



Pergamon

International Journal of Law and Psychiatry
25 (2002) 557–571

INTERNATIONAL JOURNAL OF
**LAW AND
PSYCHIATRY**

Euthanasia trials in Japan: Implications for legal and medical practice

Miki Hayashi^{a,*}, Toshinori Kitamura^b

^a*Department of Sociocultural Environmental Research, National Institute of Mental Health, National Center of Neurology and Psychiatry, 1-7-3 Kohnodai, Ichikawa, Chiba, 272-0827, Japan*

^b*Professor, Department of Psychiatry, Kumamoto University School of Medicine, 1-1-1, Honjo, Kumamoto, 860-8556, Japan*

1. Introduction

A variety of recent developments in medical technology enable physicians to prolong life, a goal long sought by the medical profession. Artificial life support, in particular, has changed the medical environment, and physicians now seem to pay more attention to prolonging life than to pain relief and other important aspects of quality of life as it relates to medical care.

The perception of quality of life differs from one individual to another. Some patients may desire to live regardless of their physical condition, whereas others may desire to be “killed” before pain becomes intolerable. For the latter, the issue of euthanasia arises.

Euthanasia has generally been conceived and debated, in Western countries, as the deliberate ending, on request, of the life of a patient suffering severe physical pain. Modern medicine has, however, made substantial progress in the area of palliative care in recent years. Although not all physical pain can be alleviated, palliative care has changed the frames of reference for euthanasia. Euthanasia has become not only an issue of freedom from pain but also an issue of the patient’s right to self-determination. Medical technology frequently offers a variety of clinical options in relation to which the patient has the possibility of personal choice. Euthanasia may be viewed in this context as one among several choices of how to die when prematurely faced with the final stages of life.

In Western countries, there has been much discussion of the legal, ethical, sociological, psychological, and political ramifications of euthanasia. In the Netherlands, euthanasia has

* Corresponding author. Tel.: +81-427-372-0141; fax: +81-427-371-2900.

E-mail address: hayashi@ncnp-k.go.jp (M. Hayashi).

been practiced for some time within certain guidelines (Hirano, 1996; Sneiderman & Kaufert, 1994; Van der Maas et al., 1996; Van der Wal et al., 1996; Wachter, 1992), and in April 2001, a draft bill to legalise euthanasia and physician-assisted suicide passed the first sitting of the Parliament (Weber, 2001) (This law is now in effect since April 2002). In Oregon, a draft bill was passed in 1994 to permit physicians to assist in the suicide of terminally ill patients in accordance with their requests to die “with dignity” (Oregon Rev. State §127.800 et. seq.). The Northern Territory of Australia passed a similar law to permit physicians to assist in the suicide of patients (Northern Territory of Australia, Rights of the Terminally Ill Act 1995, No. 12 of 1995), which was promptly rescinded by the Australian Commonwealth Parliament that holds powers over Northern Territory law.

Japan, by contrast, has been slow to consider legislation for euthanasia. This does not mean that shortening the lives of terminally ill patients by doctors occurs rarely in Japan. Rather, it signifies an unwillingness to discuss euthanasia openly. The frequency of euthanasia is unknown, as no direct and comprehensive data have been recorded.

Hashimoto and Nakatani (1983) conducted a study by questionnaire among medical and nursing staff, seeking information regarding their experiences of situations in which terminally ill patients, suffering severe pain and with no prospect of relief, wished to end their lives and family members supported their desire. More than a quarter (28.3%) of the respondents reported having experienced such situations. These findings confirm that medical personnel are in fact confronted with such requests from patients and their families. A questionnaire distributed to Japanese university students and their parents showed that 86.3% of them believed that a request for a fatal dosage from a terminally ill patient experiencing severe pain should be acceded to as a rightful individual choice (Hayashi et al., 2000).

During the past decade, there have been several “euthanasia” court cases in Japan, all of which ended in a “guilty” verdict, but it should be noted that there is still no Supreme Court decision. Since the Kochi case in 1990, euthanasia has been discussed more openly in Japan. The social background to this new openness is the realisation, in recent years, of the advent of an ageing society. The public has become more interested in the problems of prolonged life and of terminal treatment and care.

Definitions and classifications of euthanasia are slightly different in Japan from those accepted in the West, and an exposition follows. Because, to some extent, the details of trials and court decisions reflect Japanese national sentiment towards, and slightly different conceptions of, euthanasia, a brief review of Japanese court cases dealing with euthanasia will be of interest and will provide a background for international readers.

2. Definitions and classification

As the Japanese term for euthanasia, “anraku-shi,” literally means peaceful (“anraku”) death (“shi”), much emphasis has been placed on its role in the alleviation of an “agonising life” deriving from “terminal illness,” but less importance has been placed on the patient’s own decision than in Western countries. The term “euthanasia” in Japan does not mean

mercy “killing” but peaceful death and therefore covers a variety of actions that would not be considered to be euthanasia in Western countries. The Japanese language defines “killing” somewhat more narrowly than does English. For instance, it is said, “He died due to a car accident” but not “He was killed in a car accident”.

