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A SURVEY RESEARCH OF DOCTORS' ATTITUDES TOWARD EUTHANASIA IN BOSTON AND IN TOKYO

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I. Decision of the Nagoya Court of Appeals —Research Purposes

A dramatic decision¹⁾ referring to the conditions under which euthanasia would be legally permissible was handed down by the Nagoya Court of Appeals in Japan, 1962.

The defendant, being engaged in agriculture after he had graduated from high school, was a kind and serious youth who was taking good care of both his parents and his younger brothers. His father, Fukaichi, who had been stricken with a cerebral hemorrhage and was bedridden, began to lose much

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1) High Court Criminal Reports, Vol. 15, No. 9, p. 674 (Dec. 22, 1962).

of his appetite and grew weak at the beginning of July, 1961. His legs and arms were paralyzed in a twisted position and he claimed he had an excruciating pain when he moved them even slightly. What was worse was that he was often attacked by violent fits of hiccups, which shook his rigid and paralyzed legs and arms so heavily that he writhed in the agony of pain, crying, "Kill me!" or "I wish to die as soon as possible." Unable to watch his father suffer from such unbearable pain and listen to his screams, and being told by the attending doctor that nothing further could be done for his father, on the tenth of July the defendant made up his mind to accept his father's desire to die. About 5 o'clock in the morning on July 26 he added a small amount of organic phosphoric acid insecticide, E P N, into a bottle of milk delivered earlier in the morning and left it where it had been. His mother, without knowing the fact that insecticide had been mixed in the milk, served it to the defendant's father, who happened to request milk about at half past seven in the morning, and he died of organic phosphorism about at half past twelve in the afternoon.

The Nagoya Court of Appeals, reversing the judgement²⁾ of the trial court, sentenced him this time for "murder upon request"³⁾ to one year in prison with a stay of execution for three years, and held as to euthanasia:

"Though there has been a controversy as to whether euthanasia should be legally permissible on the ground of justification, we can permit it only under the following strict conditions since it results in artificial extinction of valuable human life.

- (1) A patient should be suffering from a fatal disease recognized incurable in the light of modern medical knowledge and techniques and his death should be imminent.
- (2) He should be suffering from such an excruciating pain that nobody

2) The defendant had been convicted of "patricide" according to the Penal Code of Japan, art. 200 providing: "Every person who has killed his (her) lineal ascendant or a lineal ascendant of his (her) spouse shall be condemned to death or punished with penal servitude for life." and was sentenced to three years and six months in prison. Recently this article was judged by the Supreme Court as unconstitutional against the Equality Clause. . Supreme Court Criminal Reports, Vol. 27, No. 3, p. 265 (1973).

3) The Penal Code of Japan, art. 202 provides:

"Every person who has instigated or assisted another person to commit suicide or has killed a person at such person's request or with his consent shall be punished with penal servitude or imprisonment for not less than six months nor more than seven years."

could bear to watch it.

- (3) It should be performed only for the purpose of relieving the patient's agony of death.
- (4) There should be a patient's own sincere request or consent when he has a clear consciousness and an ability to express his own will.
- (5) As a rule it should be performed by a doctor; otherwise there should be special circumstances justifying that it could not be performed by a doctor.
- (6) Appropriate means acceptable from the ethical point of view should be taken.

Applying these conditions to the present case, we admit, as mentioned above, that the defendant's father, Fukaichi, was really suffering from incurable disease and was at the edge of death, and that he writhed in the agony of pain imposed upon him every time he moved his body, and that his suffering, intensified by fits of hiccups, was almost unbearable to watch and that the defendant's act was carried out solely for the purpose of relieving pain from Fukaichi, so that the conditions from (1) to (3) above mentioned were satisfied without doubt. There is no need, however, to debate the condition #4 to conclude that the defendant's act does not come within the legally justifiable euthanasia, because it is clear that the defendant's act failed to meet two conditions, i. e., #5 and #6. We can not admit that there were any special circumstances that prevented the defendant from asking the doctor to perform it and furthermore the means taken by defendant, to pour organic phosphoric acid into the milk to be served to the patient, can not be recognized as ethically appropriate."⁴⁾

Perhaps this is the first judgement ever made in the world that indicated the detailed conditions under which certain types of euthanasia could be legally permissible, though in this specific case these conditions were not recognized as being satisfied. Irrespective of whether those conditions are recognized as proper or not, this judgement has a great significance in the point that the official court declared the possibility of

4) High Court Criminal Reports, op. cit., pp. 677-679.

legal euthanasia when it met the above-mentioned conditions. The court, however, delivered no opinions as to the concept of euthanasia; what type of euthanasia is permissible; nor did it show any legal grounds as to why certain type of euthanasia presented in the case were permissible if they met the conditions.

