Grounds and Necessary Conditions for the Legalization of Euthanasia: Comparative Approach of Legal Theory Regarding Euthanasia between Japan and the Netherlands

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1. The definition of euthanasia

The term "euthanasia" is not a legal term, and is used in various senses throughout the world. One can distinguish three forms of euthanasia.

The first is known as "passive" euthanasia. It refers to the shortening of life through not carrying out treatment, as in for instance stopping transfusion because it prolongs pain in a case where life can be prolonged by blood transfusion. This is also called "euthanasia through non-action" and "assisting with death by leaving to die". Negative euthanasia does not differ much from death with dignity in the sense that the time of death is quickened by the failure to give medical treatment.

The second form is "indirect euthanasia", which is also known as "therapeutic euthanasia". This is a case where the amount administered as medically established form of painkilling in terminal treatment inevitably leads to a shortening of life, as when, for instance, the patient's life is shortened as a result of the side-effects of an increased dose of a strong painkiller such as morphine used

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** "Anyone who commits a criminal act to which he was forced by necessity will not be punished".

to remove pain. This is also called "assisting death that accompanies shortening of life as a derivative result".

The third form is "active euthanasia", also called "homicidal euthanasia", which refers to the action of actively terminating life by injection or administering drugs etc. in order to let the patient die peacefully. This is also known as "assisting to die with the intention to shorten life".

Since the Remmelink Report of 1991, the first two forms of euthanasia are thought of as part of a physician's day-to-day duties, and are not included under the concept of euthanasia in the Netherlands; only active euthanasia is dealt with as euthanasia. Euthanasia is defined as follow: Euthanasia is an intentional termination of a patient's life at his own request. (See the Remmelink Report mentioned below)

By contrast, in Japan all of the above forms are discussed as part of the concept of euthanasia as a useful distinction of the line between legality and illegality. This article too deals with the various forms of euthanasia, but as it examines the issue in comparison with the Netherlands, the emphasis will be on active euthanasia.

2. Euthanasia in the Netherlands: a Japanese perspective

In December 1993, the media reported that the Dutch parliament had passed a bill on euthanasia, sending shockwaves around the world. The Vatican issued a critical comment saying that the Dutch were trying to do what the Nazis did, whereas in Japan, partly due to misleading reports in the media, there were contradictory whispered comments: one the one hand the Netherlands was said a scary place where one could not enter hospital without worrying, while on the other it was expected there would be euthanasia tours to the Netherlands. It is obvious that either comment was based on misunderstanding.

This Dutch legislation was in fact not the enactment of a single euthanasia law, but the amendment of one article in a previously existing Law Regarding the Disposal of the Dead, stipulating the obligation to report any act of euthanasia. Moreover, the Dutch penal cod, in addition to the act of homicide, provides for commissioned

homicide (section 293 of the Dutch Penal Code) and assisted suicide (section 294); as no amendments were made to the stipulations of theses laws, euthanasia is still considered to be an illegal punishable crime, both before and after the amendment.

However, in connection with the ageing of the population, and changes in the background conditions relating to medical care such as the advancement of medical technology and full provision of health insurance, euthanasia has been practised on 2300 people per annum in the Netherlands, mainly by family doctors (according to the 1991 Remmelink report, which is based on a nationwide survey). Ever since in 1984 the Supreme Court, dealing with a case of euthanasia, accepted a plea of necessity based on section 40** of the Penal Code, ruling that "a physician's duty to abide by the law and respect the life of his patient may be outweighed by the duty to help a patient who is suffering unbearably, who depends upon him and for whom, to end his suffering, there is no alternative but death", euthanasia has been dealt with as permissible as long as it is carried out in order to relieve unbearable pain based on judicial precedent, even though it is an illegal act prohibited under criminal law. The above amendment of the law constitutes a legal confirmation of this practice.

