

# Should Euthanasia be Legalized in Japan? : The Importance of the Attitude Towards Life\*

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## 1. Bioethics and the Society's Attitude towards Life

It goes without saying that bioethical issues do not exist in a vacuum. They are always surrounded by a particular socio-economic and political environment. For example, some features of important institutions in a society constitute the background of bioethical issues and hence, influence the way to deal properly with such issues. Bioethical discussion must always take into consideration the socio-economic and political context of the issues in question. Bioethics, which deals literally with matters of life and death, must make every effort to avoid as much as possible serious mistakes by paying attention to the socio-economic and political context of the issues.

What bioethicists must take into consideration is the attitude of their society towards life embedded in its socio-economic context. What I mean by "attitude towards life" of a particular society is not a general and invariant feature of the culture, but rather the attitude concretely manifested by major governmental policies especially social security policy, by

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the mores shaped by those policies, and by the characteristics of the major institutions, such as medical institutions, which are created in part by governmental policies. Accordingly, the attitude towards life of a society can change, that is, improve or deteriorate in accordance with economic and political factors, for example the economic situation and the hegemonic ideology. Finally, bioethicists also must make their best effort to contribute to the creation of a proper attitude towards life which will orientate a society's deliberation of bioethical issues and produce concrete policy proposals with a clear understanding of the practical implications of their proposals in their own society.

The issue of whether euthanasia should be legalized in Japan requires exactly these considerations and precautions, especially because in Japan the concepts of self-determination and autonomy tend to be used to cover up the explicit and implicit socio-economic and political pressures upon individuals' decision-making processes. With the actors pretending those pressures do not exist, people's decisions are then treated as if they are in fact free and autonomous ones.

## 2. The Authenticity of Autonomous Decisions

At first glance a person's autonomous decision must be respected and, if a person decides to seek for euthanasia or physician-assisted suicide, that decision certainly has a moral power. Nevertheless, a person's 'autonomous decision' should not be accepted at face value without the examining the authenticity of that person's autonomy. Not all seemingly autonomous decisions are in fact authentically autonomous ; there are many features of contemporary Japanese society which put significant pressures upon an individual to make a particular choice. In other words,

those external pressures tend to make the other alternatives unrealistic or unacceptable and so constrict choice. Under certain circumstances, the presence of choice may be an illusion. As will be shown, there are serious reasons for being skeptical about the authenticity of a person's autonomous decision about the end of life in the Japanese medical system.

The problematic features of Japanese society which put pressure upon people's end-of-life decisions are the persistence of doctors' paternalism in the Japanese medical system, the inadequacy of the nursing care system and the underdevelopment of hospice care. I will deal with each of these three issues. But before discussing doctor's paternalism and the inadequacies of the Japanese nursing care system and of hospice care, let me review the legally accepted view of euthanasia in Japan.

### 3. Euthanasia in Japan :

#### Four conditions for Tolerated Active Euthanasia

There is no law which recognizes passive or active euthanasia. However, there is an influential court decision (Yokohama District Court in 1995 on a mercy killing case at Tokai University) part of which contains a legal test under which active euthanasia is tolerated. Active euthanasia requires the following four conditions : 1) the patient's death is inevitable and imminent ; 2) the patient is suffering from unbearable physical pain ; 3) the doctor has already done everything possible to remove the pain ; and finally 4) the wish of the patient to die has been made clear. Even in the abstract, these four conditions are problematic. For example, the rapid improvement of drugs to control pain has made unbearable physical pain very rare. If we focus on physicians' willingness to strictly comply with these conditions for active euthanasia, the situation is more worrisome.

One major factor is paternalism.

#### 4. The Problem Doctor : Persistence of Doctor's Paternalism

In spite of the fact that words such as “autonomy,” “self-determination” and “informed consent” are often mentioned in a discussion of the doctor-patient relationship in Japan, the reality is far from what the frequent invocation of the words would suggest. Furthermore, after hearing these buzz words so often, some people tend to yield to the illusion that the values of autonomy, self-determination and informed consent are actually incorporated into and have become part of the Japanese medical system. In the Japanese medical system, doctors' paternalistic attitudes towards patients still persist and create many problems. I will mention four indicia of the strength of paternalism by Japanese physicians.

A) You cannot rely on your doctor to tell the truth about a diagnosis of cancer.