Among the conditions which made "euthanasia" legally permissible, the court enumerated the one: "As a rule it should be performed by a doctor; otherwise there should be special circumstances justifying that it could not be performed by a doctor." This condition is a mandatory one for legal euthanasia, so that if a doctor declined to perform "euthanasia" when he was asked to do so by his patient, little room would be left for legally permissible euthanasia because of the lack of this condition. Hence, a doctor's active cooperation is required. Moreover it could usually be only determined by doctors whether a patient was suffering from incurable disease or whether he was faced with imminent death. "Ethically appropriate means", though the meaning of these words are very vague, could be also provided only by doctors. Thus the problem of euthanasia is crucially concerned with doctors. Without taking doctor's attitudes toward euthanasia into consideration, we can not reach a correct conclusion as to the legal aspects of euthanasia.

This was why I made the following surveys as to the doctors' attitudes toward euthanasia. I wanted to know whether there was an actual possibility that a doctor would perform some type of euthanasia by request from his patient and also wanted to find something which would contribute to establishing proper concepts of euthanasia from the standpoint of criminal law, by surveying (1) the status quo of the problem of euthanasia and doctors' attitudes toward it, (2) doctor's attitudes toward the euthanasia legislation and (3) doctors' opinions as to euthanasia.

II. Method of Survey and Questionnaire

A. The Method of the Surveys

The survey was originally made in Tokyo in December in 1964. I mailed a questionnaire to all the 360 physicians and surgeons practicing medicine in the Setagaya ward in Tokyo. I got 131 replies, which were used for this research.

The survey in the Boston area, Massachusetts, was made in March in 1972. I mailed the questionnaire put in Section II B to 450 physicians and surgeons⁵⁾ practicing medicine in that area. Among 174 replies which I received from the doctors, 160 effectively responded to the questionnaire.

B. The Contents of the Questionnaire

The questionnaire printed below was originally made in Japanese for the survey in Tokyo and was translated into English to make the same survey in Boston.

HYPOTHETICAL SITUATION

Suppose the following situation:

- (1) A patient is suffering from a fatal disease that is generally recognized to be incurable.
- (2) His death is certain to result within a short period of time.
- (3) He suffers from unbearably excruciating physical pain because of the disease.
- (4) He has expressed a wish to die rather than continue to live in unbearable pain.
- (5) His family has also expressed a wish that he die rather than continue to live in unbearable pain.

QUESTIONNAIRE**I. Have you ever been confronted with such a situation?**

- (1) Yes.

5) They were selected at random from the telephone book of the Yellow Pages, Directory Area Code 617, 1972, Boston Area, pages 891—906.

(2) No.

II. If you were now confronted with the foregoing situation, how would you deal with it as a physician or a surgeon?

A. For the purpose of relieving pain, what would you do?

(3) Administer treatment which would result in immediate death.

(4) Give narcotics or other drugs for the relief of pain even if it is clear that increasing dosage would eventually result in death before the patient's expected demise from the disease alone.

(5) Undertake no treatment for the relief of pain if it would cause the patient to die before his expected demise from the disease alone.

(6) Others. (Please explain on the answer sheet.)

B. If you chose item 4, 5, or 6 for the relief of pain, what would you do to treat the disease and/or prolong life?

(7) Continue to provide treatment for the disease and/or treatment designed to prolong the patient's life, even though the condition is considered to be incurable.

(8) Discontinue both kinds of treatment.

