《論　　説》

Recent socio-legal issues concerning end-of-life care in Japan※

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1. Introduction

1-1 Japan as a super-aged and high-mortality society

Japan's society is more rapidly aging and has higher mortality than any other country. According to the data available from the Japanese

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This article is a significantly expanded and supplemented version of the oral presentation（entitled 'Recent features of the socio-legal framework for end-of-life care in Japan'）that the author gave at the 'World Federation of Right to Die Societies International Conference 2024（Dublin, Ireland）' on September 20, 2024. The oral report itself was limited to a summary explanation of less than 10 minutes, and there is no opportunity for it to be published in the future. This article is based on the oral report and has the same fundamental purpose. However, they were prepared as completely separate works, both in terms of quality and quantity. Therefore, this article is published under a new title.

government, the population of adults aged 75 years and older, is expected to continue to increase[1]. Japan is also expected to enter a period of high mortality, accompanied by a sharp increase in the number of patients with dementia and older adults who are living alone[2]. Mortality is estimated to peak by 2040[3]. Another study examined deaths by age over recent years and found a sharp increase in the number of deaths in recent years, especially among individuals aged 85 years or older[4]. Currently, about half of the annual deaths in Japan occur in those aged over 85 years. This upward trend is expected to peak in 2040, when the number of deaths will reach approximately 1.7 million; nearly 60% of those will be adults aged 85 years old or older[5].

1-2 From Hospital to Home

The development of a super-aged and high-mortality society has caused various problems in Japanese healthcare, such as securing a place to die. In Japan, this place has shifted over the past 70 years as follows[6]: In 1951,

1）Cabinet Office of Japan.(2024). *Annual Report on the Ageing Society* (*Summary*) *FY2024,* p. 3.

2）See: Kaneko, Ryuichi. (2017). The arrival of a high-mortality society［Japanese: 多死社会の到来］, *Journal of the Tokyo Institute of Municipal Research*, 108（7）, pp. 42 ff.

3）See: Kaneko, Ryuichi. (2016). Aspects of population ageing and people in need of care［Japanese: 人口高齢化の諸相とケアを要する人々］, *Journal of Social Security Research*, 1（1）, p. 78.

4）For an English translation of the presentation, see: Kaneko, Ryuichi.(2019). 35% ageing population, how should we respond to the '2040 problem'?［Japanese: 高齢化率35%,「2040年問題」にどのように対応すべきか］, *FPCJ Press Briefing*, p. 20.

5）Iijima, Katsuya.(2022). Changes in social structure and the ideal of healthcare for the elderly［Japanese: 社会構造の変化と高齢者医療の理想像］, *The Journal of the Japanese Society of Internal Medicine*, 111（5）, pp. 1007 ff.

6）Japanese Ministry of Health Labour and Welfare.(2023). *Vital statistics of Japan Final data 2022*, Volume 1, General mortality, Table 5.5: Trends in deaths by

hospital, home, and nursing home deaths accounted for 11.6%, 82.5%, and 0% of all deaths, respectively, whereas in 2021, the percentages had changed to 67.4%, 17.2%, and 13.5%, respectively. Hospital deaths have steadily increased since the 1950s; while deaths at home declined until the mid-2000s, there are signs that this number may be increasing. The number of deaths in nursing homes has increased since the late 2000s. These trends clearly changed between 2019 and 2020, when the COVID-19 pandemic began. Hospital deaths trended downwards, and home deaths trended upwards.

Japan will need to care for many terminally ill patients in the future, but establishing new hospitals and long-term care facilities is expensive. The Japanese government has reduced healthcare spending and the number of hospital beds, citing financial difficulties. Terminally ill patients will therefore need to face their deaths in places other than medical institutions. Furthermore, a questionnaire survey[7] found that a relatively large majority of respondents wished to spend their final days at home, where they were accustomed to living. In response to this situation, the Japanese government is helping to implement end-of-life care at homes rather than medical facilities[8]. This trend accelerated during the COVID-19 pandemic, when medical institutions restricted the admission of terminally ill patients to concentrate medical resources on infectious disease control[9].

However, as deaths in hospitals have outnumbered deaths at home for

place of occurrence.

7) See: Japanese Ministry of Health Labour and Welfare.(2023). *Report of the 2022: Survey on attitudes towards medical care in the last stage of life*[Japanese: 令和４年度人生の最終段階における医療に関する意識調査報告書], p. 51.

8) Fukui, Sakiko. et al.(2021). Provision and related factors of end-of-life care in elderly housing with care services in collaboration with home-visiting nurse agencies: a nationwide survey, *BMC Palliative Care*, 20 (1), article number 151, pp. 1 ff.

9) Shibata, Masashi. et al.(2024). Changes in the place of death before and during the COVID-19 pandemic in Japan, *PLoS ONE*, 19 (2), pp. 1 ff.

almost half a century in Japan, the knowledge and skills for end-of-life care are no longer present in everyday life situations. This has led to the "disappearance of the culture of end-of-life care" from the Japanese family environment[10]. In other words, Japanese people tend to entrust decisions about where and how to spend the final days of their lives and how they should be supported to medical professionals. Therefore, end-of-life care at home should offer hope to Japanese people, but as they have become unaccustomed to death, it actually creates anxiety. The overwhelming majority of deaths continue to occur in medical institutions for several reasons, including Japanese people's high dependence on hospital care, the strong belief that dying in a hospital is good for the public, the inadequate systems to support death at home, and families' anxiety about end-of-life care[11].

1-3 Contents of this Report

The question of how to die is an extremely personal issue. However, in Japan, it is also greatly influenced by the individual's environment. As society encourages a transition to death at home, families are often asked to make choices and take responsibility for end-of-life care. This report reviews the impact of such changes in the social conditions surrounding end-of-life care on legal practices. To this end, I analysed which enacted legal norms were disincentives for the parties concerned when deciding on the content of end-of-life care (**2. Status of existing statutes**). In Japan, to overcome such legislative deficiencies, euthanasia justification requirements were first presented by the courts of criminal justice. With reference to this history, I confirm that this response has reached its limits (**3. Limitations of response**

10) Shinmura, Taku.(2001). *The era of dying at home*[Japanese: 在宅死の時代], Hosei University Press, pp. 2 ff.

11) See: *id.* pp. 138 ff.

through criminal cases). In Japan, these criminal justice responses have been replaced by the formulation of administrative guidelines to compensate for legislative deficiencies in a provisional manner. This study examined the current situation (**4. Temporary measure under administrative guideline**). Furthermore, I show that the administrative guideline has even gained normative importance in recent civil cases (**5. Reflecting administrative guideline in civil cases**). Finally, I summarise the advantages and disadvantages of the legislative deficiencies that have been compensated for by the administrative and judicial organs in Japan. (**6. Conclusions**).

2. Status of existing statutes

In end-of-life care, the question of when, where, and how to die is understood to be a matter that should be decided by the individual. First, I confirm that the Constitution, the supreme law of Japan, considers the individual's right of self-determination to be most important (**2-1 Constitutional issues**). Here, I would like to point out that the right to self-determination is not given a clear legal normative status in Japan. In addition, I will introduce the current situation and cultural context in which the right to self-determination to die is restricted in the criminal law, which is a subordinate law (**2-2 Criminal law issues**). I show that civil law responses are also inadequate regarding decision-making in end-of-life care (**2-3 Civil law issues**).