Most researchers in Japan (Kai, 1995; Kanda, 1996; Kanazawa, 1961; Machino, 1993, 1995; Naito, 1984) have defined euthanasia as an act “to ease the pain of patients and let them die peacefully in the final stage of a terminal illness, in a situation of serious physical suffering with no prospect of recovery.” To end unbearable physical pain is the purpose of letting them die. The observation of pain by people around the patient is of importance and not just the patient’s will or request. This emphasis is reflected in the Nagoya High Court’s criteria laid down in 1972. The justification of euthanasia in Western countries does not admit such influences and rests on the autonomous request of the patient. In the Netherlands, for instance, euthanasia is defined as “the intentional termination of life by another party at the request of the person concerned” (Hirano, 1996).

In Japan, euthanasia is conventionally classified into four types: (a) active euthanasia, (b) indirect euthanasia, (c) passive or negative euthanasia, and (d) pure euthanasia. “Active euthanasia” is the intentional acceleration, with no therapeutic purpose, of the end of the life of a patient who is in the final stage of a terminal illness or is enduring serious physical suffering with no prospect of recovery. The term “euthanasia” is generally confined to this meaning in the West. “Indirect euthanasia” is the giving of treatment to alleviate agonising symptoms, but with side effects shortening the life of a terminally ill patient, and in the West is not generally considered problematic. “Passive euthanasia” is the withdrawal of life-sustaining treatment from terminally ill patients, and although it does not generally come within the definition of euthanasia in the West, it is nevertheless an issue of some moral concern. “Pure euthanasia” is treatment to alleviate the symptoms of severe pain in a terminally ill patient, without substantial effects of shortening life but facilitating a peaceful death, an approach that, in the West, is called palliative care.

Although classified as euthanasia in Japan, as elsewhere, the procedures of “pure euthanasia” are not controversial in law because the life of the patient is not terminated by another person’s intervention. The remaining three types of euthanasia are legally controversial in Japan because the termination of the patient’s life is involved. Nevertheless, the goal of pure euthanasia to remove intolerable physical pain is the core purpose of all types of euthanasia in Japan.

The Japanese Penal Code (1907, still in force) provides that the punishment for homicide is death or penal servitude for life or for no less than 3 years (Article 199). The act of attempting suicide is not itself punishable, but participation in another’s suicide, by “instigating or assisting another to commit suicide or to kill another at the request or with the consent of the latter,” is illegal (Article 202). Article 202 provides for penal servitude or imprisonment for no less than 6 months and no more than 7 years. No special statutes in Japan either specifically permit or prohibit euthanasia.

Although the act of euthanasia is, by default, subject to Articles 199 and 202, the Penal Code recognises some exceptional circumstances in which conduct coming within the definitions of a crime may be deemed justified and not punishable. The Japanese Criminal

Code defines a justifiable act in Article 35 as “an act done in accordance with law and ordinances or in the pursuit of lawful business”. Although euthanasia cannot be regarded as an act in accordance with the law, “indirect euthanasia” may possibly be permissible as medical treatment, in so far as the latter is regarded as the pursuit of lawful business. However, both “passive” and “active” euthanasia” are with difficulty classified as medical treatment, *per se*.

“Passive euthanasia” may be regarded as permissible, even though not a medical treatment, provided the patient refuses life-sustaining therapy, because physicians have no duty to continue useless treatment of patients with no hope of recovery. “Active euthanasia” has been argued for as a humanitarian act, showing compassion for another’s pain. To this has been added, in recent years, the argument for the patient’s right to self-determination: that the patient’s choice between short life with unbearable pain and liberation from unbearable pain should be respected, and the law should not intervene in this extraordinary case (Fukuda, 1994; Ida, 2000).

3. Cases

3.1. *Tokyo District Court case 1950*¹

The first Japanese “euthanasia” trial was held in 1950. In a case before the Tokyo District Court, a son had poisoned his mother with potassium cyanide. The mother had been hemiplegic due to cerebral haemorrhage and had expressed a wish to “go back to my own country, Korea.” The Tokyo District Court ruled that the mother had not suffered from physical pain but had only wanted to escape from her psychological suffering. Because, as the court articulated it, physical pain is required to justify euthanasia, the accused was sentenced to 1-year imprisonment with probation of 2 years. However, it is of note that the court held, *obiter dictum*, that it might be permissible to shorten the life of a patient suffering the severe pain of an incurable or fatal disease.

3.2. *Nagoya High Court case 1972*²

In 1962, a son poisoned his father with insecticide mixed in milk. The father had been paralysed following cerebral haemorrhage. He shouted repeatedly “Kill me!” and “I want to die!” due to severe pain. The son, known by many people in the community as a caring child towards both father and mother, had considered it his “duty” to obey his father’s wish and poured insecticide into his milk. The mother, unknowingly, gave the milk to her husband, who eventually died.