III. Assuming that all the facts are the same as the hypothetical situation above:

There is a doctor who knows that increasing the dosage of pain-relieving narcotics administered to a patient would cause death sooner than would be expected from the disease alone. Nevertheless, unable to watch his patient suffer from such unbearable pain, he administers the increased dosage for the purpose of relieving pain, which eventually causes the patient's death as he anticipated it would.

C. How do you think this doctor would be dealt with under the present criminal system?

(9) He would be punished as a criminal.

(10) He would not be punished as a criminal.

(11) I do not know.

- D. Irrespective of the present criminal system, in your own opinion, do you think that this doctor should be punished as a criminal?
- (12) He should be punished.
 - (13) He should not be punished.
 - (14) I do not know.
- IV. If there were a bill which would legalize "mercy killing" under certain conditions, would you support it?
- (15) Yes. (Will you explain in Section V under what conditions you would support it?)
 - (16) No.
 - (17) I do not know.
- V. If you have any opinions about "euthanasia" or "mercy killing", will you describe them?

III. Results in Boston and Comments

A. The Summary of Concepts of Euthanasia

In the questionnaire only the relationship between pain-relieving means and the cause of death are referred to, but no concepts of euthanasia are presented. Hence it may not be clear what type of euthanasia they would perform when this data show that 74 per cent of the doctors, for example, chose item #2. To begin with, let me give an outline of the concepts of euthanasia, which will be fully discussed later in Section VI.

In the broadest meaning euthanasia is classified into two categories based upon the characteristics of the person upon whom it is performed: the first category of euthanasia consists of the persons with physical pain, and the second of the persons without physical pain. I will call the first category of euthanasia "pain-relieving euthanasia" and the second "policy-oriented euthanasia". The "pain-relieving euthanasia" will be performed only for the purpose of relieving physical pain and the "policy-oriented

euthanasia" will be performed for some other purposes. The concern of this paper is limited only to the "pain-relieving euthanasia".

The "pain-relieving euthanasia" can be further divided into the following five types based upon a variety of combinations between pain-relieving means and the cause of death:

- (1) "Medical treatment type" euthanasia in which an ordinary pain-relieving means is not attended with the causation of death.
- (2) "Risk type" euthanasia in which an ordinary pain-relieving means is attended with the probability of causing death.
- (3) "Necessity type" euthanasia in which an ordinary pain-relieving means is attended with the certainty of causing death.
- (4) "Active" euthanasia in which letting a person die is considered as a pain-relieving means.
- (5) "Omission type" euthanasia in which artificial life-prolonging measures or curative treatment causing, increasing or prolonging physical pain are discontinued as a pain-relieving means.

In this paper I often refer to "high risk type" euthanasia, which means the euthanasia in which pain-relieving means has a high probability of causing death.

Applying the above definition of the concepts of "pain-relieving euthanasia" to each item in Question-II-A, item #3 corresponds to "active" euthanasia, item #4 to "necessity type" euthanasia, item #5 to "medical treatment type" euthanasia and possibly item #6 to "risk type" euthanasia.

B. Total Results and Comments on Them

The results of each answer to the six Questions are presented in Table 1. The numbers corresponding to each item shows the percentages of the doctors who chose that item as their answer in each question. The figures in parentheses are the numbers of samples responded to each item.

a) Results and Comments as to Question-I

In terms of Question-I asking: "Have you ever been confronted

with such a hypothetical situation?", 59 per cent of doctors answered "Yes", 39 per cent said "No", and 2 per cent gave no answer.

① This shows that 3 out of 5 doctors have already been confronted with such a situation where his patient was suffering from terminal, incurable, and painful disease, wishing to die. It is reasonably assumed that here are so many situations in actuality where the problem of euthanasia occurs.

b) Results and Comments as to Question-II-A

In terms of Question-II-A asking: "For the purpose of relieving pain, what would you do as a physician or surgeon, if you were now confronted with the foregoing

Table I. Total results in Boston.

