Ethical and Legal Debates in End-of-Life Care in Japan

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Events

Early 2000's	A series of criminal/court cases
Late 2000's	Publications of many guidelines by the government and medical and academic associations
2012	Publication of a draft law by a group of Diet members

The Imizu Munincipal Hospital Case

- 2000–2005
- A surgeon let 7 cancer patients die by withdrawing the respirator.

- Patients' age: 50–70
- All unconscious and terminally ill

- The surgeon believed it would be better for the patients. The patients' families gave consent.

The Sagamihara Case

- 2002
- A 40 years old, male patient of ALS

- Respirator dependent for two years
- Being taken cared of by his mother at home

- Asked the mother to “turn the respirator off” and died

The Kawasaki Kyodo Hospital Case

- 2002
- A, 58 years old, male patient of bronchial asthma
- Suffered an asthma attack while taking taxi, and fell unconscious.
- His wife and son asked for treatment termination.
- The attending physician removed oxygen tube from his throat, and then, administered muscle relaxant agent to kill.

Legal decisions

2004	Hokkaido Haboro Hospital	Withdrawal of respirator	Exempted from persecution
2006	Imizu Humincipal Hospital	Withdrawal of respirator	Exempted from persecution
2009	Kawasaki Kyoto Hospital	Removal of oxygen tube & Administration of muscle relaxant agent	Convicted of murder
2005	The Sagamihara case	Withdrawal of respirator by the patient's mother	Convicted of murder of hire

Major Guidelines on Ethics of Terminal Care

2007	Ministry of Health, Labor and Welfare, "Guidelines concerning the Decision-Making Process at the Last Stage of Life" (rev. 2015)
2007	Japan Medical Association, "Guidelines concerning Terminal Care"
2007	Japan Association for Acute Medicine, "Recommendations concerning Terminal Care in Emergency Medicine"
2008	Science Council of Japan, "Report on Terminal Care"
2009	All Japan Hospital Association, "Guidelines concerning Terminal Care"
2012	Japan Geriatric Society, "Guidelines concerning the Process of Decision-Making for Elderly Care"

Death with Dignity Bill (2012)

Prepared by The Group of Diet Members for
the Legalization of Death with Dignity

- Article #1: This law specifies necessary matters concerning determination of the terminality of illness, withdrawal of life support based on the patient's will, and exemption of legal responsibilities [of physicians].

- Article #9: [Physicians are] exempted from civil, criminal, and administrative responsibilities if they withdraw life sustaining treatments.

An argument against legalization

- Legalization has negative impact on the vulnerable populations.

- The poor, disabled, or old will be pressured to forgo life extending treatments once forgoing becomes a legal option.

"One of the most potent arguments against physician-assisted death (PAD) hinges on the worry that people with disabilities will be subtly coerced to accept death prematurely.... [This argument] now play a prominent role in the public policy debate about legalizing PAD. "

D. Mayo and M. Gunderson, "Vitalism Revitalized: Vulnerable Populations, Prejudice, and Physician-Assisted Death," *Hastings Center Report*, 32(4), 2002.

“We should first create a social system in which people can live as long as they want without the need to worry about being burdens to others; otherwise the ill and old people would be put under pressure to end their lives if we simply affirm [passive] euthanasia.”

“Statement of Citizen’s Group to Prevent Legalization of Euthanasia,” 1978

“If a patient of serious physical disability says he is prepared to end his life by refusing treatment, both his family and doctor would feel relieved and not encourage the use of respirator any more. If advance directive to forgo treatment becomes legally effective, these patients would be pressed to prepare such document…”

Misao Hashimoto, Vice Pesident of Japan ALS Society, 2012

“Once the law is created, it will be unavoidable that those who are dependent on respirator or feeding tube for their life be exposed to a silent pressure of the society; “why do you still want to live when others have chosen a death with dignity?”

Ibid.

- How legitimate are these worries?