Doctors still often do not tell cancer patients the true nature of the patient's disease. The reason usually cited is that if informed, the patient would lose hope and die sooner than if kept ignorant. One hospice doctor stated that the rate of truth telling to the cancer patients in Hyogo Prefecture is about 30%<sup>(1)</sup>.

The revelation of the truth to the cancer patient is called “kokuchi” in Japanese. The word has an inescapably condescending tone built in it: a socially superior person does “kokuchi” to a person below. The persistence of the use of this word shows the true status of autonomy and self-determination in the Japanese medical system, and shows the danger of

the uncritical use of those words.

B) You cannot easily extract sufficient information from your doctor.

Because of the prevalence of the paternalistic attitude of doctors and of the over-crowding in the hospitals and clinics, it is not easy to talk with your doctor for a period of time long enough to make an informed decision on matters of life and death. For example, sixty-three percent of outpatients and fifty-four percent of in-patients wish to know the contents of their medical records, and out of them twenty-one percent of outpatients and the twenty-five of in-patients say that the reason is that they wish to know the true diagnosis of their disease, the state of their disease, and the nature of their treatment<sup>(2)</sup>. The crucial condition for proper decision-making at the end of one's life, the flow of information between doctor and patient, is clearly not being met in the present Japanese medical system.

C) The Doctors' paternalistic attitude makes it difficult to create a real team approach to patient care.

Due to the rigid social structure in the Japanese medical system, another crucial channel of communication between patient and doctor via nurses and other health care providers does not work well. In the Japanese medical system, nurses are still undervalued and treated as second-class citizens in the medical community. Hence, conferences on individual cases are an occasion for doctors to convey their opinions to other staff members and there is no real, mutual consultation. As a result, crucial information can be lost.

Hierarchy in the medical system prevents setting up a smooth communication channel among health care deliverers through which nurses can convey what they learned from daily contact with the patients. There

is no ethos among doctors which encourages doctors to listen to what patients tell them with humane and professional humility.

D) Japanese doctors are reluctant to use morphine to reduce the pain of terminally ill patients.

According to 1997 the International Narcotics Control Board (INCB) statistics with respect to the amount of the therapeutic morphine used per million people per day, Japanese doctors are clearly much more reluctant to use morphine to alleviate the pain of their patients in comparison with their counterparts in other developed nation, using on average 12.9 gram in comparison with Australia (101.9), Canada (92.8), UK (86.0), US (64.2), France (64.2) and Germany (16.8)<sup>(3)</sup>. The reluctance to use pain killers leads to unnecessary suffering and amplifies the patient's fear of the supposedly unendurable pain during the dying process. Paternalism and ignorance on the part of doctors are a deadly combination which gives the wrong reason for the legalization of euthanasia. In Japan, people think that one of the major reasons for euthanasia is an inevitable and unendurable pain as the accompaniment of dying process. This situation in Japan is in a striking contrast with the Dutch situation, illustrated by the fact that one survey shows only 5% of Dutch respondents cited pain as the possible reason for euthanasia<sup>(4)</sup>.

## 5. The Inadequate Care of the Elderly and the Handicapped

Until now, the focus has been the persistence of the doctors' paternalism and the harm it causes. In the following I will discuss the socio-economic and political contexts surrounding the issue of euthanasia in Japan, which are shaped by the governmental policies. The key point is that

the prospect for long-term care of the elderly is so bad that patients may “voluntarily” choose euthanasia or suicide. In this discussion of the inadequacy of the nursing care system, I will discuss two points ; murder of the ill by family care givers and the outrageous inadequacies of Japanese nursing care insurance scheme.

First, murder because of the burden of the nursing care (kaigo satsujin)

In Japan from time to time people read small articles in the newspaper on the murder of a nursing care recipient, often a bed-ridden person, by the nursing care- giver and, sometimes, an article about double suicide of both the care-giver and the nursing care recipient. The articles are short, because people have got so used to these kinds of incidents ; they are not big news any more. This mundane quality to such tragedies is certainly not a healthy development. These avoidable human tragedies have not been dealt with seriously by the society as a whole. The government has not exerted itself to eliminate it by deploying proper resources in adequate amounts. Hence, the phrase “nursing care hell” (kaigo jigoku) is a part of contemporary Japanese language. The phrase expresses how difficult, exhausting and overwhelming is the nursing care of the elderly sick at home.