3. The euthanasia debate in Japan

Since in Japan there has been no nationwide survey on euthanasia as in the Netherlands, the reality is unknown. Moreover, euthanasia is not only illegal under criminal law, but there also has been no precedent where it has been viewed as legal. In fact, discussions and surveys regarding euthanasia frequently meet with strong resistance and rejection in Japan. The reasons for this may be surmised as follows.

a. Association of euthanasia with elimination of the socially weak

Strong resistance is provided by those who fear that if permitted, euthanasia will be carried out even on those who do not want it; this feeling runs particularly strong in those with a weak position in society. In reaction to the TV program introducing the Dutch situation, there were strong protests from those with illnesses to which euthanasia was applied.

b. Physicians' and medical practioners' rejection of external interference

Previously, physicians were able to exercise supreme decision on matters regarding medical treatment, but the euthanasia issue may change that. Establishing empirical evidence regarding the practice of euthanasia necessitates an enquiry into the way medical treatment is carried out, upsetting the order in the sanctuary of medical practice, which has been established by practitioners themselves, and is therefore strongly resisted by them. The introduction of the legal principle of informed consent means that it is no longer possible to say that the method of treating a patient is decided solely by the physician, but in Japan there is a fair number of practitioners who are opposing informed consent itself, so that informed consent at this stage is no more than a non-codified legal doctrine.

c. Distrust of physicians and contemporary medical practice in society at large

Physicians in Japan have long enjoyed high social rank and commanded respect, but there are also many who feel uneasy about medical practioners' high-handedness. This feeling of unease is partly due to a lingering distrust of medical practitioners because of the past situation as mentioned above under b., where the physician was in charge of all decisions, and did not provide the patient with sufficient information (more recently, the GCP Standard stipulates that patients must be given sufficient explanation regarding their treatment and consent to it, but this is frequently being ignored, and cases are reported where forgery of the patient's letter of consent is suspected); partly, it is also caused by anxiety about the direction of modern medical treatment itself, which is entering an area never experienced by man before.

These objections cannot be taken lightly, but at the same time create a climate where it is difficult to discuss the euthanasia issue objectively. The argument that the existence of possible problems regarding some technique should lead to restriction of that technique so as to prevent their occurrence is often viewed on the same level as an active affirmation of that technique is by no means unique to euthanasia, as evidenced by the debates on brain death and infertili-

ty treatment.

In a decision which received international attention, given on the 22nd of December 1962 by the High Court in Nagoya, while finding the defendant in the case under consideration guilty, the court gave a general ruling stating that the illegality would be nullified if the following six conditions were met:

(1) That the patient is afflicted by an illness that is incurable from the viewpoint of current medical knowledge and technology, and the time of death is imminent

(2) That the patient is under intense pain, to a degree that others cannot bear watching

(3) That the action is performed with the sole objective of easing the patients terminal pain

(4) If the patient is fully conscious and is able to express his will, that a sincere request or consent is made by the patient

(5) That the action is carried out in principle by a physician; in cases where this is not possible, that there are special circumstances that make it sufficiently affirmable why the action could not be carried out by a physician

(6) That the method can be acknowledged to be of sufficient ethical propriety

However, this ruling has been criticized on the following grounds: in not making the patient's consent an absolute must (condition 4), it carries the inherent danger of diminishing the importance of life; on the other hand, the demand for ethical considerations (condition 6) as a basis for deciding on euthanasia leads to a de-facto denical of euthanasia. Still, this legal precedent has important implications in that in all subsequent court cases dealing with euthanasia verdicts of guilty were given after examining the case against condition 6.

More recently, in the first case where euthanasia was practised by a physician, the Yokohama district court on the 28th March 1995 again found the defendant guilty, but gave as a general ruling the necessary conditions for the legality of the three categories it established, "passive euthanasia", "indirect euthanasia" and "active euthanasia".

The outline of the case is as follows. The defendent, who was

an assistant in a university medical faculty and a physician, received a request from the older brother of male patient, who had been admitted with multiple myeloma in a state of almost total unconsciousness to the hospital attached to the same medical faculty, to stop treatment as he could not bear watching his brother's pain. In response, he (1) disconnected the intravenous drip and catheter. The brother continued to request that he give him peace, as he could not bear to hear his snoring. In response, the defendant (2) injected the patient with twice the usual amount of a tranquilizer which has a side-effect of inhibiting respiration, and an antipsychotic agent. Being then told that the patient was still breathing, and that he would like to take the remains back to his father's house soon, he (3) terminated the patient's life by injecting him with potassium chloride, which causes heart failure. The prosecution indicted the defendant for murder on the count of fact (3).

