Code (Article 202) and the situation at hand doesn't provide enough justification⁴.

3. Definition and judicial cases of “death with dignity” in Japan

Now in Japan, “death with dignity” (in other word, natural death) is sincerely and broadly discussed. However, the definition of “death with dignity” doesn't clearly exist in Japan. I define it as patient's refusing artificially life-prolonging medical treatments and withholding or withdrawing them⁵. The difficult points lie in that the patients often lose their consciousness and therefore can't directly express their physical pain and wishes of their own life or death by themselves. And also the measures of artificially life-prolonging medical treatments are diverse; e.g. artificial ventilator, artificial nutrition, artificial dialysis and so on. Furthermore, the patient's conditions are various like as permanent vegetative state, the last stage of cancer, Alzheimer' disease, ALS and so on. Considering such varieties, we must make a rule for resolution of problems of “death with dignity”.

Before considering on making a rule of them, I present judicial cases on “death with dignity” in Japan. Recently we have two cases on “death with dignity” in Japan.

⁴ To details including judicial cases, see Kai, *supra* note (1), in Groenhuijsen/Laenen (ed.), *Euthanasia and Comparative Perspective*, pp. 188–193.

⁵ See Katsunori Kai, *Songenshi To Keihō* (Death with Dignity and Criminal Law), 2004, Seibundō, Tokyo, pp. 1–2.

1. Yokohama District Court 28 March 1995⁶.

This case is called “Tokai-University-Hospital-Euthanasia-Case”. The fact was the following.

The patient, who was 58 years old man, was in hospital because of myeloma. He was in the sixth grade of consciousness (no reaction to a pain stimulus) and in critical condition with difficulty in breathing, with loud snore. A young doctor in charge of the patient was requested to remove an intravenous drip injection etc. in order to release the patient from the pain. The doctor worried about how to deal with the situation and then made a nurse remove the intravenous drip injection and the airway. Subsequently the eldest son of the patient said to the doctor, “It is unbearable for me to hear my father’s snore. Please make him comfortable”. The doctor then injected twice the usual amount of sedative drug with a side effect to restrain breathing into the patient, but the situation of the patient did not change after an hour. The son requested the doctor to do again the same thing. So the doctor injected psychotropic drug twice as usual with a side effect to restrain breathing into the patient. As the situation did not change after an hour, the son said hotly to the doctor, “What are you doing? My father is still breathing! I want to take him home soon.” Consequently the doctor decided to comply with the son from the mental state of pressure. And he firstly injected drug for an irregular pulse twice as usual with a side effect of transient cardiac arrest into the patient, but the situation did not change. Thus finally he injected 20 ml of potassium chloride (KCL) without dilution into the patient and consequently the patient died.

The court found the doctor guilty of homicide, and sentenced him to 2 years imprisonment with hard labor with a suspension of the sentence of 2 years (Article 199 of the Criminal Code). In that judgment, the court pointed out 4 requirements to make active euthanasia by doctor lawful. (1) The patient is suffering from an unbearable physical pain. (2) The patient’ death is unavoidable and the time of death is imminent. (3) The doctor tries everything to remove or relieve the patient’s physical pain and there is not any other alternative measure. (4) There is an explicit expres-

⁶ Hanrei-Jihō, No. 1530, p. 28; Hanrei-Times No. 877, p. 148. See also Kai, *supra* note (3), pp. 157 ff.

sion of the patient's will to consent to shorten his life. It is controversial if these requirements are appropriate and enough or not to justify active euthanasia, and I think it not enough in the third requirement⁷. Here, however, I mention rather 3 requirements concerning withholding and withdrawal of artificial life-prolonging medical treatments, which were stated as *obiter dictum*.

The court said the following. Stopping medical treatment is permissible under certain conditions based on the right to self-determination of patients and the limit of physician's duty to perform the medical treatment. (1) The patient should be in such terminal condition that he or she is suffering from incurable disease and no chance of recover, and death is unavoidable. (2) There should be the patient's expression to require to stop medical treatment at the time of stopping it. In medical practice, however, there are more cases lack of the patient's clear expression than with his or hers, and there are many cases where his or her family requires to stop medical treatment or the physician confirms the wishes of the patient's family. So in such cases it can be permitted to judge based on the patient's estimated will with clueing living will or advance directives, furthermore based on the family's expression. (3) Objects of stopping medical treatment are all measures for cure and life-sustaining including medication, artificial dialysis, artificial ventilator, blood transfusion, artificial nutrition, rehydrate and so on.