Before making judgment, the Nagoya High Court ruled that euthanasia could be justified if all of the following criteria were fulfilled: (1) Based on contemporary medical knowledge

¹ Judgement of April 14, 1950, *Saibanshohihou*, 58, 4.

² Judgement of Dec. 22, 1972, *Hanreijihou*, 324, 11.

and technology, the patient is judged to be suffering from an incurable disease and death is imminent. (2) The patient is suffering unbearable pain and it is extremely difficult for observers to witness the patient's agony. (3) Euthanasia is performed only for the purpose of alleviating the patient's suffering. (4) The request for or consent to euthanasia is given by the patient when conscious and in full competence to express the decision. (5) Euthanasia is performed by an attending physician (responsible medical officer), or if performed by other persons, there are compelling reasons for this. (6) The method of euthanasia is ethically acceptable.

On these grounds, the court decided that the action of the accused was not permissible, because it was not performed by a physician and the use of insecticide was not ethically acceptable. The accused was sentenced to 1-year imprisonment with probation of 3 years.

Subsequently, in 1990, four district court decisions—Kagoshima, Kobe, Osaka, and Kochi—were based on this ruling by the Nagoya High Court. In each of the four cases, the patient was killed by an offspring or spouse, and the accused was judged guilty on the grounds that not all of the six conditions were met.

3.3. *Kagoshima District Court case 1975*³

A man strangled his wife to death with a towel and a rope while she was sleeping. She had been suffering from tuberculosis in addition to “jiritsu-shinkei-shiccho-sho” (imbalance of the autonomic nervous system) and had repeatedly requested her husband to let her die. “Jiritsu-shinkei-shiccho-sho” is a popular but extremely vague medical term used by Japanese medical (usually nonpsychiatric) practitioners. It is applied to a constellation of vegetative symptoms such as palpitation, sweating, headache, and nausea as well as psychological symptoms such as depression, anxiety, and hypochondriasis in the absence of any laboratory findings to support a medical diagnosis. The diagnostic labels most appropriate to the condition, according to the *Diagnostic Manual of Mental Disorders 4th edition (DSM-IV)* (American Psychiatric Association, 1994), are probably Major Depression, Generalised Anxiety Disorder, or Somatoform Disorder. From the description in the court report, it may well be speculated that the wife had been suffering from some type of psychiatric morbidity. However, there appeared to be no record that she had been treated by or had consulted a mental health professional.

The court ruled that her death had not been imminent and the means had not been ethically acceptable. The accused was sentenced to 1-year imprisonment with probation of 3 years.

3.4. *Kobe District Court case 1975*⁴

A man strangled his mother to death with an electric appliance cord. She had been suffering from hypertension and had suffered a stroke with hemiplegia. Following another

³ Judgement of Oct. 1, 1975, *Hanreijihou*, 808, 112.

⁴ Judgement of Oct. 29, 1975, *Hanreijihou*, 808, 112.

stroke, she said that she “could not live long”. The son sympathised with this sentiment and he performed euthanasia to “ease her suffering”.

Applying the Nagoya rule, the court ruled that death was not imminent, pain was not extremely unbearable, and there was no explicit demand from the patient. The son was sentenced to 3-year imprisonment with probation of 4 years. This 3-year sentence is longer than for the other “euthanasia” cases, perhaps because the mother never expressed a wish to die but only said that she could not live long.

3.5. *Osaka District Court case 1977*⁵

A husband killed his wife, who had been in hospital with terminal gastric cancer, with a knife. She was suffering from severe pain and had repeatedly requested that he kill her because she had no prospect of relief. The court ruled that he should have asked the attending physician to reduce her pain and that the method used was not ethically acceptable. The husband was sentenced to 1-year imprisonment with probation of 2 years.

3.6. *Kochi District Court case 1990*⁶

A man strangled his wife, who had been suffering from cartilage cancer and had requested him to assist her in dying. The court sentenced him to 3-year imprisonment with probation of 1 year for the same reason as the above case.

To summarise, in each of these six court decisions, euthanasia was performed by the patient’s spouse or family member who sympathised with the patients’ agony. The courts followed the precedent of the Nagoya High Court and cited its six criteria for a permissible act. The accused were found guilty because these guidelines were transgressed.

3.7. *Tokai University Hospital case 1995*⁷

On April 13, 1990, at Tokai University Hospital, a Japanese doctor injected potassium chloride into a 67-year-old man in the terminal stage of cancer following a request to “please ease him” by the patient’s son. The patient was comatose at the time of euthanasia. The accused, Dr. Tokunaga, had joined the medical team 2 weeks before the patient’s death. This team included two professors of medicine and several other doctors. Because the patient himself was not informed of the diagnosis, only the son consulted with the medical staff.

By the time the accused doctor assumed a part in the patient’s care, the patient was already comatose. The day before euthanasia was performed, the wife and the son strongly urged the doctor to withhold drip infusion and withdraw the bladder catheter, because they thought that

⁵ Judgement of Nov. 30, 1977, *Hanreijihou*, 879, 158.