		Items	100%	(160)
Q I		1. Have been confronted	59	(95)
		2. Have not been confronted	39	(62)
		No answer	2	(3)
Q II	A	3. Cause immediate death	1	(2)
		4. Give pain-relieving drugs which would result in death	74	(119)
		5. Give pain-relieving drugs which never cause death	1	(1)
	B	6. Others	23	(36)
		No answer	1	(1)
		7. Continue treatment for disease and/or prolonging life	50	(80)
Q III	C	8. Discontinue both	43	(68)
		No answer	8	(12)
		9. Would be punished	18	(29)
	D	10. Would not be punished	49	(70)
		11. Do not know	29	(47)
		No answer	3	(5)
Q IV	D	12. Should be punished	8	(13)
		13. Should not be punished	82	(131)
		14. Do not know	6	(9)
		No answer	4	(7)
		15. Support a bill	31	(50)
		16. Do not support a bill	54	(86)
		17. Do not mind either	15	(24)

situation?" 74 per cent chose item #4: "Give narcotics or other drugs for the relief of pain even if it is clear that increasing dosage would eventually result in death before the patient's expected demise from the disease alone", 23 per cent chose item #6: "Others", and only 1 per cent chose item #3: "Administer treatment which would result in immediate death", and also another 1 per cent chose

item #5: "Undertake no treatment for the relief of pain if it would cause the patient to die before his expected demise from the disease alone."

② The figure of 74 per cent, taken on its face value, indicates that about the three-fourth of the doctors administer narcotics or other drugs in the same situation as that of hypothesis, even if it is *clear* that increasing dosage would eventually result in death.

I designed the item #4 to know the doctors' attitudes toward the above-mentioned "necessity type" euthanasia by assuming the situation where usual pain-relieving means would clearly hasten or cause death because of the dosages necessarily increased for a patient's habituation to narcotics or drugs. But there were some doctors who, choosing item #4, commented that the prognosis in this area was so vague and fell into such a "grey zone" that it might be very difficult to draw a definite line between the certainty of causing death and the probability of it. I can easily imagine that it is impossible to predict precisely whether or not "this" will actually be the last lethal dose when doctors use narcotics or other drugs judiciously for the relief of pain. In that sense these two can easily be mixed up, and among them there seem to be a common attitude: they do not mind causing death. Thus it may be permitted to say that at least the doctors who recognized the high risk of causing death by their subsequent pain-relieving acts but did not mind it chose item #4.

Thus I conclude that 74 per cent of doctors who chose item #4 administer narcotics or other drugs for the relief of pain without minding the high risk of causing death from such an approach. It means that "necessity type" of euthanasia and "high risk type" of euthanasia are now performed by 3 doctors out of 4.

③ Most of the 23 per cent who chose item #6 believe that the concept of euthanasia is unnecessary because it is possible to relieve pain without hastening or causing death.⁶⁾ Some of them admit the risk of causing death

6) See Section V, B at 52.

but deny attributing death to their pain-relieving acts. Their attitude toward causing death is very negative, while that of above-mentioned doctors who perform "high risk-necessity type" euthanasia is positive. It follows that item #6 represents both "medical treatment type" and "low risk type" euthanasia.

④ The doctors who chose item #6 suggested various kinds of other pain-relieving means than the administration of narcotics, such as potent tranquilizers, surgical nerve block, new use of old methods (hypnosis, acupuncture, etc.), which will not necessarily result in death. Some of the doctors emphasized the importance of ancillary therapy, such as intravenous fluid, good nursing care and encouragement, saying, "They are very helpful in making the patient as comfortable as possible during the remaining period of his life." Another doctor asserted that judicious use of narcotics with other sedatives would never result in death.

⑤ Only two doctors chose item #3 corresponding to "active" euthanasia. It may be quite natural that only two doctors out of 160 chose item #3, because their acts clearly fall under murder under the present criminal system. It must be mentioned, however, that there were two other doctors who explicitly mentioned that they wished to choose item #3 instead of item #4, but that present criminal law and the protection of their medical licences prevented them from doing it.

⑥ It was my surprise that only one doctor among 160 chose item #5 which was originally designed to correspond to "medical treatment type" euthanasia. All the doctors who I expected would choose this item chose item #6. As I cannot find any difference between the doctor of #5 and the doctors of #6 in the way of providing pain-relieving means, hereafter he will be counted as one of the doctors of item #6.

c) Results and Comments as to Question-II-B

In terms of Question-II-B asking what the doctors would do to treat the disease and/or prolonging life besides pain-relieving acts, 50

per cent of the doctors chose item #7 saying that they would continue one or both of them, 43 per cent chose item #8 saying that they would discontinue both of them, and 8 per cent did not give any answers.

