A Cultural Perspective on Euthanasia

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Introduction

In April 1991, a young physician working at Tokai University Hospital gave an intravenous injection of potassium chloride to his terminally ill patient. He did so after repeated requests by the family to ease his suffering. The physician was subsequently charged with murder. In March 1995, he received a two-year prison term. However, he was given a two-year suspended sentence, because of the family’s suspected pressure to end the patient’s suffering and because of the lack of a system to manage this kind of situation. At that time, the Yokohama District Court clearly outlined four conditions required for active euthanasia to take place as follows:

1. Pain is intolerable.
2. Death is imminent.
3. No alternative method for alleviating suffering is available.
4. The patient’s own request or consent must be obtained.

This case should not have been considered as an example of active euthanasia because the patient was comatose and thus unable to complain about any pain or suffering, and also the patient had never made a request for active euthanasia to his attending doctor. But this case was introduced as an example of active euthanasia in Japan and has thus raised many opportunities for discussion on euthanasia.

Unfortunately, there was another ‘euthanasia’ case in Kyoto. In April 1996 the hospital director gave a muscle relaxant to a terminally ill patient. He had had stomach cancer for two years which had been treated at that hospital. But, he had never been informed of the true diagnosis. Therefore, of course, he had not requested active euthanasia at all. Again, this case was introduced as active euthanasia, which means that there is some confusion over the terms such as euthanasia, death with dignity and mercy killing, etc.

This article addresses the backgrounds which produced such euthanasia-like cases and the problems in terms of human rights and dignity in Japan.

Methods & Results

In order to investigate physicians’ attitudes toward critically ill patients and euthanasia, two studies were conducted.

In one study, part of an international study on medical decision-making, 132 Japanese physicians participated and were asked to fill in a questionnaire. Those data were compared with those from other doctors from U.S.A, Chile, and Germany. The findings are published elsewhere.

As part of the study, the Japanese physicians were also asked what they would do in a “Tokai case.” Two thirds answered that they would have increased the dose of opioids after an explanation was given to the family that it might shorten the patient’s life. This reaction was very interesting, because morphine had not been used so frequently in Japan.

In another study, 62 Japanese psychiatrists and 72 American psychiatrists, who were mainly working in the field of consultation-liaison psychiatry, were asked about their attitudes toward suicidal ideation among physically ill patients. As shown in Figure 1, more Japanese psychiatrists are afraid that informing cancer patients of their true diagnosis can cause suicidal ideation. Further, Figure 2 demonstrates the comparative answers to the following questions: A competent patient with an incurable illness requiring life support requests termination of this support.

What do you call the termination of medical care by the physician?

Figure 1: Differences between American and Japanese psychiatrists’s reactions to suicidality related with truth-telling

Truth-telling causes suicidality.

Japanese

American

rarely
sometimes
usually
always
Many Japanese psychiatrists think of such termination as mercy killing rather than allowing death to occur naturally.

**Discussion**

These studies revealed that Japanese physicians are likely to be afraid that telling the truth might cause suicide and that there is still ambiguity in the concepts of active euthanasia, passive euthanasia, physician-assisted suicide and dignified death. There are some problems and limits which may further prevent discussion on human rights and dignity in the practice of medicine, which may reflect the Japanese nationality and traditional value system. First, there has been less interest in palliative care, therefore pain management and psychiatric care for terminal patients were less discussed even among professionals. However, in 1995 the International Congress of Psycho-Oncology was held in Kobe, and the first congress of the Japanese Society of Clinical Thanatology was held in Tokyo. Also, the Japanese Society of Palliative Medicine was founded this year with its first congress in 1996, which was introduced to the public through TV and newspapers. These things indicate that there has been increasing interest in this topic not only by professionals but also the public. Such a social movement is expected to contribute to the development of palliative care medicine in Japan.

Second, the practice of team care, especially in terminal care settings, is still less mature. This was also pointed out by the court in the ‘Tokai Case’. In Japan, harmonious relationships have been highly valued and encouraged. However, the group which has been thought of as a virtue among Japanese is different from the team which is necessary in treating patients. In the practice of team care, the members have to express professional opinions from different viewpoints, and discuss various options to achieve a final decision. Such a decision-making process has not been generalized in clinical settings in Japan. As frequently observed, there are few opinions by people other than doctors in team meetings, so plans for treatment proposed by doctors are always followed without being criticized. The practice of team care is not possible without various ideas from different viewpoints by each professional who has an ‘autonomy’.