In judging this case, the decision first indicated the general conditions for permitting euthanasia regarding the above three circumstances as follows (in doing so, it ruled that the termination of treatment, i.e. death with dignity, could be treated in the same way as passive euthanasia).

1) For any kind of euthanasia, that the patientis under intense unbearable physical pain. Apart from existing pain, this may also include that can be expected with certainty, but does not include mental pain.

2) That the patient's death is inevitable and imminent. The degree of immediacy of the time of death is relative, but for active euthanasia it needs to be high. However, for passive and indirect euthanasia it may be lower.

3) That the patient has expressed his will. For active euthanasia there needs to be a clear indication of the patient's will, whereas for passive and indirect euthanasia a presumed indication based on the patient's previous expression or the family's expression is acceptable. The condition 4) of the Nagoya High Court's decision mentioned above should be changed to this one.

4) For active euthanasia, that all ways of administering medical treatment for elimination and amelioration of pain have been ex-

haused, and a state has been reached where no alternative means are avaialbe.

The condition 5) of the Nagoya High Court's decision mentioned above should be changed to this one, and conditions 3) and 6) of that decision are unneccessary.

The conditions for permitting active euthanasia according to the above ruling can be summed up as fofllows.

a. That the patient suffers from unbearable physical pain.

b. That the patient's death is unavoidable and imminent.

c. That the patient has clearly expressed his will that his life should be shortened.

d. That all ways of eliminating and ameliorating of the patient's physical pain have been exhausted, and no alternative means are available.

The decision under consideration further examined whether among the above steps taken by the defendant (1) fulfilled the permissable conditions for passive euthanasia (stopping treatment), (2) for indirect euthanasia, and (3) for active euthanasia; judging that the following conditions were lacking: for (1), condition 3), for (2), conditions 1) and 3), and for (3), conditions 1), 3) and 4), thus finding the defendant guilty.

This decision is meaningful in that it amended the shortcomings of the above Nagoya High Court decision and found that for passive and indirect euthanasia a presumed indication of will is acceptable; above all it deserves credit for indicating the general conditions for permitting euthanasia by a physician in present-day Japan regarding the circumstances of euthanasia. However, standard d. for positive euthanasia "that no alternative means are available" has been criticized for being vague.

It is not possible to say that the necessary conditions for legality have been established, but the fact that such rulings are appearing means that euthanasia is necessary in Japan, too. Continuation of the present state, where an objective discussion is not possible and which constitutes no more than maintaining the status quo, is problematic from the viewpoint of both the welfare of the patients suffering from unbearable pain and the mental suffering of the prac-

titioners; in sum, it must be concluded that the status quo is providing extremely unsatisfactory results. In this sense, analysis by the legal establishment is a must, and it is possible to say that the above Yokohama district court decision has made a contribution to this debate.

This paper considers the grounds and necessary conditions for the legalization of euthanasia on the basis of the above-described situation in Holland and Japan.

4. Pain-killing treatment and euthanasia

Traditionally, the argument concerning euthanasia was conducted on the basis of "liberation from terminal pain". However, with the progress in analgesic medicine and its universal application, many forms of pain that previously were thought could be eliminated only through death, can now be allieved through medical measures, causing a change in the basis of the euthanasia issue. In Japan, "death with dignity" is legally permissible, as are the similar "passive euthanasia" and "indirect euthanasia", but regarding "active euthanasia" the opinion denying its legality is gaining the upper hand, judging it "allowing not to eliminate pain but the person who endures the pain is a contradiction in terms of standard logic".

However, the first argument against this is, if at this point in time each terminal patient tormented by pain can really be said to be enjoying the benefit of analgesic medicine. It is said that with the phenomenal progress in the treatment of acute pain of cancer patients, which is the form of pain feared most, 90% of patients can be sedated, but this can only be an abstract medical possibility in therapeutic technology. Unless each patient can be guaranteed sufficient analgesic treatment not as an abstract possibility, but as a real and concrete possibility, the exclusion of active euthanasia from legal forms of euthanasia may be said to fulfil not even the traditional need for euthanasia, which needs to eliminate acute pain worse than death. Before declaring all forms of active euthanasia illegal, a medico-sociological survey of analgesic medicine is indispensable.