2-1 Constitutional issues

The phrase 'right to self-determination' does not exist in the Japanese Constitution; it is a so-called unwritten right[12]. Nevertheless, in today's

12) Maki, Misaki.(2006). Issues on the right to self-determination［Japanese: 自己決定権の論点］, *Reference*, 56 (5), pp. 92 ff.

constitutional jurisprudence, it is commonly accepted that such rights are included in the 'right to the pursuit of happiness' which is included in Article 13 of the Constitution of Japan[13]. The text of the article reads as follows.

> The Constitution of Japan
> Article 13.
> All of the people shall be respected as individuals. Their right to life, liberty, and the pursuit of happiness shall, to the extent that it does not interfere with the public welfare, be the supreme consideration in legislation and in other governmental affairs[14].

However, the content of this right to the pursuit of happiness is abstract, and the controversy over the scope of its guarantee has not yet been settled in Japan[15].

Thus, in Japan, the right to self-determination is shaped by court decisions. For example, the 'right to refuse blood transfusion' was recognised in the 1992 'Jehovah's Witnesses non-consensual blood transfusion case[16]'. This is a precedent for the 'right to refuse treatment', which allows the patient to refuse even medically effective treatment if they do not consent to it. However, in this specific case, the Japanese Supreme Court did not use the phrase 'right to self-determination'. The right to refuse such treatment was presented simply as 'a content of personality rights'. Personality rights here are generally interpreted as rights limited to decision-making in relation to

13) Ashibe, Nobuyoshi,(revised by Takahashi, Kazuyuki).(2023). Constitution [Japanese: 憲法], 8th ed., Iwanami Shoten Publishers, pp. 122 ff.

14) Underlines added by the author.

15) Kimitsuka, Masaomi.(2018). The right to the pursuit of happiness and its standards of judicial review[Japanese: 幸福追求権と司法審査基準], *Yokohama Law Review*, 27 (1), pp. 61 ff.

16) Supreme Court of Japan, Judgement of February 29, 2000; *Minshu*, 54 (2), at 582.

religious beliefs[17]. There are strong objections to interpreting this as a broad recognition of the right to lifestyle self-determination[18].

Accordingly, the right to self-determination lacks a clear-cut provision in the Constitution of Japan, and the scope of its guarantee is based on an abstract interpretation of personality rights, which are ad hoc and vague. It is not, as in Europe, an important constitutional right linked to the concept of 'human dignity', but rather, in Japan, merely a concept that appears as a right under private law in situations of private adjustment of interests[19]. In Japan, the concept of 'human dignity' itself does not have the same absolute principle as it does in Europe, and it is more commonly used in the relative sense of 'respect for the individual[20]'.

In this context, the expression 'death with dignity' is used differently in Japan than in other countries. It also includes actively assisted suicide in Western countries, in the sense that human beings must not be firmly medicalised. On the other hand, in Japan, death with dignity only refers to respecting individual decision-making and only to passive euthanasia or withholding and withdrawal of treatment; this does not include assisted suicide.

As mentioned above, even the constitutional fundamental values of 'self-

17) Ishibashi, Hideki.(2022). Refusal of blood transfusion on religious grounds［Japanese:宗教的理由による輸血拒否］, in: Kai, Katsunori & Tejima, Yutaka (ed.), *100 Selected judicial precedents on medical law*［Japanese: 医事法判例百選］, 3rd ed., Yuhikaku Publishing, p. 71.

18) Nobata, Kentarou.(2007). Patients' right to self-determination' in judicial precedents［Japanese: 判例における「患者の自己決定権」］, *Hakuoh Law Review*, 1, pp. 155 ff.

19) Ishii, Tomoya.(2011). Basic theory on the protection of personal rights［Japanese:人格権保護の基礎理論］, *Journal of Private Law*, 73, pp. 148 ff.

20) Douzono, Toshihiko.(2018). 'Respect for the individual' and 'human dignity'［Japanese:「個人の尊重」と「人間の尊厳」］, *Historia philosophiae*（*Tetsugakushi*）, 60, pp. 35 ff.

determination', 'personality', and 'dignity' have unique connotations in Japan that differ from those of other countries. In comparative legal discussions, this 'similar but very different' point seems to cause discrepancies in mutual understanding.

2-2 Criminal law issues

In end-of-life care situations, the right to self-determination is criminally restricted in Japan. The most prominent barrier is Article 202 of the Japanese Penal Code. This criminalises participation in assisted and consensual homicides. The text of the article reads as follows:

> Penal Code of Japan
> (Participation in Suicide; Consensual Homicide)
> Article 202
> A person who induces or aids another person to commit suicide, or kills another person at the other's request or with other's consent, is punished by imprisonment or imprisonment without work for not less than 6 months but not more than 7 years.

Under this provision, any act that shortens a person's life is illegal, even if the person has consented. Legalising euthanasia requires consistency with these legal dispositions. Is this criminal law provision constitutional at all? As mentioned above, the constitutional basis for the right to self-determination is weak in Japan, and there is still debate as to whether such a right includes 'self-determination on dying'. Generally, the Japanese Constitution is not considered to guarantee the right to demand-assisted death. Therefore, Article 202 of the Japanese Penal Code is not considered unconstitutional[21].

21) Isobe, Tetsu / Kawashima, Haluka.(2022). Hard law, soft law or self-discipline which regulation for the medicine at the final stage of life in Japan, in: Rohlfing-Dijoux, Stephanie / Hellmann, Uwe(ed.), *Culture and Law*, Nomos, p. 168.

First, a closer look at this provision reveals certain oddities, such as Participation in Assisted Suicide being placed before it, while Consensual Homicide is placed after. In terms of the subjectivity of the act of taking a person's life, the perpetrator is usually the principal offender in Consensual Homicide, whereas person behind Participation in Assisted Suicide is an accessory offender. In other words, the Japanese provision places accessory offences before principal ones. Regarding sentencing, although principal offences typically have heavier sentences and accessory offences have lighter ones, the provision punishes the accessory offence category with the same severity as the principal offence category, with the accessory offence category noted first. Why does this occur?

In medieval Japan, there was a custom of 'seppuku（belly cutting）' in samurai（warrior）society. Under Japanese feudal morality, this act showed that an individual was required to be prepared to judge themselves and take responsibility for their actions; this made seppuku socially significant, and performing it preserved honour for both an individual and their family[22]. However, when the modern Penal Code was compiled nearly 150 years ago in Japan, seppuku was considered a prehistoric custom that needed to be abolished; and legal historical research has confirmed that Article 202 of the Japanese Penal Code was drafted in response to this[23]. The answer to the

22）Korneeva, Svetlana.(2019). On the formalisation of seppuku［Japanese:切腹の形式化について］, *Teikyo Journal of Japanese Culture*, 26, pp. 1 ff.