⁶ Judgement of Sep. 17, 1990, *Hanreitaimuzu*, 742, 224.

⁷ Judgement of March 28, 1995, *Hanreijihou*, 1530, 28.

these treatments were causing “distress” to the patient. The accused initially refused to do so, explaining that they were necessary medical treatment, but the son and the wife were insistent. The accused finally acceded to their wishes and withdrew the drip infusion and catheter. The wife then left the hospital, but the son stayed beside his father’s bed and began to feel that his father’s respirator was causing him suffering. The son asked the accused to take away the respirator and then to ease his father’s pain. Failing to persuade the son to change his requests and understanding the burden on the family members, the doctor then decided to stop all medical treatment, without consulting any other medical staff. He also decided to administer the injection of potassium chloride, which caused the death of the patient. During the course of his hospital stay, the patient had never asked any physician for aid in dying.

This is the first euthanasia case in Japan in which a medical doctor was identified as the performer of euthanasia. This case was widely publicised in the media, several documentary books were published (Irie, 1996; Miwa, 1998), and significant public debate has resulted. Against a changing social background, with Japan becoming a highly aged society and with growing public interest in the problems of treatment and care of the terminally ill, the court was expected to explicitly delineate the legal criteria for allowing euthanasia.

On March 28, 1995, the Chief Judge at the Yokohama District Court established a set of four new legal prerequisites for physician-assisted voluntary euthanasia:

1. The patient is suffering unbearable physical pain.
2. The patient’s death is unavoidable and imminent.
3. All possible palliative treatment and care to ease the patient’s physical pain and suffering have been provided and no other alternatives are available.
4. The patient has expressed a clear and voluntary desire to have his or her life shortened.

Because it was concluded that only the second requirement was fulfilled in the action of the accused, he was found guilty of homicide by the Japanese Criminal Code Article 199 and sentenced to 2-year imprisonment with a 2-year suspended sentence.

In *ratio decidendi*, the court also articulated that, to provide for “death with dignity,” medical treatment may be discontinued (a) when the patient is terminally ill with no prospect of relief and (b) when the patient’s willingness is explicit with regard to the discontinuation of treatment by medical personnel, or if the patient is unconscious, the patient’s desire can be presumed.

The Yokohama District Court’s decision took into account the development of palliative medical technology since the Nagoya High Court’s decision regarding cases of euthanasia. It also appears that the Yokohama District Court did not consider that an observer’s perception of the patient’s pain as unbearable was a necessary condition for allowing euthanasia.

3.8. Recent cases

Since the Tokai University Hospital case, cases at Keihoku Hospital (1996), Kochi Aiwa Hospital (revealed in 1997), and Kenko-en (revealed in 1997) have been investigated but not

prosecuted. In the Keihoku Hospital case, the medical director of the hospital injected muscle relaxant into a 50-year-old comatose patient. There had been a long relationship, not only as doctor and patient but also as close friends, between the two (Guest, 1996). In both the Kochi Aiwa Hospital and the Kenko-en cases, tube feeding was withdrawn from elderly patients with their families' consent but without the patients' consent.

In summary, in the Kobe and Tokai University Hospital trials, the defendants were convicted of murder (Article 199) on the grounds that the will of the patient was not expressed nor did the patients request the defendants to end their lives. In other cases, the defendants were convicted of unlawfully acceding to requested murder (Article 202). The Nagoya criteria of 1972 were subsequently cited and were the grounds on which defendants were found guilty, as not all of the six conditions for legal euthanasia were met. However, the Yokohama District Court, in the trial of the Tokai University Hospital case in 1995, established four new requirements for justifiable acts of euthanasia. The Yokohama District Court determined that, provided all four conditions were met, euthanasia would be legally permissible.

4. The practice of medicine

In most cases of euthanasia in Japan, there appears to be neither evidence that pain control was aggressively pursued nor that patients or their family members requested that the doctors provide it. In the Osaka case, for example, the only palliative medication received by the patient was pentazocine rather than the much more powerful morphine.

Traditionally, euthanasia has been justified primarily as providing liberation from unbearable pain. The [World Health Organization \(1986\)](#) pronounced that in 90% of cases, pain could be adequately palliated by medication. Advances in palliative care and treatment may eliminate most pain, removing these grounds for euthanasia. However, several Japanese newspaper articles of recent years ([Iryouyou moruhine shiyou suishin, gankanjano, 1995](#); [Moruhine shiyou 10nende 12 bai, 1994](#)) have revealed that, in Japan, doctors are reluctant to administer narcotic drugs. In comparison with the US and Canada, for example, the use of morphine is very infrequent. A Japanese newspaper article ([Gan kea "nihon kanwa iryou gakkai" ga hatsutaikai, 1996](#)) pointed out that the medical use of morphine per 1 million population is 5 g in Japan, 60 g in Canada, and 40 g in the US. In Japan, physicians may fear that treating patients with narcotic drugs will make them dependent upon these drugs.