➢ Explain two intuitive reasons to support the worry

➢ Examine two criticisms

Two reasons for the threat

- Burdens of caretakers
  - ➢ Physical; financial; psychological

- Discriminative values about disability, old age, etc.
  - ✓ “It cannot be good for them to live any longer.”
  - ✓ “It’s reasonable that they don’t want to live.”

A similar but different argument

- Legalization of physician assisted death is unacceptable because it presupposes a discriminative value.

- It discriminates between lives worth living and those that are not, and permits PAD only for the latter.

Cf. Kazuhiro Kaneko, "'The Blue Grass' Opposes to the Death with Dignity Bill," 2012

Discrimination?

- Incurable
- Terminally ill
- Unbearable pain/suffering

✓ E.g., Terminal cancer and ineffective palliative care

- Possibility of recovery
- Not terminally ill
- No pain or bearable suffering

- Incurable
- Terminally ill
- Unbearable pain/suffering

- ✓ Pre-existing disability
- ✓ Old age
- ✓ Female
- ✓ Poor
- ✓ Low education level

✓ E.g., Terminal cancer and ineffective palliative care

Criticisms

- Battin et al.:

  No evidence of the risk

- Mayo and Gunderson:

  The only alternative is to force everyone to live no matter what (revival of vitalism)

"Where assisted dying is already legal, there is no current evidence for the claim that legalized PAS or euthanasia will have disproportionate impact on patients in vulnerable groups."

M. Battin, et al., "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups," *J Med Ethics*, 33, 591-7, 2007.

Data

- Oregon: 1998-2006
- Netherlands: 1990, 1995, 2001, 2005

Old age

- Oregon: 10% of patients who died by PAS were 85 or older, whereas 21% of all Oregon deaths were among persons in this age category.

- Netherlands: Rates of assisted dying were lowest in people over 80 (0.8% in 2005)…

Disability

- Oregon: no one received suicide assistance for (non-terminal) disability alone.

  *In Oregon, PAS is legal only for the terminally ill

- Netherlands: 0.2% of patients receiving euthanasia had non-terminal disability.

Other factors

- Oregon: Patients dying by PAS were more likely to have higher education.

- Netherlands: Rates of euthanasia was higher for people of higher socioeconomic status.

The Percentage Isn’t the Issue

- Even if the number of old people forgoing treatment is relatively small, these small number of people may have been (subtly) coerced.

- Suppose the population of disabled people in our society is 10%.

- But statics shows that among those who have forgone treatment and died, only 5% were disabled.

- It may still be the case that many disabled people were exposed to the pressure to end their lives.

"[D]isability critics … seem to dismiss the risk of this error [of forcing people to live who genuinely want to die]…. this amounts to a de facto commitment to medical vitalism."

D. Mayo and M. Gunderson, "Vitalism Revitalized: Vulnerable Populations, Prejudice, and Physician-Assisted Death," *Hastings Center Report*, 32(4), 2002.

Mayo and Gunderson

- If you find the risk to the vulnerable unacceptable, you can either:

1. insist on improved safeguards to ensure that a patient's choice is genuinely free, or;

2. support medical vitalism: i.e., insist that the value of preserving life always overrides the value of self-determination.

Mayo and Gunderson

- If safeguards cannot be perfect, we still do not want to return to vitalism. So the risk should be taken to legalize physician assisted death.

Japan’s situation

- Treatment termination is not legalized, but vitalism does not seem remain very strong either.

- Why?

- Treatment termination is already practiced under the regulation of non-legal rules (guidelines / the soft laws);

- Many vulnerable people are already under the pressure to end their lives.

- Why do some people still want legalization (if treatment termination is already practiced)?

- Why the vulnerable still resist legalization (if they are already exposed to coercion)?

Why resist legalization?

- Part of what is worried about is that forgoing treatment will be recognized as a natural course of action, or an option just equally reasonable or easily available as other courses of action.

- Perhaps legalization sends a stronger message to this effect than the guidelines.

- Thank you for your attention.

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