23）In particular, in that sense, as an introduction to the conception of the French jurist Boissonade, who had a major influence on the compilation process of the former Penal Code(1880), see: Akiba, Etsuko.(1991). Considerations on the crime of participation in suicide［Japanese: 自殺関与罪に関する考察］, *Sophia Law Review*, 32（2=3）, pp. 143 ff. For a more detailed discussion of the compilation process, see also: Hukuyama, Yoshinori.(2011). The process of enactment of the 'crime of participation in suicide' in the former Penal Code.［Japanese: 旧刑法における「自殺ニ關スル罪」の制定過程］, *The Graduate School Law Review*(*Waseda University*), 138, pp. 149 ff.

question posed above becomes clear when imagining the scene of seppuku. Rarely did those who committed seppuku end their lives completely on their own; they were often put to death by the sword of a servant at their side. Seppuku was therefore a 'homicide disguised as a suicide'. The servant's act is expressed with the Japanese term Kaishaku [Japanese: 介錯]'. This term is commonly translated to 'assisted suicide' in English. However, this translation is incorrect; it is technically a consensual homicide. Indeed, in ritual seppuku, the victim, who is made to look like a suicide, is the master, and the killer, who is commissioned by the one who was not able to die on their own, is the servant. By disguising the relationship between the master and the servant, it appears that the master fulfilled his responsibilities. This has caused the principal and accessory offenses to be flipped. This legislative process, implemented nearly 150 years ago, did not naturally reflect the modern idea that suicide is an exercise of the right to self-determination. The interpretation of Japanese criminal law has also struggled to reconcile the idea that, with the appropriate provisions, suicide is a lawful concrete exercise of the right to self-determination, and the situation has not yet been settled.

Thus, provisions to eliminate pre-modern customs are still in operation in Japan. Specifically, the content was clearly not designed for contemporary end-of-life care situations. If such a provision unreasonably infringes on a patient's right to self-determination, there seems to be a great deal of room for future review.

2-3 Civil law issues

Medical practice can also be understood in terms of civil law contractual concepts[24]. However, it can be pointed out that in Japan, from a civil law

24) Yonemura, Shigeto.(2023). *Lectures on medical law*[Japanese: 医事法講義], 2nd. ed., Nihon hyoron sha Publishers, pp. 99 ff.

perspective, there are systemic inadequacies when it comes to end-of-life care decision-making. In particular, the ability of older adults with diminished capacity for decision-making is often unclear[25]. In such cases, seeking medical consent from family members is a well-established clinical practice in Japan, but only because the response is considered appropriate on empirical grounds, not because it has a clearly legal basis[26]. If the patient has no family, consent may also be obtained from an adult guardian. However, the current adult guardianship system in Japan only entrusts the guardian with disposition of the ward's property; substitute consent for medical care, which is a personal matter, is not permitted[27]. Therefore, if the law were strictly applied in such situations, none of the medical consent holders would be able to be present.

Thus, the current situation in Japan is that decisions regarding end-of-life care are made on an ad hoc basis, and the legal basis for such decisions is ambiguous. This reflects the principle of private autonomy in civil law, which

25) Maeda, Yasushi.(2008). Mental capacity and capacity to give medical consent［Japanese: 意思能力と医療同意能力］, *Journal of Social and Information Studies*（*Gunma University*）, 15, pp. 321 ff. Under the Japanese Civil Code, consent to medical treatment is not considered a so-called 'juridical act'(an act that results in the acquisition or loss of legal rights and obligations through a manifestation of intention). Therefore, the capacity to consent to medical treatment is judged on a different basis from the capacity required for such juridical acts. In other words, the capacity to give medical consent is 'the capacity to understand the meaning of the invasion in the medical act and to judge what the consequences of the invasion will be'.

26) Maeda, Yasushi.(2023). Determination of medical incapacity to consent and family consent［Japanese: 医療同意無能力の判定と家族の同意］, *Journal of Social and Information Studies*（*Gunma University*）, 30, pp. 107 ff.

27) Scheller, Andreas.(2021). Adult guardianship and the right to self-determination［Japanese: 成年後見制度と自己決定権］, *The Bulletin of Department of Health and Social Services*（*Hiroshima International University*）, 16=17, pp. 29 ff.

states that an individual must make decisions about their own affairs. However, applying this approach to all older adults who have a reduced capacity to make decisions has resulted in a phenomenon whereby older adults' right to receive medical care has been undermined[28]. This is a reversal of the original intention. Furthermore, despite the increasing number of older adults living alone, there have been cases in which people were refused admission to hospitals because no one could guarantee their identity[29]. This issue must be urgently addressed; a fundamental legal reform is necessary. Adult guardianship law reform is currently under discussion, including the abovementioned problems[30].

3. Limitations of response through criminal cases

In Japan, the Court's decisions are of great significance when compensating for the aforementioned legislative deficiencies. Japan has adopted a statutory law system, and the courts' decisions are not inherently normative. Nevertheless, there is a strong tendency for the judiciary to cover for

28) Nagano, Nobuko.(2023). Current situations and challenges in reaching agreements between adult guardians and health and care professionals [Japanese: 成年後見人と医療・介護従事者との合意形成における現状と課題], *Japanese Journal of Social Welfare*, 63 (4), pp. 62 ff.

29) Yamazaki, Sayaka. et al.(2023). Current situation of the hospitalization of persons without family in Japan and related medical challenges, *PLoS ONE*, 18 (6), pp. 1 ff.

30) As a government policy, on 25 March 2022, the Cabinet approved the Second Basic Plan for Promoting the Use of the Adult Guardianship System, which aims to make the adult guardianship system more accessible and encourage more people to use the system. In response, a study to review the adult guardianship system was consulted to the Justice Ministry's Legislative Council in February 2024. The specific date for the revision of the law is scheduled for the middle of 2026 (See: newspaper article in the Nikkei, 13 February 2024).

legislative deficiencies, even giving the country the appearance of having a case-law system. This section of the paper examines criminal cases involving end-of-life care and confirms that the issue has attracted public interest in Japan by making it a criminal matter.

3-1 Requirements for permissible euthanasia

Euthanasia is commonly conceptualised as the act of hastening a person's time of death at their request when they are in unbearable pain with the intention of removing that pain[31]. In Japan, attempts have been made to discuss various types of euthanasia by combining objective circumstances （e.g. the imminence of death and recoverability） in the person concerned with his/her subjective understanding of the situation （e.g., the purpose of the actor） as a factor.

（1） Homicide? or Suicide?

If the act of removing pain does not include a therapeutic purpose, but merely causes death, it is specifically referred to as 'active （direct） euthanasia'.

An important case involving this permissible requirement for active euthanasia is the so-called 'Tokai University Hospital Case[32]'. The facts in this case can be summarised as follows:

Tokai University Hospital Case

In April 1991, at the request of the family （wife and son） of a patient hospitalised for multiple myeloma （terminal cancer with only a few days

31） Kai, Katsunori.(2000). *Euthanasia and criminal law*,[Japanese: 安楽死と刑法], Seibundoh Publishing, pp. 2 ff.

32） Yokohama District Court, Judgment of March 28, 1995; *Hanrei Jiho,* 1530, at 28.

to live), the attending physician had no choice but to stop all treatments, including removing the intravenous drip. The patient then began to breathe roughly and painfully while unconscious. The family asked the attending physician to remove the airway device that secured his breathing passages as they wanted the patient to die peacefully during sleep without suffering. However, because the patient continued to breathe in agony after the airway device was removed, the attending physician was unable to refuse the family's request and injected the patient with double the normal dose of sedatives, which had the side effect of respiratory depression. The patient's struggling breathing did not subside, and after further request from the family, the attending physician decided to let the patient draw his last breath and injected him with a drug that brought about cardiac arrest, causing the patient's immediate death. The attending physician was prosecuted because the last act directly causing cardiac arrest in this patient constituted a homicide.