⑦ Half of the doctors make their best efforts to prolong their patient's life as long as possible or never give up the hope for the patient to be cured even under the situation where the patients' disease are generally recognized to be incurable. These attitudes are supported partly by their belief that doctor's job is to keep a patient alive, and not to let him die⁷⁾, partly by their experience that there are patients who recovered in a miraculous way from the disease diagnosed as fatal⁸⁾, and partly by their recognition of the insufficient knowledge of modern medical science.⁹⁾

⑧ On the other hand there are 43 per cent doctors who would discontinue both treatments for the disease and for prolonging life. This attitude is supported on two grounds: (1) discontinuance of artificial devices to prolong life under the terminal, incurable and painful disease is ethically permissible and (2) when a patient requests, active life-prolonging acts are not called for to doctors.¹⁰⁾ Anyway "omission type" euthanasia is performed by 43 per cent of the doctors.

d) Results and Comments as to Question-III-C

In terms of Question-III-C asking what kind of judgement the doctors would pass from the legal point of view upon the doctor who administered knowingly a fatal dose of narcotics but at the same time necessary for the relief of pain to his patient suffering from terminal,

7) See Section V, A-2 at 49.

8) See Section V, A-3 at 49.

9) See Section V, A-3 at 50.

10) This was also supported by Catholic Church. For example, see Joseph V. Sullivan, *The Morality of Mercy Killing*, p. 64 (1949 Catholic University Press).

11) Why such a treatment is not called-for is not clearly described by any doctors, but there seems to be a tendency among doctors that they think active administration of lethal dose is not permissible, but withdrawal of life-prolonging treatment is permissible. See Section V, G at 63.

incurable and painful disease, wishing to die 18 per cent chose item #9: "Would be punished as a criminal", 48 per cent chose item #10: "Would not be punished as a criminal", and 29 per cent chose item #11: "I do not know". Three percent did not give answers.

⑨ This Question-II-B was not designed to search the doctors' knowledge of criminal law, but to get the data as to whether doctors were performing some type of euthanasia thinking they would be punished. My greatest concern was to know whether the fear of doctors that they might be punished had some impact upon their choice of pain-relieving means [See ⑬ and ⑰]. According to the total results shown here, half of the doctors think that "necessity type" of euthanasia is permissible under the present criminal system, while 18 per cent think it is illegal. The remaining 29 per cent do not tell whether they think it is permissible or not.

e) Results and Comments as to Question-III-D

In terms of Question-III-D asking: "Irrespective of the present criminal system, in your own opinion, do you think that this doctor should be punished as a criminal?", 82 per cent of the doctors chose item #13 and answered that "he should not be punished", while only 8 per cent chose item #12 and answered that "he should be punished". Six per cent said by choosing item #14, "I do not know" and 4 per cent did not give answers.

⑩ Eighty-two per cent of the doctors think that a doctor who performed "necessity type" euthanasia should not be punished, while 8 per cent think such a doctor should be punished, but the reasons why they think so are not presented.

By comparing the figures of Question-III-C with those of Question-III-D, we can see great differences between doctors' legal point of view and their own opinion as to "necessity type" euthanasia. Table 2 shows this clearly. It is well assumed that there are many doctors who feel a gap

Table 2. Differences between doctor's legal point of view and their own opinion as to "necessity type" euthanasia.

III—C Would be punished	Would not be punished	Do not know
18% (29)	49% (79)	29% (47)
8% (13)	82% (131)	6% (9)
III—D Should be punished	Should not be punished	Do not know

between the present criminal law and the generally recognized opinion or ethics among the doctors as far as "necessity type" euthanasia is concerned [See ②0].

6. Results and Comments as to Question—IV

In terms of Question—IV asking:

"If there were a bill which would legalize "mercy killing" under certain conditions, would you support it?", 31 per cent of the doctors chose item #15 in the affirmative, 54 per cent chose item #16 in the negative, and 15 per cent chose item #17: "I do not know".

