rights.

According to the affirmative opinion, the trustee in reorganization can choose between the claim for the execution of lease contract and dissolution. When execution is claimed, the rent claim after the order for the commencement of reorganization becomes a common benefit claim (Article 208 (7)). According to the negative opinion, the user can continue to use the object until the expiration of the lease term. In addition, the lessor can exercise the entire rent claim as a reorganization claim or a reorganization security right.

The contract for a finance lease has aspects of hire and also of a financial deal. With respect to this case, there are two opinions based on which aspect of the legal nature of finance lease contract is emphasized. In many precedents, that claim has been treated by emphasizing the factors of a financial deal to be its actual nature. This decision of the Court is the first one by the Supreme Court which is based on the negative opinion that these precedents have depended on, and it will have an important influence on the treatment of finance lease contracts in reorganization proceedings from now on.

As a further problem, we can suggest how a finance lease contract should be treated when it is not by the full pay-out method or for an operating lease contract.

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5. Criminal Law and Procedure

a. Criminal Law

The New Requirements for Allowing the Practice of Active Euthanasia by Doctors

Decision by the Third Criminal Division of the Yokohama District Court on March 28, 1995. Case No. (*wa*) 1172 of 1994. A Case

of Homicide. 1530 *Hanrei Jihō* 28; 877 *Hanrei Taimuzu* 148.

[Reference: Criminal Code, Article 199.]

[Facts]

The illness of Patient X was diagnosed as multiple myeloma (a kind of cancer from unknown causes). Patient X was in the hospital affiliated with *Tokai* University. At first, Chief Physician A and Doctor B had treated X. The accused C had worked as a physician at the hospital since April 1, 1991 and took part in the treatment of X. The name of the illness and the condition of X were known to his wife Y and first-born son Z, not to X himself. X's condition deteriorated and he fell into a nearly unconscious state. His remaining days were numbered. Beginning on April 9, 1991, Y and Z had repeatedly requested that the intravenous drip and Foley's catheter should be removed because X appeared to be suffering severely. On all such occasions, Doctor B explained to Y and Z that the equipment should be left in place. Beginning on April 11, the accused had been assigned to treat X and to answer to his family. The facts on April 13, 1991 (the day of this event) were as follows:

(a) Y and Z, trying to release X from his painful state, demanded that the accused stop treatment, once and for all. At their request, the accused told a nurse to withdraw treatment and made her remove the intravenous drip and Foley's catheter at about midnight. Then, furthermore, Z strongly requested that the accused get rid of an airway as X appeared to feel a lot of pain. The accused explained the possibility that X would be unable to breathe if this was done. In spite of the explanation, Z repeated the demand. Thus, the accused acceded to that request, too, at about 5:45 p.m..

(b) Moreover, Z, seeing X's pathetic state caused by his labored breathing which sounded like a snore, strongly urged the accused to take action to put X out of his misery after 6:00 p.m.. As a result, in order to relieve X's labored breathing, the accused injected twice as much analgesic (the trade name "*Horizon*") as usual, knowing that it has the side effect of suppressing breathing and that the intravenous injection of it would probably hasten X's death. This occurred at about 6:15 p.m.. Then, about an hour later, acceding to

the same demand by Z, the accused injected twice as much antipsychotic medication (the trade name "*Serenēsu*") as usual, perceiving that it has a side effect of suppressing breathing. This occurred at about 7:00 p.m..

(c) Despite all these measures, X's painfully labored breathing continued, so Z became extremely upset. Z emphatically pressed the accused to put X out of his misery once and for all. Thereby, the accused made up his mind to have X leave this world, and he injected twice as much antiarrhythmia drug (Verapamil Hydrochloride, the trade name "*Warason*") as usual, perceiving that it has a side effect of transitory cardiac arrest. In spite of the injection, X's pulse, etc. did not change. Accordingly, to ensure that X would die, the accused injected a 20 milliliter dose of Potassium Chloride (the trade name "*KCL*") without dilution, which has a side effect of causing decreased blood circulation and brings about cardiac arrest if it is used without dilution. This occurred at about 8:35 p.m.. As a result, X died from cardiac arrest based on acute hyperkalemia at about 8:46 p.m..

Based on his administering the last two injections described in (c), the accused was indicted for murder.

[Opinions of the Court]

The accused is found guilty. (Later, this sentence became final and conclusive.)