In this case, the Yokohama District Court, the court of the first instance, summarised the requirements for justification (factor negating illegality) of active euthanasia in four points[33]. In Japan, these four requirements are still influential despite lower court rulings[34]. These are as follows:

(ⅰ) the patient is suffering from unbearable physical pain
(ⅱ) The patient's death is inevitable and imminent
(ⅲ) The patient's physical suffering has been exhausted, and there are no other alternatives.

33) Kai, Katsunori.(2020). Euthanasia[Japanese: 安楽死], in: Saeki, Hitoshi & Hashizume, Takashi(ed.), *100 Selected judicial precedents on criminal law: Part I*[Japanese: 刑法判例百選Ⅰ], 8th ed., Yuhikaku Publishing, pp. 42 f.

34) Kato, Maya.(2013). Significance and limitations of euthanasia[Japanese: 安楽死の意義と限界], in: Kai, Katsunori(ed.), *End-of-life care and medical law* [Japanese: 終末期医療と医事法], Shinzansha Publishing, pp. 29 ff.

(iv) The patient has explicitly expressed his/her consent to shortening his/her life.

The facts in this case did not satisfy such a justification requirement, and the defendant's doctor was convicted, sentenced to two years of imprisonment, and suspended for two years. The defendant did not appeal, and the case was finalised in the first instance.

However, nearly 30 years have passed since this case was decided, and there is room to consider whether the content is appropriate for the current medical situation. As palliative care has developed, the physical pain associated with the end of life is now reputed to be quite controllable[35]. Therefore, establishing requirement (i) above is already questionable. In this sense, active euthanasia to avoid unbearable suffering tends to be viewed as a medically manageable problem in Japan. In particular, acts that actively cause death, even when death is not imminent, will be treated as criminal offences, even if requested by the patient, and will be subject to strict social scrutiny. For example, a recent case in Japan involving a doctor who administered a lethal drug to a patient with Amyotrophic Lateral Sclerosis (ALS) at the patient's request of the patient attracted public attention. The patient lived in Kyoto, and the case is therefore called the 'Kyoto ALS patient Case[36]'. Its facts can be summarised as follows.

35) For example, the 'WHO guidelines for the pharmacological and radiotherapeutic management of cancer pain in adults and adolescents' introduced in the Japanese Society for Palliative Medicine(ed.),(2020). *Clinical Guidelines for Cancer Pain Management*[Japanese: がん疼痛の薬物療法に関するガイドライン], 3rd ed., Kanehara Publishing, pp. 39 ff.

36) The two defendants in this Kyoto ALS patient case are a doctor(Okubo) and a former doctor(Yamamoto). In addition to the suspicion of Consensual Homicide, these defendants are also charged with(1) conspiring to murder the father of one of the defendants(Yamamoto) (Yamamoto's mother is also

Kyoto ALS patient Case

In November 2019, at the request of a patient suffering from ALS, two accused doctors (one of whom later had his licence revoked due to doubts about the requirements for obtaining a medical licence) were charged with Consensual Homicide and other offences for injecting a lethal dose of pentobarbital through a gastric tube and killing the patient in her home.

At the time of the incident, the victim was receiving round-the-clock care from home carers and others. However, her condition was stable, she was able to breathe spontaneously, and her death was not imminent. In addition, the victim and the two accused doctors had only met each other on social networking sites; the doctors were not the victim's attending physicians, and there was no indication that they had an accurate understanding of the victim's medical condition. There was also a prior exchange of money between the accused and the victim, amounting to about 1.3 million yen (= 8,400 USD; = 7,900 EUR).

In this case, the Kyoto District Court, the court of first instance, set out the 'minimum necessary' justification requirements (factor negating illegality) for Consensual Homicide, which differ from the four requirements

charged as an accomplice in this case) and(2) conspiring to forge a medical certificate with the name of a doctor at a national university hospital and the title of Doctor of Medicine, which was necessary to meet the request for an incurable disease patient who wanted euthanasia overseas, which required forging a sealed official document. Each defendant is tried separately, and the sentences are handed down separately.(The judgment against Yamamoto was rendered by the Kyoto District Court, Judgment of December 19, 2023. Judgment against Okubo, Kyoto District Court, Judgment of March 5, 2024.) Both defendants have appealed. The appeal trial against Okubo was concluded on November 25, 2024, and his conviction was upheld. The defendant is currently appealing to the Supreme Court.

set out above by the Yokohama District Court. The contents can be summarised as follows.

(1) Circumstances on the patient's side.

In the case of 'Patients suffering from unbearable and severe physical pain due to their imminent death' or 'Patients who are unable to stop the progression of their illness with current medicine, who are daily terrified or despairing in the face of imminent death or the threat of losing their independent means of communication, but who are unable to commit suicide due to their lack of physical freedom', where there are no other measures that can be taken to remove or palliate the pain, etc., caused by his/her medical condition, and where the patient sincerely wishes to take his/her own life, having correctly recognised the situation in which he/she is placed.

(2) Circumstances on the doctor's side

(i) Careful assessment of medical conditions

Exhaust all medically necessary treatments and examinations and, taking into account the patient's symptoms and course of medical treatment, carefully determine whether the patient is dying or has other symptoms that cannot be treated by current medicine, and there are no other measures that can be taken to eliminate or palliate the suffering caused by the patient's condition.

(ii) Careful explanation and consent from the patient, next of kin, etc.

Explain as much as possible to the patient about his/her current symptoms, future prospects, including prognosis and the possible options available, and confirm the patient's wishes based on a correct understanding of these details, as well as carefully assessing the sincerity of the patient's wishes and the possibility of changing them,

referring to the opinions of close relatives and other relevant persons who are familiar with the patient's wishes.

(iii) Reasonableness of methods

Use of less painful and medically appropriate methods at the patient's own request.

(iv) Documenting the process.

Documenting the series of processes so they can be verified after the fact.

According to the findings of this case, the accused was not the victim's doctor or ALS specialist, did not check her symptoms or medical records, and had never examined or even visited her. The victim's current symptoms and prognosis were not accurately ascertained, taking into account the course of events up to this point. Without informing the victim's doctor, family, or others, the victim was killed in secret within just 15 minutes of meeting her for the first time, and the course of events was not recorded in a way that could be verified. Therefore, the Kyoto District Court held that the defendant's actions could not be socially equivalent and that he was guilty of Consensual Homicide. The defendants appealed this decision, but the case is still pending.

Certainly, such scandals are unfavourable. However, this does not imply that the debate on euthanasia in Japan has completely disappeared. 'Physician-assisted suicide', in which situations similar to active euthanasia are carried out in the form of a 'suicide' rather than an 'act of killing another', is becoming more common around the world[37], and is well-known in Japan. In addition, discussions about lifting the ban arise sporadically whenever

37) Jimba, Koichi.(2013). Physician-assisted suicide(PAS)［Japanese: 医師による自殺幇助（医師介助自殺)］, in: Kai, Katsunori(ed.), *End-of-life care and medical law*［Japanese: 終末期医療と医事法］, Shinzansha Publishing, pp. 77 ff.

news reports circulate, for example, a Japanese national committing physician-assisted suicide in Switzerland[38].