⑪ The legalization of euthanasia through the form of legislation was opposed by the majority (54 %) of the doctors, while one-third of the doctors supported a bill of euthanasia under certain conditions. Among 50 doctors who answered in the affirmative, more than 40 delivered their opinions as to "conditions" under which euthanasia should be legislated. Most of their opinions were focused upon how to prevent abuses and misjudgements, which I will introduce and explain in Section V. Fifteen per cent of the doctors did not commit themselves.

C. Differences According to Various Pain-Relieving Means

A variety of differences were seen between the doctors who responded that they would give narcotics or other drugs even if there were a high risk or a certainty of causing death therefrom and the doctors who responded that they would not give such narcotics or other drugs that would cause death. For the convenience of explanation I will call the former " #4 type" doctors and the latter " #6 type" doctors. As I have already mentioned, among 160 doctors 74% (119) are " #4 type" doctors and 24% (37) are " #6

type" doctors.

⑫ As to continuance or discontinuance of life-prolonging and/or curative treatment, " #4 type" doctors were evenly divided into both—48% each; while among " #6 type" doctors, 59 per cent responded that they would continue and 30 per cent that they would discontinue both. See Table 3. It may be taken rather as a matter of course that " #6 type" doctors are more likely to keep their patients alive longer and undertake curative and/or life-prolonging treatments even for a hopeless case more than the " #4 type" doctors, but even among " #4 type" doctors there are half of them who answered that they would continue the same treatments. What explanation is possible for this result? Is the continuance of those treatments to be condemned as palliative only to justify themselves or is it to be praised for the doctors' modest and wise attitudes toward life and the imperfection of medicine?¹²⁾ On the other hand it must be also emphasized that there were the other half of " #4 type" doctors who would perform "omission type" euthanasia as well as "necessity type" one.

⑬ In terms of the doctors' judgement as to the hypothetical case from the present legal point of view, no difference can be seen between " #4 type" doctors and " #6 type" doctors. See Table 4. It must be

Table 3. Percentage as to continuance of curative and/or life-prolonging treatments among " #4 type" doctors and among " #6 type" doctors.

	" #4 type" doctors 100% (119)	" #6 doctors 100% (37)	Total doctors 100% (160)
7. Continue curative and/or life-prolong- ing treatment	48 (57)	59 (22)	50 (80)
8. Discontinue both	48 (57)	30 (11)	43 (68)
No Answer	4 (5)	11 (4)	7 (2)

Table 4. Percentage as to the doctors' judgement on the hypothetical case from the present legal point of view among " #4 type doctors" and among " #6 type doctors"

	" #4 type" doctors 100% (119)	" #6 type" doctors 100% (37)	Total doctors 100% (160)
Would be	18 (22)	19 (7)	18 (29)
Would not be punished	52 (62)	43 (16)	49 (79)
Do not know	29 (34)	30 (11)	29 (47)
No Answer	1 (1)	8 (3)	4 (5)

12) I would rather support this position on two grounds: one for imperfection of medicine and the other for the safeguards against abuses of euthanasia. See the explanation at 74-75.

pointed out, however, that 18 per cent among “#4 type” doctors, 22 in sample number, are performing their pain-relieving acts thinking that they can be punished. Adding 29 per cent who answered “I do not know” to it, about half doctors are doing so at least without a firm confidence that they cannot be punished under the present law.

⑭ In terms of the doctors’ point of view as to the hypothetical case, we can see remarkable differences between “#4 type” doctors and “#6 type” doctors. See Table 5. Among “#4 type” doctors, the ones who think that such a doctor should not be punished reach the high percentage of 90, while among “#6 type” doctors only 59 per cent share this opinion. On the other hand only 5 per cent among “#4 type” doctors say that “he should be punished”, while among “#6 type” doctors 19 per cent. Further, the percentage of the doctors who reserved their opinion is far higher among “#6 type” doctors.

These figures indicate that the doctors who administer narcotics or other drugs for the relief of pain, even if there is a high risk of causing a patient to die, perform “high risk-necessity type” euthanasia holding a belief that it should be permitted from their own opinion; while these figures indicate also that less doctors among those who assert the pain-relieving narcotics or drugs never cause death entertain this belief.