However, there are recent signs that doctors are paying more attention to pain relief. From 1983 to 1993, the medical use of morphine in Japan increased more than 10-fold, from 40 to 504 kg/year ([Moruhine shiyou 10nende 12 bai, 1994](#)). The first session of the Japanese Society of Palliative Medicine was held in 1996, with over 1000 participants, including both doctors and nurses.

Will progress and increased interest in palliative medicine reduce the incidence of euthanasia? [Van der Maas et al. \(1991\)](#) interviewed 187 physicians who had been requested to perform euthanasia by patients in the Netherlands, where approximately 2700 cases of

euthanasia, as defined earlier, occur each year. The reasons given for the procedure were loss of dignity (57% of cases), pain (46%), unworthy dying (46%), being dependent on others (33%), and tiredness of life (23%). Pain was the sole reason for requesting euthanasia in only 5% of cases. [Seale and Addington-Hall \(1994\)](#) found, from a sampling of death certificates in Great Britain, that distress and dependency were more commonly given reasons than pain, both by patients and by relatives and others who knew the patient. Thus, with progress in palliative treatment, the reasons for requesting euthanasia have become more complicated, being based not only on physical pain but also on psychological distress.

Despite the importance of psychological care and treatment to ease the distress of the terminally ill, psycho-oncology and mental health in palliative care are in their infancy in Japan. [Kashiwagi \(1997\)](#) reported that doctors in Japan spend less time with terminally ill patients than with acute patients who require medical examination and treatment. [Shinno, Uchitomi, and Yamawaki \(1996\)](#) noted that 28% of patients with chronic pain also suffer from depression. The number of hospices and hospital hospice units is very limited. Few mental health professionals are trained in this area, and a stigmatising attitude towards psychiatry hinders the introduction of “psychiatric” care into palliative care. The woman patient in the Kagoshima case was given an extremely vague diagnosis but may have been suffering from depression, and no mention was made of any failure of aggressive treatment for her mental suffering. In the remaining court cases, patients received no treatment at all from mental health professionals.

5. Doctor–patient relationship

Traditionally, Japanese doctors make most decisions without input or attention to requests from patients and give patients almost no information. Patients have few opportunities to question doctors. Because doctors believe that telling a patient that he or she has cancer is tantamount to announcing a death sentence, they often keep the diagnosis secret to avoid discouraging the patient or putting him or her into a state of despair. [Kai et al. \(1993\)](#) conducted a study among physicians in Tokyo to determine whether they had ever inquired as to patients’ preferences about terminal care. Ninety-five percent had never brought up matters even close to the subject in their conversations with patients. [Asai, Fukuhara, and Lo \(1995\)](#) reported that 77% of Japanese doctors believed that physicians should discuss life-prolonging treatment with a patient’s family before discussing it with the patient, even if the patient were competent.

Doctors prefer to give the patient a “disguised” diagnosis that is easier to handle, while the true diagnosis is given to a family member ([McDonald-Scott & Machizawa, 1992](#)). As a result, doctors and family members may falsely encourage patients to believe that they will recover easily and quickly and that their disease is not incurable. This prevents frank discussion and maintenance of good relationships between doctors, family members, and patients. This policy is not necessarily the wish of patients. [Hasui et al. \(2000\)](#), for example, reported that 96.2% of students and their parents would wish to be informed of the true

diagnosis if they were to suffer from a refractory mental illness. The core of informed consent is that all medical matters should be discussed with the patient and his or her preferences sought. The problems created by nondisclosure of medical information and the neglect of informed consent in the management of terminal illness have not been sufficiently emphasised in Japan.

The fact that Japan has no general practitioner registration system, like that of Great Britain and the Netherlands, may make bilateral communication difficult in the medical setting. In Great Britain or the Netherlands, local general practitioners get to know patients over a long time period and become familiar with their health condition, habits, and values and with other family members as well. This enables frank and sincere communication (Hirano, 1998). Patients' real wishes may be difficult to judge when, suffering prolonged intense pain, they state that they want to die. They may mean rather that their pain is unbearable. In the Osaka case, a husband killed the patient because she was suffering from severe pain, but this critical factor was not discussed with doctors beforehand. Patients often desire to talk freely about their illness with doctors and to develop a supportive human relationship that can be depended on in a difficult situation.

6. Discussion

6.1. *Lack of explicit expression of the patient's will*

The Japanese definition of permissible "euthanasia" emphasises the decision made either by people close to the patient (i.e., family members or friends) or by medical professionals. The patient is not actively involved in the decision made by, or in the conduct of, the doctor. The sufferer may simply say "I want to die" or may even be unconscious. The consciousness of the patient (e.g., in the Yokohama District Court decision) is not considered. Regardless of the patient's mental condition, it is generally the people close to them who feel sympathy for them and urge the ending of their lives in order to alleviate their pain. This represents a dramatic difference between Japan and Western countries in terms of the patient's participation in decision-making.