1. Introduction

In this case, it is necessary to examine each act which the accused performed for the patient and to inquire into the legal permissibility. The reasons are as follows: (i) With respect to patients who suffer from incurable illnesses and are facing imminent death, doctors face no small number of practical situations in which they are obliged to make decisions whether to take phased measures as in this case. Therefore, it is of great significance to examine the legal permissibility of each act by the accused acting as a doctor. (ii) The practice of active euthanasia by a doctor is allowed only when every other medical means available has been tried to relieve or alleviate the patient's pain and no alternatives are left. Thus, it is necessary to in-

quire to what extent the acts done for the patient prior to the last fatal ones are allowed. (iii) The acts which were the subject of the indictment in this case were performed as the final step in a series of actions in terminal care. Therefore, in order to judge the substantial unlawfulness, the illegality which deserves punishment and the responsibility, it is necessary to examine not only the final acts as the cause for the indictment, but also the acts before them as a whole.

2. Concerning the Withdrawal of Treatment

(1) The problem of withdrawing treatment is whether it is still necessary to continue treatment for prolonging life when a patient who suffers from an incurable illness has no prospect of recovery and cannot avoid impending death. This is also the problem of death with dignity, that is, whether patients are allowed to die a natural death by discontinuing useless life-prolonging treatment.

(2) The rationale for the permissibility of withdrawing treatment lies in the next two points. The first is the theory of the patient's right to self-determination. The theory is that serious attention should be paid to the right to self-determination of a patient who has decided to die a natural death with dignity. The second is the theory of the limitation of the doctor's duty to treat. According to this theory, it is no longer a duty of doctors to continue useless treatment.

(3) The withdrawal of treatment is permitted under the following conditions:

① First, *the patient must suffer from an incurable illness, and must be in a terminal condition under which there is no prospect of recovery and death is inevitable.* This is based on the next considerations. (i) The patient's right to self-determination means neither the right to choose death itself nor the right to die, but merely the right to choose the manner of death or the dying process. (ii) If the withdrawal of treatment were allowed prematurely, i.e. in early stages, there would be a general trend undermining respect for life.

In judging whether a patient is in a terminal condition as a result of which death is inevitable, the following points are important: (i) The existence of such a state seems to be difficult to assess even medically. Therefore, it is preferable for more than one doctor to repeat the diagnosis. (ii) Such a condition is considered relative to what im-

pact the withdrawal of treatment has upon the time of the patient's death.

② Secondly, *the indication of the patient's wish to have treatment withdrawn must exist at the time of discontinuation.* The reason is that withdrawing treatment is allowed on the ground of the patient's right to self-determination.

The presumptive wish of the patient is sufficient when the patient's explicit current wish does not exist at the time of discontinuation. (I) When the patient previously expresses his or her written or oral will (living will, etc.), it can be evidence probative enough to find his or her presumptive wish. (II) When the patient expresses his or her wish too long before the discontinuation is considered, and when his or her previously expressed will is vague, it is required that his or her prior intent is complemented through the indication of will by a family member to find the patient's presumptive will. (III) When the patient does not express his or her will in advance, it is permissible to presume the patient's will in the same way.

To presume the patient's will through the indication of will by a family member, the following points are required on the part of the family member and the doctor: (i) The family member who indicates the intent to withdraw treatment must fully know the patient's character, sense of values and view of life, etc., and must be in a position from which the patient's will can be presumed precisely. (ii) The family member must have enough information and exact perception about the patient's condition, the content of treatment and the prognosis, etc.. (iii) The indication of will by the family member must be based on the sincere consideration as if the family member were in the patient's shoes. (iv) In assessing the indication of will by the family member, the doctor must collect necessary information concerning the patient's own idea or attitude as to his or her illness and the basic course of treatment, and concerning the relationship and the degree of intimacy between the patient and the family member, etc.. Thereby, the doctor must be in a precise position to fully perceive and appreciate the views of both parties.

③ Thirdly, *as for the type of treatment which is withdrawn, all medical measures can be involved.* For example, medical measures

for curing illnesses or sustaining life, such as medication, chemotherapy, dialyses, artificial breathing apparatus, blood transfusion and administration of intravenous fluids and nutrients, may all be considered for withdrawal. The kind of treatment and the time of discontinuation are determined taking into consideration the degree of imminence of death and the impact on the time of death, etc..