The second argument is that present analgesic medicine cannot be said to be functioning properly for patients such as those suffer-

ing from terminal cancer, who are attacked by intermittent acute pain. As present analgesic medicine permits the elimination of pain within the physican's norm of duty, provided the pain at the time is eliminated, the remaining part of the life must be preserved as much as possible, regardless of its quality. As a result, the patient dies gradually in a cycle of being tormented by pain when awake, while in a trance when free of pain until reaching the moment of "the last breath". How can the nation order a terminal patient approaching death fluctuating between pain and semiconsciousness, to live until the final stage in spite the patient's sincere wish to be despatched? Why is the patient not allowed to die until having experenced a full course of pain?

Is it not the essential aim of euthanasia to see pain and its elimination, the repetition of waves of painful consciousness and semiconsciousness relief as "pain overall" and liberate the patient from this pain as well? From the patient's point of view, this problem does not concern the compassion of someone taking action, nor the physican's basic logic, but his own choice concerning the "quality of life" between a "life of great pain" and a "death of little pain".

In this way, the problem of euthanasia needs to go beyond the question of analgesic medicine, requiring treatment as an issue concerning the quality of life.

5. Self-determination and euthanasia

If one sees euthanasia as an issue concerning "quality of life", this inevitably leads to the question as to who makes the decision regarding the quality.

The way of thinking that distinguishes "good life" and "bad life", and allows the possibility of terminating "bad life" depending on the circumstances itself challenges the taboo of sanctity of human life. Therefore, the traditional grounds for justifying euthanasia were sought in the areas of medical treatment and humanitarianism, which were not in conflict with the taboo of the sanctity of life.

If one thinks a little further, however, one realizes that the basis for the decision by the person taking the action (the physician) under the name of "treatment" or "compassion" has in fact been "qual-

ity of life". Rational humanitarianism tends towards social and objective considerations rather than subjective compassion. If one takes a utilitarian view of things, "quality of life" itself becomes the object of consideration, and the grounds for justifying euthanasia are sought in the principles of superior benefit and comparison of benefit and protection of the law. As a result, it becomes impossible to prevent occurrence of the phenomenon of which one must be most cautious if one approves of active euthanasia, genocide aimed at the elimination of the socially weak.

The decision regarding the quality of life must therefore rest with the will of the patient himself, which gives rise to the argument of self-determination. Therefore one must consider this issue by recognizing that if there is anyone to whom belongs the right to choose whether to continue a life of great pain or have a peaceful death, it can only be the patient himself. In concrete terms, when weighing the benefit of "necessity" as a reason for nullifying illegality, the choice of whether to give priority to a life of pain or a painfree death must be seen to become conclusive only when the patient himself has made the decision. Under normal circumstances, the weighing of benefit is carried out in an objective and utilitarian way, but since the issue of euthanasia concerns only the patient himself, a third party is not in a position to reach a conclusion on behalf of the patient on the basis of objective weighing of benefit. Therefore, self-determination of the patient is an essential element of the euthanasia issue.

The reason why self-determination is important is not because it guarantees the right choice, but because it guarantees a personal choice. Even in the event that the choice appears foolish to others, opposing it denies the status of the patient as an independent entity. The duty of the nation is to guarantee each individual such autonomous existence as widely and fairly as possible.

Having said this, there are times when self-determination is restricted — firstly, when it is harmful to others, and secondly, when the possibility of autonomous existence is preserved for the benefit of the patient. The second reason gives rises to the grounds for the punishability of "commissioned homicide". Life is a biological foun-

dation which makes autonomous existence possible; if the former ceases to exist, then so does the latter. Injuring oneself, no matter how foolish it may appear to others, is within the range of choice of self-determination. However, actions that bring about grave danger of life are prohibited because there is a danger that they will put an end the possibility of autonomous existence. In order to protect the continued autonomous existence of the individual, the nation, whose ultimate aim is the assurance of the individual's dignity, cannot be indifferent to the possibility that an individual may on the basis of mistaken judgment put himself in a disadvantagous position (discarding life, the biological foundation of autonomous existence). Commissioned homicide constitutes no less than a paternalistic interference on the part of the nation for the benefit of the patient himself.