Unfortunately, because of the lack of publicly available statistics I cannot give a precise account of the scale of this problem with respect to elderly care, but the frequency of news items on these tragic cases suggests the number of cases is not negligible. I would point out that the fact that there are not any reliable statistics concerning this important problem shows the lack of concern on the part of public authorities, their attitude towards the life of people in trouble.

Second, I would like to describe briefly Japan's disastrous new nursing insurance scheme.

The Japanese welfare system has traditionally relied on the mutual support of the family members, especially the unpaid labor of women. But the emergence of the nuclear family, the reduction of the family size due to the drop in the number of children, and the increase of women into the labor market have made the tradition of home care almost impossible to maintain. In post-war era, however, the western idea of welfare state was partially adopted by the Japanese government. That is, still the mutual support of family members is expected, but significant amount of public support started to be provided. The post-war welfare system, although insufficient to say the least, gave indispensable support to the family.

Nevertheless, the change of the structure of the Japanese family advanced more in 1980s and 1990s. Nursing care insurance, which was introduced in April 2000, is the government's answer to the increasing problem of care for the elderly through what the government called "the socialization of the nursing care." The basic idea is that nursing care must be born not by the family but by the society as a whole. Two years after the start of this new system, however, a variety of problems showed up. In addition to operational problems (discussed below), I should note a certain number of the critics of the system dispute the true motivation of the government in introducing the new system ; they claim it was not "the socialization of the nursing care" but the reduction of the government's responsibility with respect to the welfare of people who need nursing care<sup>(5)</sup>.

In the nursing care insurance system, the recipient must pay according to the benefits they enjoy, not according to their ability to pay as in the old social welfare system. Even a recipient who has such a low income that he obtains a waiver for residential tax still has to pay premiums in

the new nursing care insurance system. Furthermore, the recipient has to pay 10% of the price of the services used. In Fukuoka Prefecture, for example, a recipient now has to pay two or three times more than before. Hence, people in need of care with low incomes are pressed not to use services more than under the old, social welfare system. So there is a retrogressive character in the new nursing care insurance system.

As a consequence, nursing care has not really been socialized: the family still has to cope with the care of the elderly sick. The partial withdrawal of the government from the welfare system means the continuation of the traditional reliance upon the family members, especially women. Nevertheless, as mentioned above, the structure of the Japanese family has irrevocably changed. The family whose size has shrunk and whose women work outside cannot cope on its own with the pressure of the nursing care of its elderly. Tragedies are all too predictable. In fact, immediately after the start of the new system, actually on the very first day when the new system started, a woman in her nineties committed suicide because she knew she would become a greater burden on her family under the new system<sup>(6)</sup>. That is, since the amount of the outside help would actually decrease in the new system, there would have been more work for the family.

The attitude towards the life of the elderly who needs care, which is built into this new system, is not life-affirming and life-enhancing. On the contrary, people who need care are forced to perceive themselves as burdens to their families and society. In some instances they could feel guilty about being alive, that is, they feel like selfish parasites demanding self-sacrifice from other people. Not surprisingly, they feel they ought to sacrifice themselves and end their wretched lives. Without societal support people turn to self-sacrifice. This acquiescence to euthanasia and suicide

should not be confused with an autonomous decision to end one's life. Rather, the range of rational choices of the sick has been unnecessarily narrowed by bad governmental policy and values. Within the artificially created narrow range of options, the elderly sick, falling back on an old cultural notion of self-sacrifice which justifies and reinforces their forced choice, may hasten the end of their lives. But such decisions, springing essentially from the meager social context created by the government, cannot in any true sense be called "autonomous."

Japanese politicians, bureaucrats and executives, by the way, do not often show the so-called Japanese virtue of self-sacrifice, that is taking responsibility for a major error by committing suicide. When caught up in a scandal their obstinacy and tough refusal to voluntarily reveal incriminating evidence is born out of a ruthlessness for self-preservation, not so different from the tenacity of Enron executives. I do not think that those tough Japanese politicians, bureaucrats and business executive are un-Japanese ; they just have enough power and privilege to keep their tough hides intact.

Finally, I will discuss the underdevelopment of hospice care in Japan. Hospice care which is supposed to focus upon the quality of life of a patient during the end of life days can give a concrete alternative to euthanasia, but in fact in Japan it does not do so.