However, physician-assisted suicide is not feasible in Japan due to the punitive nature of Participation in Assisted Suicide. Even if the ban on physician-assisted suicide is lifted in Japan in the future, the practical question of whether the act is homicide or suicide cannot be determined based solely on objective facts[39]. In legal assessments, the subjective decision-making capacity of the person wishing to commit suicide is important. Determining this also entails a normative assessment of those who have control over the circumstances of the situation. In short, as long as the situation of 'homicide disguised as suicide' is assumed, the boundary between active euthanasia as a form of homicide and physician-assisted suicide as a form of suicide is infinitely vague.

(2) Active? or Indirect?

Within the concept of euthanasia, the term 'indirect euthanasia' is used particularly when death is caused by a therapeutic act that has resulted in an accelerated time of death.

However, it is difficult to identify objective differences between active and indirect euthanasia, because they are performed with the intention of palliative suffering. It is also difficult to predict how pain management procedures applied in healthcare practice will work for individual patients. In other words, the distinction between indirect and active euthanasia is in fact very blurred for terminally ill patients[40]. In this sense, there seems to

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38）For example, such reportage includes Miyashita, Yoichi.(2019). *A Japanese who accomplished euthanasia*[Japanese: 安楽死を遂げた日本人], Shogakukan.

39）Shiotani, Takeshi.(2004). *Victim's consent and self-responsibility*[Japanese: 被害者の承諾と自己答責性], Horitsu Bunka Sha Publishing, pp. 84 ff.

40）Yamaguchi, Atsushi.(1992). Life and death in criminal law[Japanese: 刑法にお

be a need for careful verification in the field of end-of-life care as to whether the 'legitimacy of the subjective objective' of treatment is supported by the 'appropriateness of the objective treatment'.

(3) Active? or Passive?

If the patient's death is accelerated by discontinuing medical treatment in accordance with his/her expressed wish, on the grounds that the continuation of the medical treatment would cause suffering to the patient, this is referred to as 'negative euthanasia'.

Therefore, in negative euthanasia, the problem is essentially patient inaction. However, if the discontinuation is triggered by an intentional act (e.g. removal of a ventilator), and only that scene is extracted and evaluated independently of the context, then it is certainly on par with active euthanasia[41].

The question of whether the discontinuation of medical treatment, which is considered to be an artificial action, should be assessed as illegal is also a common issue when discussing 'death with dignity', which will be discussed below.

3-2 Requirements for permissible 'death with dignity' (i.e. withdrawal of treatment)

The concept of 'death with dignity (hereinafter abbreviated as DD) in Japan has been understood as the act of withdrawing life-prolonging

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ける生と死], in: Arima, Akito. et al.(ed.), Life and death[Japanese: 生と死], University of Tokyo Press, p. 229.

41) Ida, Makoto.(2014). End-of-life care and criminal law, Revisited[Japanese: 再論・終末期医療と刑法], in: Iwase, Toru. et al.(ed.), *New developments in criminal and medical law*[Japanese: 刑事法・医事法の新たな展開], Vol. 2, Shinzansha Publishing, p. 134.

treatment or life-sustaining procedures in consideration of the presumed wishes of the person concerned. In Japan, such discontinuation has been described as death with dignity, meaning that humanity is not compromised. Therefore, as mentioned above, the expression DD here differs from that used in other countries, where it refers to physician-assisted suicide. Recently, the concept of DD has been discussed in terms of the straightforward expression 'withdrawal of (life-prolonging) treatment'. This report also addresses this issue in a localised sense.

DD is similar to 'passive euthanasia' in that it involves inaction on the part of medical personnel. However, in situations where DD is an issue, direct confirmation of the patient's suffering is difficult because his/her consciousness is unknown, and it is assumed that the time of death may not be imminent[42]. In other words, in the context of death with dignity, the patient's uncertain wishes regarding medical treatment, when the individual does not know how long the treatment would or should last, must be estimated by the surrounding parties. This is more distressing than euthanasia.

(1) Ambiguous case law content

An important case involving the withdrawal of treatment is the so-called 'Kawasaki Kyodo Hospital case[43]'. The facts in this case can be summarised as follows:

42) Kai, Katsunori.(2004). *Death with dignity and criminal law*[Japanese: 尊厳死と刑法], Seibundoh Publishing, pp. 1 ff.

43) Supreme Court of Japan, Decision of December 7, 2009; *Keishu*, 63 (11), at 1899. As a commentary on that precedent, see: Jimba, Koichi.(2020). Withdrawal of therapeutic actions[Japanese:治療行為の中止], in: Saeki, Hitoshi & Hashizume, Takashi(ed.), *100 Selected judicial precedents on criminal law*: *Part I*[Japanese: 刑法判例百選Ⅰ], 8th ed., Yuhikaku Publishing, pp. 44 f.

Kawasaki Kyodo Hospital case

The victim was a patient who was urgently admitted to Kawasaki Kyodo Hospital in November 1998 after being rushed to the hospital in an unconscious state due to a severe bronchial asthma attack. The accused individual was the primary physician who was responsible for managing the victim's illness for many years. Approximately two weeks after hospitalisation, the victim remained unconscious due to hypoxic brain injury. At the request of the victim's family (assessed as the defendant's own decision in the first instance), the defendant removed the endotracheal tube that was inserted to secure the airway. Extubation was expected to result in a peaceful death, but the victim began breathing painfully. Attempts to control the pain through administration of sedatives were unsuccessful. The accused instructed an assistant nurse, who was unaware of the circumstances, to administer an intravenous injection of muscle relaxants, which caused the victim's death. The attending physician was prosecuted for a series of acts, including not only the administration of muscle relaxants at the end but also the initial extubation of the endotracheal tube, which constituted homicide.

In this case, the first instance court[44] suggested a requirement of admissibility based on the 'patient's right to self-determination' and the 'limits of the duty to treat' with regard to withdrawal of treatment. However, in this case, the above 'act of extubating' and 'administration of a muscle relaxant' were deemed to constitute the offence of homicide (3 years' imprisonment, suspended for 5 years), as neither the family's request nor the imminence of death was acknowledged. According to the Court of

44) Yokohama District Court, Judgment of March 25, 2005; *Hanrei Jiho*, 1909, at 130; *Hanrei Times*, 1185, at 114.

Appeal[45], the abovementioned act of extubation was at the request of a family member, and the first instance was reversed as an inappropriate sentence（1 year and 6 months of imprisonment, suspended for 3 years）. It should be noted that it was inappropriate in this appeal for the court to present the permissible requirement to withdraw from treatment as a decision of the court in this case, and even if it relied on both arguments—the 'patient's right to self-determination' and the 'limits of the duty to treat'—the accused's conduct was considered to be unacceptable. The accused appealed, but the Supreme Court dismissed the appeal, holding the following:

"We make a determination by this court's own authority regarding the illegality of the act of removing the endotracheal tube.（…）during the period from when the victim had a severe bronchial asthma attack and was hospitalized until the removal of the tube in question was performed, no electroencephalogram or other test was performed as needed for determining the expected length of the remaining life, etc. of the victim. In light of the fact, in addition to this, that the removal of the tube was performed only two weeks after the victim had developed the disease, it can be found that at the time of the removal, it was impossible to make an accurate determination as to the possibility of the victim's recovery or the expected length of his remaining life. At the time of the incident, the victim was in a coma, and the removal of the endotracheal tube in question was performed at the request of the victim's family members who had given up hope for the victim's recovery. As it is found from the circumstances described above, the victim's family members did not make such request after being properly informed of the victim's conditions, etc. Nor can it be said that the aforementioned act of removing the tube was performed based on the presumed will of the victim. Taking into consideration all of these

45）Tokyo High Court, Judgment of February 28, 2007; *Hanrei Times*, 1237, at 153.

factors, we should say that the aforementioned act of removing the tube cannot be regarded as cessation of treatment that is legally permitted."