The alienation of the patient from decision-making may result not only from the distant character of relationships between doctors and patients but also from traditional Japanese customs of interdependency. Lebra (1976) ascribed to the Japanese an acceptance of the desirability of dependency in relationships. Sick and aged persons are expected to be dependent. Traditional social structures tie dependency to the moral requirement to perpetuate the family. The aged expect to rely on their sons and successors and their families for security, comfort, and emotional support. This is in sharp contrast with the Western ideal of life-long independence of the individual. Tanida (1996) described mutual dependency as a cherished feature of Japanese society, suggesting that personality itself, among the Japanese, is not something that belongs to the individual but rather to the family, the community, and the society. This should be borne in mind when we judge the suitability of criteria for euthanasia in Japan.

It is often argued that euthanasia should be given no legal standing because of the slippery slope it may create for people with incurable diseases. For example, patients may, as a result, feel obliged or pressured by the expectations of family members to accept euthanasia. This outcome is less likely if patients know that their doctors are willing and able to help them with palliative care as well as euthanasia and that they can still choose other means of dealing with severe pain until death arrives naturally. On the other hand, patients may be relieved to know that euthanasia is an option and this in itself may provide opportunities for discussion of the management of their terminal stage with doctors and family. This will enhance the chances of a peaceful process of dying for patients and their families. Patients should not have to fear a painful or lonely process of dying.

6.2. *Who killed the sufferer?*

According to Yamamoto and Wallhagen (1997), family members, especially women and offspring, have historically assumed the role of caregiver in Japanese families. Voltz et al. (1997) conducted a study of patients in hospices and palliative care units in Japan, Germany, and the US in which it was asked who first recommended palliative care to patients. Thirty-five percent of Japanese patients answered that it was a family member in contrast to 16% in the US and 3% in Germany.

Because doctors do not inform patients of their true diagnosis, patients are denied the opportunity to express their wishes regarding euthanasia to their doctors. It is likely that the stress family members have to face is increased because they cannot disclose the truth to patients, particularly in difficult medical situations, when they feel obliged to encourage hope in patients who themselves doubt their recovery (Asai et al., 1998). When the real situation is not disclosed to patients but is shared only between doctors and family members, the burden of decision-making regarding the medical treatment falls to a family member.

The present review of cases has shown that in trials of cases of “euthanasia” in Japan, prior to the Tokai University Hospital case, the person implementing euthanasia was not a medical professional but a family member—a child or spouse. This could be the result of the above set of conditions.

6.3. *Paternalism vs. autonomy*

Medical education in Japan is oriented towards medical science and technology. Little attention is given to moral, ethical, and psychological issues in medical practice. It almost seems that medicine is a profession in which patients provide the means for doctors to apply their scientific knowledge rather than one in which doctors use their knowledge to help patients achieve health and happiness. The course of treatment is rarely influenced by the individual patient’s personal preferences or choices among possible therapies.

In actuality, the therapeutic aims of the medical profession do not govern the patient’s private goals. This truth is not recognised by medical practitioners and scarcely appreciated by patients themselves. Patients are reluctant to demand the disclosure of medical informa-

tion because the medical profession commands respect and unquestioning obedience. Reviewing the case *Makino v. the Red Cross Hospital*, which concerned the patient's right to know of a diagnosis of cancer, Higuchi (1992) noted that the Japanese courts allowed a wide range of discretion to doctors on the grounds that paternalistic care can be in the patient's best interest.

Hayashi et al. (2000) argued that the situation in Japan is changing. Firstly, the rights of patients are being recognised with the introduction of ideas of autonomy and respect for self-determination. Secondly, more people are talking about how to die. Membership of the Japan Association of Death with Dignity (established in the 1970s as the Japan Euthanasia Association) is increasing and reached 70,000 a few years ago.

6.4. *Conditions for euthanasia*

When should euthanasia be permissible? Are the criteria established by the Nagoya High Court or the Yokohama District Court adequate?

In this paper, we have reviewed the court cases relating to euthanasia in Japan. The extremely small number of euthanasia trials does not mean that euthanasia is exceptional in Japan but rather that it has been conducted discreetly. The details of these cases suggest that (1) palliative care of the terminally ill is poor in terms of pain control and psychological care, (2) there is a lack of informed consent and respect for the patient's autonomous decision-making, (3) there is a lack of explicit ascertainment of the patient's wishes, (4) euthanasia is performed by family members who are distressed due to the burden of providing care, and (5) a strong paternalistic tradition hinders the growth of patient autonomy in Japanese medical care. In the light of this evidence, we make the following suggestions for elaboration and modification of the current determinations.

Firstly, we believe that euthanasia should be available only to adults who are competent to understand that euthanasia means the irrevocable end of their lives. Conditions 4 of both the Nagoya and the Yokohama criteria require competence as a prerequisite for euthanasia. The Yokohama District Court expresses this as the patient's "clear and voluntary desire to have his or her life shortened". What is "a clear desire"? We believe that the patient's request should have been expressed repeatedly as a sign of a settled conviction that this is the preferred solution. Furthermore, this should be ascertained before allowing a physician to carry out euthanasia.