These requirements are, on the one side, worthy to examine. On the other hand, however, I think that the first requirement is too strict to use it in practice, the second is problematic in the point of attaching too much importance to the Family's wishes, and the third is problematic in the point of recognizing to stop too easily also artificial nutrition and rehydrate⁸.

2. Yokohama District Court 25 March 2005⁹.

This case, which is decided in the same court after ten years from

⁷ See Kai, *supra* note (1), in Groenhuijsen/Laanen (ed.), *Euthanasia and Comparative Perspective*, p. 192 and pp. 193–194.

⁸ See Kai, *supra* note (3), pp. 163–166; Kai, *supra* note (5), pp. 286–289.

⁹ Hanrei-Times No. 1185, p. 114.

“Tokai-University-Hospital-Euthanasia-Case”, is called “Kawasaki-Kyodo-Hospital-Case”. The fact was the following.

The accused was the doctor in charge of the patient (58 years old man) who was in hospital with brain damage due to hypoxemia without regaining his consciousness. The doctor believed that it was better to remove the tube in the trachea before getting bacilli and, and to let the patient breathe naturally in the last moment of his life, and indeed she removed the tube, knowing that the patient would die. Contrary to her expectations, he did not die, and was breathing with difficulty, bending backward like a shrimp. As the doctor could not quiet such a breath, she thought that it was undesirable to show this situation to the patient’s relatives, among whom there were infants. She then made a nurse inject muscle-slacking drug into the patient’s vein, and killed him. Incidentally, she explained to the patient’s family that the patient was 99% in a situation of brain death, without exactly diagnosing brain death.

The court found her guilty of homicide, and sentenced her to 3 years imprisonment with hard labor with a suspension of the sentence of 5 years (Article 199 of the Criminal Code).

In this case, there was not an explicit request of the patient to terminate his life or to withdraw the tube in advance. Therefore the issue of this case was whether a series of the doctor’s behaviors were substantially justifiable or not. The logic of guilty by the district court are the following:

- 1) Discontinuance of medical treatment in terminal phase is only permissible on the ground of the respect for the patient’s right to self-determination of and/or the limit of the duty to medical care, based on medical decision.
- 2) Respect for self-determination of the patient does not imply to admitting suicide and a right to die. It allows the patient to decide for himself or herself how to live his or her own as human-existence and to practice it, and consequently to decide how to live or die in his or her in the final stage of his or her life.
- 3) There should be no prospect of the patient’s recovery, and death should be imminent. The patient should understand this, and he or she should still be sound of mind.
- 4) The patient must be well-informed, and must decide voluntarily. His decision must be sincerely expressed.

- 5) The doctor must pursue the real intention of the patient if he or she cannot directly identify the patient's voluntary self-determination, and the patient's expression.
- 6) In pursuing the real intention of the patient, we can get a convincing handhold from the documents in which his or her intentions were recorded (e.g. living will etc.), and from statements of family members or other people those who are aware of the patient's ideas on life. If in spite of all the efforts, the real intention of the patient cannot be identified, the doctor should give priority to the protection of the patient's life, based on the principle "in dubio pro vita". He will have to continue applying the most suitable medical measures.
- 7) When doctors have exhausted available medical treatment, there is no legal duty to continue or perform such treatment which is medically considered as harmful or meaningless, even if the patient wants it.
- 8) The judgment of the doctor should be persistently limited to validity of medical treatments etc. The doctor may advise the patient how to die, but it should be limited to a consulting opinion, and therefore it is not proper for the doctor to make a valuation on behalf of the patient.

I think that this logic of the judgment is appropriate to some extent because it considers the right to refuse life-prolonging measures¹⁰. The accused appealed to the Tokyo High Court.

3. The Tokyo High Court 28 February 2007¹¹.

The Tokyo High Court denied the doctrine of Yokohama District Court, and reversed the Yokohama District Court, and furthermore sentenced the doctor to 1.5 years imprisonment with hard labor with a suspension of the sentence of 3 years for the homicide (Article 199 of the Criminal Code). The Tokyo High Court took the existence of the consent by the patient's family into consideration. The logic of the Tokyo High Court was the following.

¹⁰ See Katsunori Kai, Shūmatsuki Iryō/Songenshi To Ishi No Keijisekinin (Terminal Care/Death with Dignity and Criminal Liability of Doctor), Jurist No. 1293, 2005, p. 98 ff.

¹¹ Hanrei-Times No. 1237, p. 153.