In assessing this Supreme Court decision, it is important to note that the content of the decision itself did not establish general permissibility requirements for the withdrawal of treatment. That is, the decision-making factors presented here apply exclusively to this case. For this reason, it is debated whether this decision is merely an inspection of the prima facie substantive legal requirements, or whether it emphasises medical procedural guarantees[46].

In this regard, the decision states in the opening part of its conclusions that it will determine the 'illegality' of the act of withdrawing treatment, which is at issue in this case. The significance of this can be seen as an awareness of the previous substantive legal justification requirements. If such an understanding is possible, the question arises as to which substantive legal elements correspond to grounds for negating illegality in the act of withdrawal of treatment. A clue to this may be found in the use of the expressions 'the possibility of the victim's recovery or the expected length of his remaining life' and 'presumed will[47]' of the victim in the present decision.

In particular, the issues of 'recoverability and life expectancy' have traditionally been treated in connection with the assessment of the 'limits of

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46) In this regard, as an emphasis on the importance attached to compliance with the process by this decision, see: Tatsui, Satoko.(2013). End-of-life care and the state of rules[Japanese: 終末期医療とルールの在り方], in: Kai, Katsunori(ed.), *End-of-life care and medical law*[Japanese: 終末期医療と医事法], Shinzansha Publishing, pp. 222 ff.

47) It differs from agency decision-making by the family(i.e. family will). As an explanation, see: Saeki, Hitoshi.(2012). Terminal care and patient and family will [Japanese: 末期医療と患者の意思・家族の意思], in: Higuchi, Norio(ed.), *Case studies in bioethics and law*[Japanese: ケーススタディ生命倫理と法], 2nd. ed., Yuhikaku Publishing, pp. 71 ff.

the duty to treat' in academic theory. Therefore, if recovery is possible, there may be an obligation to continue treatment. In this case, the following problem areas remain.

First, the following question arises: is there an obligation to continue treatment if there is no possibility of recovery and no change in life expectancy can be expected from physical intervention(ⅰ)? Second, is there an obligation to continue treatment even in situations where there is no possibility of recovery, but the possibility that physical intervention may alter life expectancy cannot be ruled out(ⅱ)? The following sections introduce the main theories of interpretation developed in response to the Supreme Court's decision in the Kawasaki Kyodo Hospital case, according to such case divisions.

(2) In serious acute cases

In Case（ⅰ）above, a serious acute situation can be assumed. A typical example is a situation in which a person has been seriously injured in a road traffic accident, resulting in a clinically brain-dead state.

In this case, the consequences of both the continuation and discontinuation of treatment can be legally assessed as being of equal value from the perspective of legal attribution（causality）. Even if the treatment is terminated mid-treatment due to an act of commission, it may be possible to normatively evaluate the act as an omission of the overall evaluation of the treatment process[48]. If there is no criminal duty to act in relation to the patient's death, the offence of homicide can be ruled out. Moreover, the

48）On the issue of interpreting this positive act as a normative omission, a famous German decision on the withdrawal of life-prolonging treatment(the Putz case) provides a thought-provoking judgment. As an introduction to the content of this foreign judgment in Japan, see: Jimba, Koichi.(2011). Judgment of 25 June 2010 of the German Federal Court of Justice(the Putz case)［Japanese:ドイツ連邦通常裁判所2010年6月25日判決（Putz事件）］, *Journal of Law, Politics and Sociology*(Keio University), 84（5）, pp. 73 ff.

(presumptive) will of the patient does not objectively advance the time of death in this case. This also removes the ability to consider the (presumptive) will of the patient into account in the commission of the offence.

(3) In chronic phase cases

The most distressing issues in end-of-life care occur in situations that fall under (ii) above. For example, a situation can be assumed in which the condition of a chronic disease (e.g. cancer) gradually progresses, and in its final process, the patient is on the verge of death. There, the act of discontinuing treatment can result in a meaningful advance in time of death in terms of legal assessment.

(a) Right-based Arguments

A patient's wishes during these phases can have a definitive impact on his or her view of life (way of life). In the aforementioned 'Jehovah's Witnesses non-consensual blood transfusion case', the Japanese Supreme Court held that specific self-determination concerning one's way of life amounted to 'a content of personality rights'. Thus, if some rightness can be found in a patient's decision-making, the medical profession would be legally obliged to strive to realise the patient's wishes.

However, even if the advance in the time of death is due to the (presumptive) will of the patient, it can still constitute a crime of consensual homicide in Japan. Therefore, making the right to self-determination alone an acceptable requirement for treatment withdrawal is difficult. This is also a major reason why the legislation on advance directives has failed in Japan.

First, even if a person's wishes are expressed when he or she remains conscious, it is impossible to know what he or she will think when he or she

is actually dying. On the other hand, when a person is dying, consciousness is unclear, and it is too late to understand their desires. In Japan, the question of what legal meaning (effect) should be given to this special content of the will, which can only be simulated by the surrounding parties, is under discussion[49].

(b) Duty-based Arguments

In addition, an absolute duty to continue treatment in the context of end-of-life care may cause significant disadvantages to the concerned parties, including patients. Therefore, the room for dissolution of the duty to treat is an issue of grounds for negating illegality in the crime of consensual homicide. However, this approach has not yet been established in Japan[50].

The problem lies in confusion around the concept of 'futility of treatment', which is often found in this argumentation. This concept should be examined normatively, rather than as a medically defined objective fact.

For example, if this argument assumes a definition of health as 'a state of complete physical, psychological, and social well-being[51]', as expressed by the Constitution of the World Health Organization, then end-of-life care can easily be seen as practically futile.

However, if health as a concept is reframed as 'the ability to adapt and self manage in the face of social, physical, and emotional challenges[52]', the situation changes dramatically. Rather than curing the disease, medicine should seek to maintain and complement the patient's ability to adapt to life

49) Kai, Katsunori.(2017). *End-of-life care and criminal law*[Japanese: 終末期医療と刑法], Seibundoh Publishing, pp. 229 ff.

50) See: id. pp. 245 ff.

51) This WHO definitional orientation towards 'completeness, wholeness and integrity' has remained fundamentally unrevised to date, despite the fact that various questions have been raised since its publication in 1948.

52) Huber, Machteld. et al.(2011). How should we define health? *BMJ*, 343:d4163.

and self-manage[53].

Thus, this argument cannot be developed without a normative perspective on 'what should be the essential meaning of medicine'.

4. Temporary measure under administrative guideline

The above shows that, in Japan, in addition to the difficulty of justification by the patient's right to self-determination alone under the Japanese Penal Code, the argument from the perspective of the limits of duty to treat has not been successful. Moreover, courts are state organs that aim to resolve disputes on a case-by-case basis and do not have state action to set norms as they relate to the population as a whole. Japan is not a case law country and, as mentioned above, the permissibility requirements presented above are also of a nature that should be applied on a case-by-case basis. Therefore, the actual situation, in which the permissibility requirements indicated by the courts are treated as if they have a general legal normative character, is highly problematic.