## 6. Hospice Care Is Not Easily Available in Japan

In Japan with its population of 127 million, the number of hospices is 60 and the total number of hospice beds is about one thousand. Because the average stay in hospice is two months, the number of people who die

in hospice is 6,000–7,000 per year. Contrast that tiny number with the fact that each year about one million people die in Japan, more than 250,000 of them dying of cancer. It is truly difficult for an ordinary Japanese person to take advantage of hospice care at the end of life. Moreover, the need of spiritual care has not yet been well understood in Japan. Moreover, the basic purpose of hospice care, which is to help dying patients live comfortably and meaningfully to the end of their lives, has not been understood by many doctors. They regard hospice as the place for the patients to go to die in a sort of warehouse. When the prognosis of patients is not good and there is nothing to do for them, doctors start to suggest the transfer of those patients to hospices. The suggestion by doctors to go to a hospice, without a sufficient explanation of what hospice care means, tends to be taken by patients merely as the declaration of imminent death. Consequently, the image of hospice in Japan tends to be very dark. In addition, home hospice care is truly insufficient : . The Japanese hospice movement still has a long way to go<sup>(7)</sup>.

## 7. Conclusion

Real choice is not yet possible in the Japanese medical system. Doctors' paternalism, which allows them not to learn and practice pain control, also stands in the way of effective communication with patients, their relatives, and other medical workers. These flaws in the Japanese medical system tend to make patients feel their lives are not properly valued and respected. Hospice care which could be a better alternative is not easily available to the vast majority of people who desperately need it. Furthermore, flaws in the social welfare system lower the self-esteem of care recipients and can make the life of care recipients and their relatives miser-

able. This kind of environment produces guilt feelings in the mind of care recipients and can lead to despair and ultimately the emergence of suicidal intentions. Under these circumstances, suicidal intentions must not be taken at face value. They may not be autonomous decisions but ones coerced by the misery of their environment. Therefore, a life-affirming and life-enhancing environment must be created before euthanasia is legalized in Japan. At the very least, the government and society as a whole should make a great effort to promote the affirmative, enhancing attitude towards life that must be realized in concrete policies and the reform of major institutions, such as medical institutions. It is unrealistic and hypocritical to pretend that people can die peacefully at the end of their lives while people's lives at other stages and other aspects of their lives are treated without sufficient respect and consideration. Bioethicists must be very careful not to make proposals which are reasonable in the abstract but disastrous in the reality, and must try to contribute to the establishment of the proper life-affirming and enhancing attitude towards life.

### Note

- (1) Kenji Yamagata M. D., "The Human Rights of Patients : From the Viewpoint of Hospice care" Lecture at Kwansei Gakuin University, June 28, 2000
- (2) "The Outline of the 1999 Inquiry into the Use of Medical Services" (Heisei Jyuichi Nen Jyuryo Kodo Chosa no Gaiyo), The Ministry of Welfare and Labor [http : //www.mhlw.go.jp/toukei/saikin/hw/jyuryo/00/kekka-7.html](http://www.mhlw.go.jp/toukei/saikin/hw/jyuryo/00/kekka-7.html)
- (3) Kenji Yamagata M. D., "The Human Rights of Patients : From the Viewpoint of Hospice care" Lecture at Kwansei Gakuin University, June 28, 2000
- (4) "Euthanasia : Looking at life and Death" (Anrakushi : Sei to Shi o Mitsumeru), ed. by NHK Human Body Project, NHK Publishing Company (Nihon Hoso Shuppan Kyokai) 1996
- (5) As for the content and problems of Nursing Care Insurance, the following two books give a perceptive and critical evaluation. Shuhei Ito, "Reviewing Nursing Care Insurance" (Kaigo Hoken o Toinaosu), Chikuma Shobo Publish-

ing Company, 2001 and Ryu Niki, Medical Care and Nursing Care at the Beginning of the Twenty-First Century” (21 Seiki Syoto no Iryo to Kaigo) Keiso Shobo Publishing Company, 2001

- (6) Shuhei Ito, “Reviewing Nursing Care Insurance” (Kaigo Hoken o Toinaosu), Chikuma Shobo Publishing Company, 2001, p. 10
- (7) As for the present situation of hospice care in Japan, see History of Patients in Post-War Japan” (Sengo Nihon Byonin Shi) ed. by Takeshi Kawakami in Cooperation with Shiro Sakaguchi and Hiroyuki Fujii, Nobunkyo Publishing Company, 2002, pp. 707–718

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