Firstly, the Tokyo High Court pointed out two problems of the Yokohama District Court. (1) Problem of the self-determination-approach. (a) Does the patient's determination to the line of medical treatment in terminal care mean constitutional self-determination? (b) Can we explain consistently the situation that the article 202 of the Criminal Code prohibits aiding and abetting suicide as illegal? (c) Substituted judgment or assumption by his family is to be made as to the patient who rapidly lost his consciousness, there is a danger, however, that the family expects to avoid the financial or economic and mental burden with terminal care, and fictitious aspects in confirming the real will of the patient.

(2) Problem of "duty to cure or care approach". (a) This approach is only applied in extremely terminal and limited situation, therefore it is dogmatically unreasonable to apply it. (b) There is a problem which stage we should consider as "meaningless".

Secondly, nevertheless the Tokyo High Court insisted that some legislation or guideline should be required in order to fundamentally resolve "death with dignity".

I think that the decision of the Yokohama District Court is better than that of the Tokyo High Court. Because the Tokyo High Court only denied the logic of justification by the Yokohama District Court on the one hand, and insisted on the other hand that some legislation or guideline should be required in order to fundamentally resolve "death with dignity" without giving any legal grounds. Legislation or making a guideline without legal grounds is very reckless¹². The accused in this case is now in making a final appeal. We would wait the judgment of the Supreme Court.

4. How can we make a rule for "death with dignity"?

(1) Model

¹² To this aspect see Saku Machino, *Kanja No Jikoketteiken To Ishi No Chiryōgimu (The Patient's Right to Self-Determination and the Doctor's Duty of Medical Treatment)*, *Criminal Law Journal*, No. 8, (2007) p. 47 ff.; Tanaka Shigeaki, *Songenshi Mondai Eno Hōteki Taiō No Arikata Ni Tuite (The Ideal Method of Legal Dealing with the Problem of Death with Dignity)*, *Hōsōjihō* Vol. 60, No. 7, (2008) p. 1 ff.

Now, how can we make a rule for “death with dignity” ? Especially, there are very difficult cases where the patient has lost his or her consciousness. According to my analysis from the viewpoint of comparative law, there are three or four models in this field¹³.

The first is the model of the patient’s right to self-determination like as in USA and Germany etc. In these countries, forgoing and withdrawing life-prolonging measures are decided on the ground of the patient’s right to self-determination. In case where the patient has lost his or her consciousness, the doctrine of ‘substituted judgment’ is used in connection with “living will” or “advance directive”. A merit of this model is in respecting for the patient’s wish at the last stage of his or her life. However there is a demerit that it is very difficult to decide whether the life-prolonging measures may be forgone and withdrawn when the patient didn’t clearly express his or her idea, or in the case of incompetent patients. And it is also the problem to what extent the family’s role of the patient should be evaluated.

The second is the model of deontological approach, in which forgoing and withdrawing life-prolonging measures are decided on the ground of the doctor’s professional duty. A merit of this model is in respecting for the doctor’s discretion in the very complicated situations. However at same time it has also a demerit, because there is a kind of fear that the doctor decides to forgo or withdraw the life-prolonging measures only based on his own sense of values. If the doctor judges the life-prolonging measures as meaningless or useless, the patient’s right to life is threatened.

The third is the model of “best interests test” like as in UK. A merit of this model is in that the parties concerned can decide to withhold or withdraw the life-prolonging measures through their consultations regardless the patient to be competent or incompetent. However there is a demerit that the contents of “best interests test” are rather vague.

Thus we should try to grope for the mixed type model, which emphasizes the first model respecting for the patient’s right to self-determination and add complementarily the third model of “best interests test” to it. By this mixed type model, we can deal with the incompetent patients.

¹³ See Kai, *supra* note (3) and (5).

Incidentally, French Loi n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie: JO n° 95 du 23 avril 2005 seems to be another mixed type between the first model and the second¹⁴.

(2) Official Guideline in Japan

Recently in Japan, we have some guidelines concerning it. Here we grasp the outline of recent trends on making a rule for “death with dignity” in Japan¹⁵.

As official guideline we can show “The Ministry of Health, Labour and Welfare, The Guideline on the Decision-Making-Process of Terminal Care” (May, 2007). The contents are the following.

1 The ideal method of terminal care

① It is the most important principle that the patient is informed and explained by the physicians and medical practitioner and consults with them in accordance with it, and then terminal care should be gone on the basis of the determination of the patient himself or herself.