Secondly, the Yokohama District Court held that all possible palliative treatment should have been provided. We, too, think that adequate palliative care must be given to patients and that it should include both pain control and psychiatric care. When palliative treatment cannot resolve unbearable physical pain, euthanasia can then be considered.

Thirdly, imminent death was included in both sets of criteria—as an incurable disease by the Nagoya High Court and as unavoidable death by the Yokohama District Court. We, too, think that unavoidable death with no prospect of relief from the suffering of an incurable disease should be a necessary criterion. However, if death must be imminent, then euthanasia ceases to be an available option in all cases of extreme suffering. We would argue that the logic of relief from unassuageable pain by death, as the central principle of euthanasia, implies

that euthanasia should also be available to those suffering severe, refractory, and long-term physical pain when death will be the inevitable outcome, even if it is not imminent. This, however, requires much further discussion.

Fourthly, the Nagoya criteria required that euthanasia be performed by an attending physician using an ethically acceptable method. Kai (1995) contended that the Yokohama District Court took it for granted that euthanasia would be performed by a physician. We think that the person who physically administers the means of euthanasia need not necessarily be a physician as long as an attending physician is present.

Fifthly, under the Nagoya criteria, pain as observed by people close to the patient is a major criterion. However, because pain is a subjective experience, we would argue that the *patient's* request on the grounds of pain should be the major criterion.

Finally, neither set of criteria requires a second opinion to confirm that the conditions for euthanasia are met, but we believe that this is essential. We think that this would be best offered by a family doctor or general practitioner who is likely to have known the patient for some time. The longer the doctor–patient relationship, the better the doctor is able to gauge the sincerity of the patient's expressed desire to have his or her life ended.

Recent changes in national sentiment and a transition away from the traditional value system may indicate that the Japanese people are now ready to discuss issues relating to euthanasia and would welcome a review of the two existing sets of prerequisites for legal euthanasia handed down by the Courts.

Acknowledgements

Miki Hayashi was financially supported as a Domestic Research Fellow from the Japan Science and Technology.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: American Psychiatric Association.
- Asai, A., Fukuhara, S., & Lo, B. (1995). Attitudes of Japanese and Japanese–American physicians towards life-sustaining treatment. *Lancet*, *346*, 356–359.
- Asai, A., Miura, Y., Tanabe, N., Kirihara, M., & Fukuhara, S. (1998). Advanced directives and other medical decisions concerning the end of life in cancer patients in Japan. *European Journal of Cancer*, *34*, 1582–1586.
- Fukuda, M. (1994). Anrakushi (Euthanasia). In A. Azami, & Y. Nakai (Eds.), *Iryo-kago-hou* (Medical practice law) (pp. 278–298). Tokyo: Seirinshoin.
- Gan kea “nihon kanwa iryou gakkai” ga hatsutaikai, makki iryo minaoshinougoki (For cancer care, the first session of the “Japan Palliative Care Society,” the movement to rethink terminal care) (1996, August 2) *Yomiuri Shimbun*, 13.
- Guest, R. (1996). Outrage in Japan over euthanasia without consent. *British Medical Journal*, *312*, 1627.
- Hashimoto, Y., & Nakatani, H. (1983). Anrakushi ni kansuru ishi-kangofu no ishikichousa (Questionnaire study regarding the attitude of doctors and nurses towards euthanasia). *Nihon Iji Shimpo*, *3075*, 48–52.

