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# Euthanasia, assisted suicide, and cessation of life support: Japan's policy, law, and an analysis of whistle blowing in two recent mercy killing cases

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## Abstract

Issues pertaining to euthanasia, assisted suicide, and cessation of life support continue to be a subject of worldwide interest. Euthanasia- particularly “active” euthanasia- is not considered legally or socially acceptable in most countries. In Japan, the first judgment of a case involving euthanasia took place in 1949. Since then there have been another five cases that reached the point of sentencing in 1990.

All six cases were examples of so called “active euthanasia”, in which the termination of life was performed by family members. However, the focus of discussion has been changed dramatically in recent years, owing to two prominent cases of mercy killing in 1995 (Yokohama) and 1996 (Kyoto), respectively. Medical doctors were involved in both of these cases, and euthanasia moved from being a theoretical problem to a practical dilemma. These cases also drew attention to the fact that assisted suicide could be distinguished from euthanasia.

The first part of this paper will summarize the current status of euthanasia and the cessation of life support in Japan, focusing on its historical background and policy. The second part will briefly sketch the characteristics of Japanese law and then will examine the two recent cases of mercy killing mentioned above to try and determine the roles of whistle blowing in the medical practice arena, with particular reference to Japanese culture. This analysis is a challenge to elucidate how ethics and the law interact, and influence medical practice in a specific cultural context. © 2002 Elsevier Science Ltd. All rights reserved.

*Keywords:* Euthanasia; Assisted suicide; Cessation of life support; Mercy killing; Japan; Whistle blowing

## Introduction

Since the first judgment of a euthanasia case in the Tokyo District Court in 1949, another five cases, most of them occurring in the late 1970s, finally reached the point of sentencing in 1990. All six cases were examples of so called “active euthanasia”, in which the termination of life was performed by family members. Those accused were found guilty of “homicide upon request” and received suspended sentences. However, the focus of discussion has changed dramatically

in recent years, owing to two prominent cases of mercy killing in 1995 (Yokohama) and 1996 (Kyoto), respectively (see Appendices A and B). Medical doctors were involved in both of these cases, and euthanasia moved from being a theoretical problem to a practical dilemma. These cases also drew attention to the fact that assisted suicide could be distinguished from euthanasia.

The first part of this paper will summarize the current status of euthanasia and the cessation of life support, focusing on policy. The second part will briefly sketch the state of Japanese law and then will examine the two recent cases of mercy killing to try and determine the role of whistle blowing with particular reference to Japanese culture.

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## Historical background

### *“Death with Dignity” and the hospice movement*

The Japan Society for Dying with Dignity (formally called the Japanese Euthanasia Society) was established in 1976 and initiated a law allowing for the withdrawal of life-sustaining treatment, according to a patient's previously expressed instructions. The bill was drafted by the Society in 1979, after which Diet members were lobbied until the mid 1980s. However, the bill was not voted upon or finalized. Many objected to it on the basis of ideas pertaining to respect for life, and the need for protection of vulnerable people. It should also be noted that by “*Death with Dignity*” those who drafted the bill were specifically interested in forgoing life-support, not active euthanasia or assisted suicide. After that, the Society changed its strategy by refocusing its attention on the implementation of a Living Will, rather than trying to change legislation. This modification was based on the Society's understanding that the medical profession had in general agreed with their ideas, and that it would be expedient to pursue these beliefs without having them formally legalized. According to the Society, there were very few complaints from patients or their families that their wishes about ending life had not been respected by physicians. Moreover, physicians who followed patients' Living Wills, although they were not legally binding, had never been prosecuted in court.

The movement by the Society and Japanese participation in the worldwide hospice movement were factors that helped to bring about new kinds of facilities for dying patients in Japan. The first palliative care unit (PCU) opened in 1981, and by March 2001 there were 79 PCUs/hospices approved by the government. In the early stages, Christian and Buddhist groups were active in establishing these facilities. At present, however, hospice or palliative care is covered by the national health insurance system. These facilities mainly treat cancer patients. However, only about 2% of cancer patients die at PCUs/hospices, because there is a lack of such facilities and some psychological resistance to using them. The issue of truth telling is also a factor in Japan, where cancer patients are not fully informed of their diagnosis and prognosis (Hattori et al., 1991; Akabayashi, Kai, Takemura, & Okazaki, 1999b; Akabayashi, Fetters, & Elwyn 1999a). Physicians may be less willing to suggest hospice treatment, or treatment in a PCU if a patient is not fully cogent that he or she is dying.

### *People's attitudes toward euthanasia, cessation of life support, and advance directives*

In a nation-wide newspaper poll (Yomiuri Shimbun, in 1992,  $n = 3000$ ), 86% of the respondents accepted the idea of death with dignity (defined as forgoing life-support in

case a patient is hopelessly ill and death is imminent), and 74% said that they would want to choose “death with dignity” if they became terminally ill. When considering treatment choices for incurable terminal cancer, 81% said that they would prefer pain control and a comfortable dying process even if it shortened their lives.

A survey in 1993 by the Ministry of Health and Welfare ( $n = 5000$ ) revealed similar results. This data indicates that most ordinary Japanese at present think so-called quality of life or quality of care is more important than the mere prolonging of life. These attitudes are considered to be universal where modern Western medicine or ideas relating to palliative care have been introduced.

Nonetheless, Japanese people seem to have somewhat ambivalent feelings when it comes to the question of advanced directives. A questionnaire study administered to healthy people (in 1995,  $n = 210$ ) revealed that more than 80% of the respondents knew the term “Living Will” and said that they wanted to express their preferences about the type of medical care they would get in the future (Akabayashi, Kai, Itoh, & Tsukui, 1997b). However, 88% answered they would give a lot of leeway to surrogates to override their preferences. When asked who should be the surrogate decision-maker, 80% answered they would designate “family or relatives”, in most cases, a spouse. Those who did not want to express their preferences in advance (18%) listed reasons against doing so. These included psychological resistance to talking about death and dying, difficulty in imagining the future, and trust in their families.

It is clear then, that Japanese people basically believe that expressing one's will in advance is good practice. At the same time, a fair percentage of people wanted to leave end of life decisions to doctors and family, even in situations where they could decide for themselves. This attitude is often referred to *omakase*, an attitude of dependency among the Japanese. It is related to the family's role in Japan where historically even life and death have to be seen as a family affair (Akabayashi, Fetters, & Elwyn, 1999a; Akabayashi & Voltz, 2001).

### *Physicians' attitudes toward end of life care*

In a comparative study of Japanese and Japanese-American physicians in 1994, respondents were asked which life-sustaining interventions doctors would recommend to a patient with a prognosis of one month for metastatic gastric cancer (Asai, Fukuhara, & Lo, 1995). Significantly more Japanese physicians were affirmative for life-sustaining treatment replying said they would recommend blood transfusions for gastrointestinal bleeding (74%), total parenteral nutrition (68%), and vasopressors for life-threatening hypotension (62%) when the patient did not know of his diagnosis and prognosis.

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