3. Concerning Euthanasia

(1) It is said that there are three types of euthanasia. (I) Passive euthanasia occurs when the time of death is hastened by withdrawing life-prolonging treatment so as not to protract a patient's pain (the omission type). Passive euthanasia falls into the above-mentioned category of withdrawing treatment. Thus, the problem is whether passive euthanasia is allowed as a method of withdrawing treatment. (II) Indirect euthanasia occurs when the means to relieve or alleviate pain has the simultaneous possibility of life-shortening as a side effect (the treatment type). One rationale for the permissibility of indirect euthanasia is the idea that it is thought to be within the scope of acts of treatment which are performed mainly to relieve or alleviate pain and which are medically appropriate. The other rationale is the right to self-determination of the patient, who makes a choice to relieve or alleviate pain in spite of the danger of shortening his or her life. (III) Active euthanasia occurs when the means that is the direct cause of death is intentionally used to set a patient free from pain. One rationale for the permissibility of active euthanasia is the doctrine of necessity; that is, when there are no alternatives for getting relief from pain, the choice of sacrificing life is allowed. The other rationale is the theory of the patient's right to self-determination, which insists that the choice is left to his or her self-determination.

(2) The requirements that allow indirect or active euthanasia are as follows:

❶ *The patient must have intolerable physical pain.* (i) The existence of the pain is affirmed not only when it exists actually, but also when it is certainly expected to afflict the patient. (ii) To allow euthanasia, mental pain is not sufficient, but physical pain must exist.

❷ *The patient's death must be inevitable, and the time of death*

must be imminent. (i) The ground for this requirement is to achieve an equilibrium between the interest of relieving or alleviating pain and the cost of shortening life. (ii) The degree of imminence of death is considered in relation to the selected method of euthanasia. In active euthanasia, a high degree of imminence is required. On the other hand, in indirect euthanasia, a lower degree of imminence is sufficient.

❸ *It must be the case that every other medical means available has been tried to relieve or alleviate the patient's physical pain and no alternatives are left.*

❹ *The patient who consents to shorten his or her life must explicitly indicate his or her wish to do so in order to have active euthanasia performed.* (i) In active euthanasia, the explicit indication of wish by the patient is required, because his or her wish expressed as the exercise of the right to self-determination means the choice directly connected with life-shortening. (ii) In indirect euthanasia, the presumptive will of the patient is sufficient, because the act is thought to be within the scope of acts of treatment which are medically appropriate. The patient's wish is allowed to be presumed based on the indication of will by his or her family member.

4. The Analysis concerning the Concrete Acts of the Accused in This Case

(1) *Concerning the Removal of Intravenous Drip, etc. in (a)*

In the present case, at the time of the removal of intravenous drip, Foley's catheter and airway, there was not an explicit current will of the patient that requested the withdrawal of treatment. Also, the patient's antecedent will was not expressed in advance. Therefore, the problem is whether the patient's will can be presumed based on the indication of will by his family members who requested the discontinuation. In this case, to be sure, such family members are supposed to have known the patient's character, sense of values and view of life, etc. well, because they were his wife and son who had lived with him for a long time. But they did not have an exact knowledge of the patient's condition, such as the state of consciousness and the nature and extent of his pain. Moreover, it was not until less than two weeks before that the accused as a doctor in charge came into contact with the patient and his family members. The ac-

cused was not in a precise position to fully perceive and appreciate the patient and his family members. It does not follow that the patient's will can be presumed based on the indication of will by his family members. Therefore, the requirement for withdrawing treatment is unsatisfied.

(2) *Concerning the Injections of Analgesic and Antipsychotic Drugs in (b)*

These injections had the possibility of hastening the time of the patient's death. However, the object of relief or alleviation was his labored breathing which sounded like a snore, not physical pain. Also, as mentioned above, his will cannot be presumed based on the indication of will by his family member. Therefore, these injections are not permitted as indirect euthanasia.

(3) *Concerning the Injections of Antiarrhythmia Drug and KCL in (c)*

Because the patient was unconscious and did not react to any pain at the time of these injections, he was not in a condition in which he felt physical pain. (Requirement ❶ was unsatisfied.) Thus, at the same time, it does not follow that every medical means available had been tried to relieve or alleviate physical pain, that no alternatives were left and these injections were unavoidably done. (Requirement ❸ was unsatisfied.) Moreover, the patient did not indicate any explicit will as request for euthanasia. (Requirement ❹ was unsatisfied.) Therefore, these injections are not permitted as active euthanasia.

(4) *Conclusion*

Concerning the acts in (c) which are the object of the indictment in the present case, the substantial unlawfulness, the illegality which deserves punishment and the responsibility are not negated, even if the series of acts performed for the terminal patient are examined as a whole.