However, even in academic circles, the establishment of substantive legal norms has been a matter of mixed debate and continues to be discussed. There is no prospect of legislation in this regard, and there are limits to the response by the criminal justice system. This led to a rush to establish procedural safeguarding norms in Japan pending the presentation of substantive legal justification requirements. In May 2007, while the aforementioned Kawasaki Kyodo Hospital case was still pending, the Japanese Ministry of Health, Labour, and Welfare (MHLW) formulated the first guidelines on the withdrawal of life-prolonging treatment that could be

53) On the significance of this new health concept, see: Matsuda, Jun.(2018). *Euthanasia and death with dignity at present*[Japanese: 安楽死・尊厳死の現在], Chuokoron-Shinsha, pp. 218 ff.

announced at a national level. These guidelines were initially titled 'Guidelines on the Decision-Making Process for Terminal Care[54)]'. The content has now been revised to incorporate the concept of advance care planning（ACP), which has become popular in other countries in recent years, in addition to the need to support end-of-life care at home as Japanese society progresses towards super-aging and high mortality. The name has now been changed to 'Guideline on the decision-making process for medical and nursing care at the last stage of life '（hereafter 'Process Guidelines'). These guidelines provide an exemplary decision-making process for those involved in end-of-life care while creating a system in which the medical and care team, including doctors, nurses, carers, and social workers, support patients and their families during the last stage of life.

According to the Process Guidelines, the establishment of multiparty（team）discussions is important in such decision-making. In previous criminal cases, including the aforementioned Kawasaki Kyodo Hospital case, insufficient opportunities for discussion were provided and treatment was withdrawn under circumstances were a single medical practitioner had total or almost total decision-making power. It could be said that this reflection was taken into account in the content of the guidelines. Furthermore, the recent adoption of the ACP concept emphasises that the patient's wishes can change over time, and that discussions about medical and care plans should be repeated.

The process guideline also provides some indication as to how decisions should be made when the patient's will cannot be confirmed and states that the following procedure should be used:

54）For more information on how this guideline was developed, see: Higuchi, Norio.（2008）. *Considering healthcare and the law 2*［Japanese: 続・医療と法を考える］, Yuhikaku Publishing, pp. 83 ff.

(1) When the patient's family can infer the patient's wishes, the basic principle is to respect the wishes and choose the best option on the patient's behalf.
(2) When the patient's family cannot infer the patient's wishes, the basic principle is to choose the best option on the patient's behalf through adequate
discussion among the patient's family and those who may function as surrogates for the patient. This process may need to be repeated over time or as the patient's mental and physical conditions and medical evaluations change.
(3) When a patient has no family or similar group, or his or her family or group entrust decision-making to the medical and nursing care team, the basic principle is to choose the best option on the patient's behalf.
(4) What is discussed during this process must be documented each time the discussion takes place.

In exceptional cases, when the patient, family, and medical/care team cannot reach an agreement on a treatment plan even after all these procedures, a committee of experts who can discuss and advise on treatments becomes necessary.

Thus, in Japan, the creation of a system to guarantee a 'process' for decision-making in the last stage of life through administrative guidelines is recommended. However, these guidelines do not provide substantive legal requirements regarding what constitutes legally permissible euthanasia or death with dignity. It only sets out the process of discussion and decision-making. Nevertheless, according to these guidelines, it is preferable in practice to comply with this government policy and undergo a careful decision-making process as it may confirm an agreement that is acceptable to all.

However, from a legal theoretical point of view, it is not clear what the legal effect of compliance with the outlined process would be. In particular, the question remains as to whether compliance with such guidelines provides immunity from liability[55]. Perhaps it is not as simple as 'everything is permissible as long as procedures are followed'. This is because a system in which medical practitioners are exempt one-sidedly as long as certain procedures are fulfilled does not raise the normative awareness of medical practitioners. Processes are merely a means to an end. This purpose seems to be justified by raising the normative awareness of those involved.

Nor is it reasonable to think that 'as long as there is a procedure, everything will go well'. Patients receiving end-of-life care are vulnerable. Vulnerable individuals may be concerned about having others' attention on them as they may fear loneliness. One's original hope may be unconsciously silenced and enslaved by the superficial decisions one has made for oneself. Procedures can also provide opportunities to accomplish this.

It would seem, therefore, that lawyers should see no other role in this situation than to support 'narrative-based medicine[56]'. Is it possible to construct procedures that contribute to this with a view to their effect on substantive law? The biggest challenge for the future lies in identifying the signs of 'proceduralisation[57]' looming over substantive law.

5. Reflecting administrative guideline in civil cases

Furthermore, the process guidelines introduced above have begun to

55）See: Tatsui, op. cit. supra note 46, pp. 228 ff.

56）As highlighting a similar methodology from the perspective of the medical profession, see: Yukioka, Tetsuo.(2012). *What is healthcare?*[Japanese: 医療とは何か], Kawade Shobo Shinsha Publishers, pp. 93 ff.

57）As an advocate of such a view, see: Jimba, Koichi,(2015), Euthanasia and death with dignity[Japanese: 安楽死・尊厳死], *Hogaku kyoshitsu*, 418, p. 15.

affect court decisions in civil cases. As mentioned above, in medical practice in Japan, when a patient finds it difficult to make decisions regarding treatment or care for an illness or other reasons, the decision is often left to the family. However, when there are disagreements between family members, legal conflicts may arise. The process guidelines were referred to for the first time in a recent civil case, which established a policy in this regard. The facts in this 'Rissho Koseikai Annexed Kosei Hospital Case[58)]' can be summarised as follows.

Rissho Kosei-kai Affiliated Kosei Hospital Case

Plaintiff X is the heir (eldest daughter) of decedent A (then aged 89), who died in the defendant's hospital (Y_1). In addition to the above-mentioned hospital (Y_1), the defendants are the eldest son (Y_2) and his wife (Y_3), who are also heirs. According to Plaintiff X, while decedent A was in the hospital in August 2007, Y_2 increased the rate of nasogastric tube feeding, which allegedly caused decedent A to vomit and develop aspiration pneumonia. Nevertheless, both the eldest son (Y_2) and his wife (Y_3) refused to prolong Decedent A's life. It was alleged that the hospital (Y_1) failed to prolong A's life without confirming the wishes of decedents A and X, and that A died of subsequent sepsis and acute renal failure. In particular, in relation to the refusal of life-prolonging measures, Plaintiff X alleged that Defendant Y_1 owed a duty of care to Decedent A to confirm her wishes after fully explaining them to her or discussing them fully with her family, including the plaintiff, to determine the best course of treatment for her, but failed to do so. They also argued against Defendants Y_2 and Y_3 that, since Decedent A was in a relatively clear state of consciousness for some time after admission to the hospital in

58) Supreme Court of Japan, Decision of February 1, 2018; LEX/DB 25560344.

question, and there were times when she was able to confirm her will, Defendants Y_2 and Y_3's refusal to prolong her life without confirming her will was illegal as it damaged her life and the interests of her family in receiving their cooperation and care.

In response, Defendant Y_1 argued that Decedent A was not in a condition to make decisions regarding life-prolonging measures and was at a stage where it would have been possible for her to die within a short period of time, and that Y_1 had explained this to Y_2, the representative of the family, and had obtained a consensus from the family that they would not request life-prolonging measures. Y_1 argued that Plaintiff X, despite having had many opportunities to meet with doctors, had never actively expressed her own opinion regarding life-prolonging measures. Y_2 and Y_3 also claimed that the family members had discussed the matter twice and agreed not to request life-prolonging measures; that they, as representatives of the family, had informed the doctors to that effect; and that X had never actively raised any objections on this.