Third, strong paternalistic tendencies still exist in Japanese clinical settings. This tendency may lead to physicians’ exclusiveness, arbitrary decision-making and dogmatism. In the previous cases, the physicians gave injections arbitrarily in spite of nurses’ opposition. In general, such a paternalistic tendency is augmented by patients’ denial of their disease and the treatment for it, which is still rather prominent among Japanese patients. In order to demonstrate the psychological effects of hysterectomy, the author interviewed 50 patients prior to their operations. The conclusion was that hysterectomy produced a minor psychological effect on them, but more surprisingly, many patients answered they did not know of their disease, nor the kind of operation they would receive, nor its complications. As to a question “why not?”, they answered that they did not want to know, and that they left everything to their doctors. Some patients said that patients have only to believe in doctors. These ‘leaving-everything’ attitudes are derived from patients’ defence mechanism of ‘denial’, and contribute to the enhancement of doctors’ paternalism.

Fourth, but more importantly, revealing the truth is not yet popular in Japan, especially in oncology. Still, although gradually changing, few physicians inform cancer patients of their true diagnosis. According to a national survey taken in 1994, 20% of cancer patients were informed of their true diagnosis. These figures differ according to the sites and stages of cancer, and the location and the kind of hospitals, and also the personal ideas of the doctors. Physicians, when they find a malignancy, usually first tell the true diagnosis to their family, but not to patients themselves. One of the reasons is that physicians wonder if their patients can
endure the stress of knowing they have cancer. Therefore, when talking with the patients, they prefer terms such as ‘just a tumor’, ‘cancer-like disease’, ‘pre-cancer state’, etc. And they recommend chemotherapy and radiotherapy in order to prevent true cancer developing.

According to our recent study investigating the prevalence of psychiatric disorders among otolaryngology cancer patients, there was no significant difference between the revelation of the truth or not. Rather, the patients who were not informed were more likely to have psychiatric complications, as shown in Figure 3. Throughout their interviews, all cancer patients, even when not informed, seemed to suspect having cancer, and patients who had not been informed felt isolated because they could not believe in their doctors any longer. Using the defense mechanism of ‘denial’, they did not ask their doctors directly about their true diagnosis, and as such, doctors and patients were talking only superficially. These situations cannot produce good palliative/terminal care.

Figure-3: Psychiatric complications according to the truth-telling among 50 otolaryngology cancer patients.

<table>
<thead>
<tr>
<th></th>
<th>No Truth-telling</th>
<th>Truth-telling</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=29</td>
<td>48.9% Psychiatric Disorder(+)</td>
<td>42.9% Psychiatric Disorder(+)</td>
</tr>
<tr>
<td>Psychiatric Disorder(-)</td>
<td>Psychiatric Disorder(-)</td>
<td></td>
</tr>
</tbody>
</table>

Figure-4: Truth-telling and family splitting

Another aspect of revealing the truth only to family is that this might produce a split in patient-family relationships as in Figure 4. Japanese are still likely to have a stronger affiliation to their family. But in cases where only the other family members are informed of the truth, they are likely to keep away from the patient and to talk superficially. Therefore, the more terminal patients’ condition, the less their families can talk to them. Even at the end of life, they cannot express deep appreciation to each other.

Finally, but most importantly, it is clear in our country that physicians are likely to expect the patient’s family to make a decision rather than the patients themselves, even in deciding whether to continue life support or not. In a case when the truth has not been revealed, the patient naturally cannot decide on a proper course of treatment. Even when the truth has been revealed, the cancer patient cannot decide by himself. It is natural for patients under severely stressful situations to involve others in decision making, especially family members. Moreover, the patient should depend on the family because he feels guilty about being a long term burden on them.

Recently, the concepts of informed consent, QOL etc. were introduced, and such matters as revealing the truth, dignified death, terminal care and bio-ethics have been gradually discussed among professionals and the public in Japan. It is especially very striking that the public have joined the discussion on these topics. Japanese adhere to a mix of the traditional medical model and the modern one. All discussions and movements in foreign countries cannot be applied to our society without some modification. For example, family affiliations even though they have recently become looser in Japan, will definitely be stronger than in the other countries. Family members will therefore keep playing an important role in the decision-making process.

It is by further discussion, also of Japanese characteristics, that will ultimately lead to improved terminal care in Japan.

References

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