- Hasui, C., Hayashi, M., Tomoda, A., Kohro, M., Tanaka, K., Dekio, H., & Kitamura, T. (2000). Patients' desire to participate in decision-making in psychiatry: a questionnaire study in Japan. *Psychological Report*, 86, 389–399.
- Hayashi, M., Hasui, C., Kitamura, F., Murakami, M., Takeuchi, M., Katoh, H., & Kitamura, T. (2000). Respecting autonomy in difficult medical settings: a questionnaire study in Japan. *Ethics and Behavior*, 10(1), 51–63.
- Higuchi, N. (1992). The patient's right to know of a cancer diagnosis: a comparison of Japanese paternalism and American self-determination. *Washburn Law Journal*, 31, 455–473.
- Hirano, M. (1996). Oranda ni okeru anrakushi to sono haikei (Practice and previous history of euthanasia in the Netherlands). *Nichiran-Gakkai Kaishi*, 41, 1–22.
- Hirano, M. (1998). Oranda ni okeru anrakushi mondai no yukue: Syabotto jiken o tyuusin ni (New problems on euthanasia in the Netherlands: the Chabot's case). *Nichiran-Gakkai Kaishi*, 44, 19–40.
- Ida, M. (2000). Anrakushi to songenshi (Euthanasia and dying with death). *Gendai keijihou*, 15, 81–89.
- Irie, Y. (1996). *Shi heno tobira—Tokai Daigaku anrakushi satsujin* (The door to death—Tokai University euthanasia murder). Tokyo: Shinchosya.
- Iryouyou moruhine shiyou suishin, gankanjano (Medical use of morphine promoted) (1995, March 4) *Asahi Shimbun*, 1.
- Kai, I., Ohi, G., Yano, E., Kobayashi, Y., Miyama, T., Niino, N., & Naka, K. (1993). Communication between patients and physicians about terminal care: a survey in Japan. *Social Science and Medicine*, 36, 1151–1158.
- Kai, K. (1995, March 28). Chiryokouityuushi oyobi anrakushi no kyoyouyouken—Toukaidaigaku byouin “anrakushi”-jiken hanketsu (Heisei 7.3.28, Yokohama Chisai hanketsu) (Permissible euthanasia—Tokai University “euthanasia” case (Judgement of Yokohama District Court)). *Hougakukyoushitsu*, 178, 37–45.
- Kanazawa, F. (1961). Anrakushino mondai (Problems towards euthanasia). *Touhokudaiigaku Hougaku*, 25(1), 122–130.
- Kanda, H. (1996). Anrakushi ni tsuite (About euthanasia). *Kinki Daigaku Hougaku*, 43, 119–155.
- Kashiwagi, T. (1997). Taminarukea niokeru seishin-igakutekimondai (Psychiatric problems in terminal care). In Y. Takahashi (Ed.), *Seishinigakukara kangaeru sei to shi* (Life and death from a psychiatric perspective) (pp. 20–31). Tokyo: Kongo Shuppan.
- Lebra, T. S. (1976). *Japanese patterns of behaviour*. Honolulu: The University Press of Hawaii.
- Machino, S. (1993). Anrakushi—Yurusareru satsujin? (1) (Euthanasia—Permissible murder? (1)). *Hougakukyoushitsu*, 152, 63–70.
- Machino, S. (1995). “Tokai-daigaku anrakushi-hanketsu” oboegaki (Comment on the “Tokai University euthanasia court decision”). *Juri*, 1072, 106–115.
- McDonald-Scott, P., Machizawa, S., & Satoh, H. (1992). Diagnostic disclosure: a tale in two cultures. *Psychological Medicine*, 22, 147–157.
- Miwa, K. (1998). *Anrakushi-saiban* (The euthanasia court). Tokyo: Ushio Shuppan.
- Moruhine shiyou 10nende 12 bai, makki kanjano itami chiryo shinto: mayakuhakusyo (10 times use of Morphine in 10 years, widespread palliative care to terminal patients, narcotic white paper) (1994, November 12) *Mainichi Shimbun*, 26.
- Naito, K. (1984). Anrakushi (Euthanasia). *Hougakukyoushitsu*, 41(28), 28–33.
- Seale, C., & Addington-Hall, J. (1994). Euthanasia: why people want to die earlier. *Social Science and Medicine*, 39, 647–654.
- Shinno, H., Uchitomi, Y., & Yamawaki, N. (1996). Itami to gankanjano seishinshoujouno soukan (Psychiatric relationship between pain and cancer patients). *Current Therapy*, 14, 297–300.
- Sneiderman, B., & Kaufert, J. M. (1994). *Euthanasia in the Netherlands: a model for Canada?* Manitoba: Legal Research Institute of the University of Manitoba.
- Tanida, N. (1996). “Bioethics” is subordinate to morality in Japan. *Bioethics*, 10, 201–211.
- Van der Maas, P. J., Van Delden, J. J. M., Pijnenborg, L., & Looman, C. W. N. (1991). Euthanasia and other medical decisions concerning the end of life. *Lancet*, 338, 669–674.
- Van der Maas, P. J., Van der Wal, G., Haverkate, I., De Graaff, C. L. M., Kester, J. G. C., Onwuteaka-Philipsen, B. D.,

- Van der Heide, A., Bosma, J. M., & Willems, D. L., (1996). Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. *New England Journal of Medicine*, 335, 1699–1705.
- Van der Wal, G., Van der Maas, P. J., Bosma, J. M., Onwuteaka-Philipsen, B. D., Willem, D., Haverkate, I., & Kostense, P. (1996). Evaluation of the notification procedure for physician-assisted death in the Netherlands. *New England Journal of Medicine*, 335, 1706–1711.
- Voltz, R., Akabayashi, A., Reese, C., Ohi, G., & Sass, H. (1997). Organization and patients' perception of palliative care: a cross-cultural comparison. *Palliative Medicine*, 11, 351–357.
- Wachter, M. A. M. (1992, March–April). Euthanasia in the Netherlands. *Hastings Center Report*, 23–30.
- Weber, W. (2001). Netherlands legalise euthanasia. *Lancet*, 357, 1189.
- World Health Organization (1986). *Cancer pain relief*. Geneva: World Health Organization.
- Yamamoto, N., & Wallhagen, M. (1997). The continuation of family caregiving in Japan. *Journal of Health and Social Behavior*, 38, 164–176.