[Comment]

1. The Court specified that passive euthanasia falls into the category of withdrawing treatment (death with dignity) which does not require the purpose of relieving or alleviating pain, and that the

permissibility of passive euthanasia is only inquired when there is a problem of the latter. Accordingly, in the present case, it mattered whether the acts in (a) were allowed as withdrawal of treatment. Moreover, the problems were examined whether the acts in (b) were allowed as indirect euthanasia, and whether the acts in (c) were allowed as active euthanasia. In the process, the Court argued over the requirements for withdrawing treatment, indirect euthanasia and active euthanasia.

2. Although it was only the acts in (c) that were the cause of the indictment in this case, the Court referred to the requirements for withdrawing treatment and indirect euthanasia. Thus, the problem is whether these parts of the decision are only *obiter dicta.* A majority of the commentators construe them as *obiter dicta,* explaining that the judicial reasoning is beyond the facts constituting the charged offense.

The Court stated as follows: [1] Because it is not until no alternatives are left that active euthanasia is allowed, it is also necessary to examine the acts before those in (c); [2] In order to judge the substantial unlawfulness, the illegality which deserves punishment and the responsibility of the acts which were the cause of the indictment, it is required to examine the circumstances as a whole, including the acts leading up to the euthanasia. However, even if the reasoning in [1] means that the act performed as euthanasia is illegal when there is an alternative means to relieve or alleviate pain, it is sufficient to point out only the existence of a lawful means. But it is not necessary to examine the permissibility of each actual act by the accused. Also, the method of judging, as in the reasoning in [2], is not always theoretically inevitable.

The substantial reasons why the Court referred to the problems about withdrawing treatment and indirect euthanasia seem to lie in the next points: (i) With regard to the present state of terminal care, the Court thinks it is rare for doctors to be immediately pressed to make active euthanasia the only choice. The Court regards as usual situations where doctors take different phased medical measures to relieve or alleviate the pain of terminal patients before they are urged to make a decision to engage in active euthanasia as a final method.

(ii) The Court admits that euthanasia is not illegal under certain requirements, but, as mentioned below, the Court's requirements for euthanasia are very strict. Under the requirements, there would be no possibility of allowing euthanasia for unconscious terminal patients. Thus, it is construed that the Court's reasoning arises from the premise that terminal patients' pain should be relieved or alleviated by withdrawing treatment (death with dignity) rather than by euthanasia.

3. So far, the precedents concerning active euthanasia have all involved cases in which the patient's relatives (husband, son) performed it. Though all the precedents theoretically allowed active euthanasia under certain requirements, the permissibility of it was negated at the conclusion of each of the cases. In the present case, the doctor in charge practiced active euthanasia for the in-patient at his family member's request. Thus, this decision is the first case in which the problem of active euthanasia by a doctor was dealt with, and has received a great deal of public attention.

(1) The leading case about active euthanasia is the decision by the Nagoya High Court (on December 23, 1962, 15-9 *Kōkeishū* 674). The Nagoya High Court set forth the next six requirements for the permissibility of active euthanasia: Ⓐ The sick person must suffer from an illness or disease incurable through the knowledge and arts of modern medical science, and the time of death must be imminent. Ⓑ The pain must be extreme so that no one has the heart to watch him or her. Ⓒ The act must be performed only for the purpose of easing the sick person's pain. Ⓓ In the case where the sick person is conscious and he or she can indicate his or her will, there ought to be his or her own sincere request or consent. Ⓔ In principle, the act must be performed by the hands of a doctor; otherwise there ought to be a special reason why it is impossible to obey the principle. Ⓕ The method must be considered to be ethically proper and tolerable.

On the other hand, this Court set forth four requirements for the permissibility of active euthanasia by a doctor: ❶ The patient must have intolerable physical pain. ❷ The patient's death must be inevitable, and the time of death must be imminent. ❸ It must be the case that every other medical means available has been tried to

relieve or alleviate the patient's physical pain and no alternatives are left. ❹ The patient who consents to shorten his or her life must explicitly indicate his or her wish.

There are great differences between the decision by the Nagoya High Court and that by this Court. First, this Court restricted the "pain" in Ⓑ to "physical pain" under ❶. Second, this Court changed the requirement of Ⓔ to that of ❸. Third, as far as active euthanasia by a doctor is concerned, this Court made the requirements of Ⓒ and Ⓕ unnecessary. When a doctor practices active euthanasia in terminal care, it is taken for granted that the doctor only has the purpose of easing pain and selects the method fit for the purpose (for example, methods to lessen pain). Fourth, requirement Ⓓ does not mention the case in which the sick person is imperfectly conscious and he or she cannot indicate his or her will, so it is unclear whether active euthanasia is allowed in such a case as well. On the other hand, requirement ❹ in this decision always requires the explicit indication of will by the patient who consents to shorten his or her life so that active euthanasia might be allowed.