② Whether to start or not, to change the contents of medical treatments or not, to stop them or not should be carefully decided on the basis of medical appropriation and suitability.

③ It is required for health care team to palliate sufficiently the patient’s pain and other uncomfortable symptoms as possible, and to provide synthetic health care including mental and social support to the patient and his/her family

④ This Guideline is not intended for active euthanasia which intends to shorten the patient’s life.

2 Decision-Making-Process of the terminal care plan

¹⁴ To this French Act see the translation and the explanation by Mari Honda, in Nobuyuki Iida/Katsunori Kai (Ed.), *Shūmatuki Iryō To Seimeirinri* (Terminal Care and Bioethics), 2008, Taiyō Shuppan, 2008, p. 223 ff. And I must thank to Judge Christian Byk in Paris Court of Appeal for his polite response to my question on this Act in Paris September 2007 and his lecture “L’EUTHANASIE EN DROIT FRANÇAIS” in Waseda University 12th March 2008. The latter lecture has been translated into Japanese by Ms. Yoshimi Kakimoto on *Comparative Law Review* Vol. 43, No. 3 (Institute of Comparative Law, Waseda University), 2009, p. 153 ff.

¹⁵ To detail see Iida/Kai (Ed.), *supra* note (14).

Decision-Making-Process of the line of terminal care is following.

(1) In case where the patient's will can be certified;

① The basis is the patient's decision-making on the basis of informed consent after special medical consideration and the terminal care should be done as health care team which consists of multi-medical professions.

② In deciding the medical treatment plan, the patient and medical practitioners should come to an understanding each other, and put the contents of agreement in order into documents.

In that case, as passage of time, change of the patient's condition, and alternation of medical evaluation may demand, paying attention to changeability of the patient's will, the patient should be given the explanation each time, and the patient's will has to be reconfirmed.

③ In this process, it is desirable that the contents of decision are informed to the family as far as the patient doesn't reject it.

(2) In case where the patient's will can't be certified;

In this case, health care team has to judge it carefully according to the following order.

① If the family can assume the patient's will, fundamentally the presumptive will should be respected and the best plan of medical treatment for the patient should be adopted.

② If the family can't assume the patient's will, fundamentally they should consult carefully with the family as to what is best for the patient, and adopt the best health care plan for the patient.

③ If the patient has no family or the family entrusts the judgment to the health care team, they should adopt the best health care plan for the patient.

(3) Setting up the committee which consists of plural professions.

In deciding the medical treatment plan in the case of above (1) and (2),

- if it is impossible to decide the contents of health care within the health care team because of the sick condition,

- if, in consulting between the patient and the medical practitioners, the agreement to appropriate and suitable contents of health care can't be reached,

- if the opinions aren't agreed among the family, or if, in consulting with the medical practitioners, the agreement to appropriate and suitable

contents of health can't be reached,

the committee which consists of plural professions has to be set up separately, and consideration and advise have to be done as to health care plan etc..

The meaning of this Guideline is in the point that one official rule has been just established in Japan. Theoretically, it is important to respect for the patient's right to self-determination and for terminal care by a professional team. However we must know the limits and problems of this Guideline. How can we use this Guideline ? Medical practice is now confronting with this subject, because it remains many vague aspects in important points. Where is the limit of the substituted judgment ? How should be the role of family ? What criteria do we use as to forgoing (including withdrawing) artificial life-prolonging treatment ? Do the ethical committees function effectively ? We must overcome these subjects from now on.

Incidentally, also in Japan, making guidelines in this field is increasing (e.g. Japan Medical Association, Japanese Society for Palliative Medicine, Japanese Association for Acute Medicine etc.). We must adjust these guidelines to the Official Guideline. Further, we have a trend to legislation on "death with dignity" among Members of Parliament and Japan Society for Dying with Dignity in Japan. However it seems for me that the easy legislation has some important problems.

5. Conclusion

As a result, we can say that generally there are careful attitudes on euthanasia in Japan. There is also a kind of distrust to medical professions in the background of this situation. Therefore many people trend to reject to establish a kind of an act or provision which makes "active euthanasia" lawful like in the Netherlands or "physician assisted suicide" like in the State of Oregon in USA.

Many people, however, wish that the problems on "death with dignity" would be resolved sooner in Japan. Thus we should firstly make an effort to do it. Which is better, guideline system or legislation in the issue of "Death with Dignity" ? I think that guideline system is better than

legislation, because though the former is no sanction, it is more flexible.

In any case, we should discuss on these issues on condition that the patient's right to life should be enough protected.