In this case, the first instance court[59] stated that the process guideline at the time (the 2007 version before the current revision) 'does not have legal normative status', but held that it was 'helpful in examining the physician's duty of care in making decisions about end-of-life care', as follows. With regard to Y_1, the courts followed the division of cases set out in the process guidelines: (1) if the patient's will can be confirmed, the decision is based on the patient's decision; and (2) if the patient's will cannot be confirmed, the best course of treatment for the patient is adopted, either by obtaining the patient's presumed will from the family or by having a full discussion with the family. With regard to part (i), it cannot be denied that it was difficult

59) Tokyo District Court, Judgment of November 17, 2016; *Hanrei Jiho*, 2351, at 14; *Hanrei Times*, 1441, at 233.

for Decedent A to make her own decisions regarding life-prolonging measures; therefore, it cannot be accepted that Y_1 had a duty of care to confirm her will after giving her sufficient explanation. With regard to the second part (ii), the method of collecting the opinions of the patient's family members through the key person cannot be considered unreasonable, and it is within the doctor's discretion to adopt such a method. If family members other than the key person have opinions that differ from those of the key person and the doctor is aware of this, it is desirable to hear the opinions of those family members individually. The court held that the doctor could not be found to have breached its duty of care to determine the best course of treatment for Decedent A, because there was no evidence that the plaintiff actively objected to the treatment at the time of the incident. In addition, with regard to Y_2 and Y_3, if a member of the patient's family, who is regarded as a key person by the doctor, knows that the patient and other family members have different opinions on life-prolonging measures, dared to ignore and interfere with them, which could be regarded as a violation of the personality rights of the parties concerned and thus illegal. However, in this case, it was held that no such fact could be confirmed for Y_2 and Y_3. Therefore, the plaintiffs' claims were dismissed. The same conclusion was subsequently upheld by the Courts of Appeal[60] and the Court of Final Appeal, as appropriate.

Thus, this case has attracted practical attention because the decision is in line with the process guidelines regarding how decision-making on end-of-life care should be carried out. However, the adoption of process guidelines as criteria for determining the legal standard of due care is controversial. Indeed, there are views that positively assess such references to administrative guideline as reasonable[61]. On the other hand, according to the

60) Tokyo High Court, Judgment of July 31, 2017; LEX/DB 25560343.

61) Ikka, Tsunakuni / Miura, Yasuhiko.(2019). A case in which claims for damages

Commentary to the Process Guideline, it was formulated 'to confirm the basic points on which a broad consensus can be reached among both patients and medical professionals, and to present these points as guidelines will contribute to the realisation of medical care at better the last stage of life[62],' and was never intended to be used as a judicial norm in the first place. Such a phenomenon can also lead to the disfigurement of public debate, with de facto legislative actions carried out in administrative bodies that do not have a democratic basis. The position of these administrative guidelines as judicial norms in Japan should continue to be discussed[63].

6. Conclusions

Based on the above, the recent features of the sociolegal framework for end-of-life care in Japan can be summarised as follows. In Japan, there is no legislation in place regarding end-of-life care; as a result, the legal norms on which medical professionals should rely have not been clarified. In addition, not only in cases where patients are unable to clearly express their will but also in cases where they can clearly express their will, Article 202 of the

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by other family members against a family member who did not want life-prolonging treatment for a terminally ill patient and against a hospital that did not carry out the same treatment were not accepted（Case study）［Japanese: 終末期の患者への延命処置を望まなかった家族及び同処置を実施しなかった病院に対する，他の家族による損害賠償請求が認められなかった事例（判決紹介）］, *Journal of Medical Law*, 34, pp. 162 ff.

62）See: the section of 'Background to the Preparation of the 2007 Version of the Guideline' at the beginning of the 'Guideline Commentary on the Decision-Making Process for medical and nursing care at the Last Stage of Life'.

63）Kobayashi, Maki.(2022). Conflicts about life-prolonging measures among family members［Japanese: 家族間における延命措置の葛藤］, in: Kai, Katsunori & Tejima, Yutaka(ed.), 100 Selected judicial precedents on medical law［Japanese: 医事法判例百選］, 3rd ed., Yuhikaku Publishing, pp. 200 f.

Penal Code makes Consensual Homicide and Participation in Assisted Suicide, and the risk of criminalisation cannot be dispelled in the field of terminal care, making difficult decisions have always had to be made. In previous criminal cases, the grounds for negating the illegality of the identified criminal offence have been presented by the courts in exceptional forms. However, such exceptions are only indicated by courts and have never been granted on the facts.

In this context, the limits of setting justification requirements and examining the permissible scope of conduct and grounds for the exemption of healthcare professionals on a case-by-case basis, particularly in criminal cases, have also been pointed out. Japanese courts are national bodies that aim to resolve disputes on a case-by-case basis, and do not have the state action to set norms that relate to the population as a whole. However, there are no legislative prospects in this area.

Therefore, the establishment of procedural safeguarding norms in Japan was hastened by the relatively mobile executive branch. As of May 2007, the Japanese Ministry of Health, Labour and Welfare（MHLW）developed the first guidelines on rules for withdrawal of life-prolonging treatment, which can be communicated at a national level. Although these administrative guidelines have been revised, they are still considered important in practice. The latest revisions include the concept of ACP, which has become popular in other countries in recent years, and the need to support end-of-life care at home in a super-aged and high-mortality society. Thus, in Japan, administrative guidelines recommend the creation of a system to guarantee a ‘process’ for decision-making in the final stage of life. However, these guidelines do not set out substantive legal requirements for what constitutes legally permissible euthanasia or death with dignity. They only define the processes of discussion and decision-making.

However, from a legal theoretical point of view, administrative guidelines

are not laws in and of themselves, and the legal effects of compliance with the procedures set out therein are not always clear. In particular, the question remains whether compliance with the guidelines results in immunity from legal liabilities.

In this regard, a recent civil case has drawn attention to how the court referred to these guidelines developed by the MHLW when assessing decision-making on end-of-life care. This means that administrative guidelines are also influencing judicial decisions and are beginning to have a judicial normative character. However, while the administrative guidelines are acknowledged to have the advantage of being fast and flexible, their operation has also been questioned because they do not have a democratic basis.

This study has depicted the phenomenon of bloated administrative guidelines on legal issues regarding end-of-life care in Japan. One factor is the stagnation of legislation in this area of healthcare, which points to a dysfunctional parliament. For each person to live a dignified life, it is essential to actively discuss and study the right to self-determination in death and the procedures for exercising it, with a view toward legislating the matter. In the future, these discussions will hopefully occur in a way that involves the entire populace. Research conducted in Japan has shown that people with high levels of self-determination experience high levels of happiness[64]. If this is the case, it would seem that the right to pursue happiness, which is also enshrined in the Japanese Constitution, should be sought by forming a society that is tolerant of the expression of will that reflects one's own views of life and death.

64）Nishimura, Kazuo & Yagi, Tadashi.(2019). Happiness and self-determination – An empirical study in Japan, *Review of Behavioral Economics*, 6（4）, pp. 312 ff.