(2) In the present decision, the next points are noteworthy in describing the difference between the requirements for withdrawing treatment and those for euthanasia:

I. The existence of "physical pain" is necessary only for indirect or active euthanasia (under requirement ❶).

II. Under requirement ① for withdrawing treatment, the patient must be in a terminal condition from which there is no prospect of recovery and death is inevitable. On the other hand, under requirement ❷ for indirect or active euthanasia, not only the inevitability of death, but also the imminence of death is necessary. The instant decision, however, points out that the degree of imminence of death is considered in relation to the method of euthanasia, and a high degree of imminence is not always required in indirect euthanasia. Therefore, the particular distinction between death with dignity and indirect euthanasia seems to be unclear.

III. According to this decision, active euthanasia is permitted only when the patient's explicit, wish is given. The reason offered is that the patient's wish, expressed as the exercise of the right to self-

determination, means the choice directly related to life-shortening. On the other hand, in order to withdraw treatment or engage in indirect euthanasia, according to this decision, the presumptive wish of the patient is sufficient, and can be presumed based on the indication of will by a family member.

In academic opinions, it has been said that the consent or indication of will by the patient's family member is needed as the requirement for withdrawing treatment, but the significance and function of the will indicated by the family member is vague. It is still unclear whether the indication of will by the family member is only a fact necessary for presuming his or her wish, the substitute for the wish or a right peculiar to a family member. The decision in the instant case made it clear that the indication of will by a family member is the fact for presumption. According to this decision, in indirect euthanasia, the patient's wish is also allowed to be presumed from the indication of will by a family member, grounded on the idea that indirect euthanasia by a doctor is within the scope of acts of treatment which are medically appropriate.

(3) Concerning active euthanasia, this decision came to the conclusion that, because the patient was unconscious and did not react to any pain at the time of the injections, he was not in a condition in which he felt physical pain (see, *Opinions of the Court 4* (3)). However, terminal patients are usually unconscious and do not react to pain. In the case of patients who are in a nearly unconscious state, the establishment of requirement ❶ means that there is no situation in which active euthanasia may be allowed. According to this decision, requirement ❶ is also applied to indirect euthanasia, so the range of the permissibility of indirect euthanasia is limited as well. In addition, in cases of the terminally ill, it is difficult to require the explicit indication of wish by the patient as in requirement ❹ for active euthanasia. Therefore, while the Court as well as the precedents theoretically approves the permissibility of active euthanasia under certain requirements, this decision is understood to block euthanasia in practical terminal care. Moreover, under requirement ❸, the criterion as to whether "no alternatives are left" is ambiguous. The criterion for requirement ❸ must be made clear, especially in

relation to the possibility and limitation of analgesic treatment.

This decision grounded the permissibility of active euthanasia on the doctrine of necessity and the theory of the patient's right to self-determination. It seems to mean as follows: where the interest in relieving or alleviating pain conflicts with that in maintaining life, the latter is usually superior, but the patient's choice makes the former superior, and active euthanasia is justified. However, this type of thinking is very problematic. (i) To begin with, it is doubtful whether it is possible to balance the interest in relieving or alleviating pain against that in maintaining life, and whether it is appropriate to balance both legal interests which belong to the same person. (ii) According to this decision, the patient's right to self-determination means neither the right to choose death itself nor the right to die. Thus, such a right to self-determination can hardly uphold the superiority of the interest in relieving or alleviating pain over that in maintaining life. (iii) In necessity, the balancing of legal interests is to be done from the standpoint of the objective legal order, and is not to depend upon the victim's choice. (iv) Essentially, necessity is the justification admitted in a situation of danger, which allows the infringement of legal interests belonging to a third party who has nothing to do with the danger or the party who does not unlawfully give rise to the danger, grounded on the necessity of protecting other legal interests in the danger and the social solidarity of the members of the community. Therefore, the doctrine of necessity is construed to be unsuitable for the solution of the problem as to what doctors should do for patients who make a choice to die.

The present decision is highly important in that it stated the new requirements for allowing active euthanasia, and will have great influence on the euthanasia debate hereafter in Japan. However, this decision is substantially problematic at several points, as discussed above.

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