Paternalism is permissible because of concern for a person's autonomy and freedom, and therefore in cases where there is no possibility of continued autonomous existence, and the sincerity of the wish to die is objectively guaranteed by facts, the grounds for the punishability of commissioned homicide, i.e. the paternalistic restriction on the right of self-determination of one's life must be rejected in favour of the patient's right to exercise the final self-determination (the realization of autonomous existence), and the patient's freedom of deciding how to continue to live (how to die) is guaranteed on the basis of his own choice. These are the grounds for nullifying the illegality of commissioned homicide.

This also provides an answer to the question which is frequently posed concerning the argument for active euthanasia – if the relief from pain is the chief motive, why is the patient's self-determination so important, or conversely, if self-determination is so important, why does it require the existence of pain? In other words, since the choice between a painful life and a peaceful death must be the patient's decision, while on the other hand the nation has the duty of preserving autonomous existence for the patient's sake as long as there is the possibility of it, both aspects are necessary. This means that the idea of self-determination acts both as a brake to prevent abuse by not permitting euthanasia for patients who do not wish it,

and implies that it will not do to fully recognize the patient's right to die.

In this way, the argument for active euthanasia aims to guarantee the patient's self-determination regarding his own life as long as the impossibility of autonomous existence and the sincerity of the wish to die are objectively assured by facts; the necessary practical conditions for euthanasia therefore need to decided on this basis (both the Death with Dignity Act (1994) of the Oregon State in the United States, and the Right of Terminally III Bill (1995) of Australia's Northern Territory, which legalize euthanasia, are thought to be based on the idea of right of self-termination in the above sense).

6. The necessary conditions for active euthanasia

If one argues for active euthanasia on the basis of self-determination as above, the necessary conditions for its legality can be defined as follows:

a The patient is medically considered to be incurably ill and is close to death

b The patient is physically suffering to an unbearable or severe extent

c The patient has previously expressed his explicit will that his life be terminated

Regarding b, in the Netherlands the suffering may also be "mental suffering" (Supreme Court ruling of 21sty June 1994 in the Chabot case), but as mental suffering carries the risk of having to rely on the patient's subjective appeal only when it comes to assessing its presence and extent, it ought to be limited to physical suffering only, since the impossibility of autonomous existence and the sincerity of the wish to die are not objectively assured.

Regarding c, in the Netherlands active euthanasia is also permitted "when there is not request from the patient" according to the decree accompanying the amendment of the law, but as long as self-determination is regarded as the basis of euthanasia, it ought to be limited to cases where there is an explicit request from the patient.

Needless to say, euthanasia should not be permitted for incompetents such as people with congenital defects, the mentally han-

dicapped, and comatose patients. Permission to interfere to end their lives on the basis of the argument of assumed consent would imply legal assistance for elimination of the socially weak, casting a dark shadow over the issue of euthanasia.

7. Supplementary comments

As argued above, the Dutch amendment of the law constitutes a de facto legalization of euthanasia with reporting procedure. However, the penal code still treats euthanasia as a punishable illegal act. Therefore, the above amendment of the law means that legislation sanctions a situation whereby euthanasia is legal on the one hand, and illegal on the other. This contradictory measure may be assumed to have been taken in the Netherlands on the basis of the consideration that "approval on the one hand and illegality on the other – this duality acts as a safeguard freeing the patients from the worry that they may be driven to death, while enabling them at the same time to request a dignified death".

As a result, the legality of cases of euthanasia where it is not immediately clear if they are legal or illegal cannot be determined until indicted by the prosecution, decisions have been made in the first and appeal trials, and eventually by the Supreme court. Therefore physicians have to practice euthanasia under the risk of becoming a defendant and being found guilty in the future, a flexible practice that is unthinkable in Japan.

Dealing with the issue by skilful operation while exposing the physician to the risk of indictment and punishment cannot said to be an appropriate way of dealing with the extreme issue of life or death. As the Japanese way of dealing with abortion by decreeing the reason for blocking illegality by the Eugenic Protection Law illustrates, it is necessary to legally clarify the distinction between legality and illegality by giving preference to legislation of a Euthanasia Law that clearly states the necessary conditions for legality.