⑮ In terms of legislation of euthanasia there are great differences between “#4 type” doctors and “#6 type” doctors. See Table 6. We can see far more positive attitudes among “#4 type” doctors toward the legali-

Table 5. Differences as to their own opinion on the hypothetical case between “#4 type” doctors and “#6 type” doctors.

	“#4 type” doctors 100% (119)	“#6 type” doctors 100% (37)	Total doctors 100% (160)
Should be punished	5 (6)	19 (7)	8 (13)
Should not be punished	90 (107)	59 (22)	82 (131)
Do not know	3 (4)	14 (5)	6 (9)
No Answer	2 (2)	8 (3)	4 (7)

Table 6. Differences as to legislation between “#4 type” doctors and “#6 type” doctors.

	“#4 type” doctors 100% (119)	“#6 type” doctors 100% (37)
Support a bill	37 (44)	14 (5)
Do not support	45 (54)	81 (30)
Do not know	18 (21)	5 (2)

zation of euthanasia through the form of legislation than among “#6 type” doctors, but it must be pointed out that euthanasia legislation is supported only by the 37 per cent doctors even among those who would perform “high risk-necessity type” euthanasia at a patient's request.

D. Differences According to Curative and/or Life-Prolonging Treatments

⑩ One particular difference is seen in the method of selecting pain-relieving means between the doctors who continue and those who discontinue the treatments. Seventy-one per cent of the doctors who continue the treatments chose item #4, while among the doctors who discontinue them, the significant percentage of 84 chose item #4. On the other hand 27 per cent of the former and 16 per cent of the latter chose item #6. These figures indicate the tendency that the doctors who discontinue both kinds of treatment prefer “high risk-necessity” type of euthanasia compared with the doctors who continue; and at the same time indicate that “high risk-necessity type” euthanasia is usually accompanied with “omission type” euthanasia, since 84 per cent of the doctors who discontinue it chose item #4.

E. Differences According to Doctors' Legal Judgements and Their Own Opinions on “Necessity Type” Euthanasia

⑪ Does the difference in the doctors' legal judgements about “necessity type” euthanasia, shown in the hypothetical case, have any impact upon the doctors' choice of pain-relieving means? Looking at the Table 7, we cannot find any differences. Both doctors who consider it legal and

Table 7. Percentages of pain-relieving means according to the differences in the doctors' legal judgements.

	Would be punished		Would not be punished		Do not know	
	100%	(29)	100%	(79)	100%	(47)
“#3 type” means	0	(0)	1	(1)	2	(1)
“#4 type” means	76	(22)	78	(62)	72	(34)
“#6 type” means	24	(7)	20	(16)	23	(11)
No Answer	0	(0)	0	(0)	2	(1)

illegal under the present law perform their pain-relieving acts almost at the same rate. This means, with the result in ⑬, that the difference in the doctors' legal judgement is not related to their choice of pain-relieving means.

⑮ In contrast with the above, the differences in the doctor's own point of view as to the performer of the "necessity type" euthanasia have a great influence upon the doctors' way of choosing their pain-relieving means. See Table 8. Among the doctors who believe that "he should be punished under the present law", only 46 per cent adopt the "#4 type" means, while 82 per cent among the doctors who believe that the performer should not be punished. On the other hand 54 per cent among the former employ "#6 type" means, while only 16 per cent among the latter. This result indicates, with the result in ⑭, that at present the problem of euthanasia is the problem of each doctor's belief or philosophy as one doctor wrote to me¹³⁾. But what must be questioned then is as to whether we can leave this problem only to each doctor's philosophy. It seems to me what is important is not to protect doctor's philosophy but how to protect patient's interest. In that sense the problem of euthanasia should be solved by going beyond the individual doctor's philosophy.

⑯ The same tendency as in ⑮ was revealed with regard to continuance or discontinuance of life-prolonging measures and curative treatment. See Table 9. The doctors who think in their own opinion that the performer of "necessity type" euthanasia should not be punished tend to perform "omission type" euthanasia more frequently as compared with the

Table 8. Relation between the doctors' own point of view and pain-relieving means.

	Should be punished	Should not punished	Do not know
	100% (13)	100% (131)	100% (9)
"#3 type" means	0 (0)	2 (2)	0 (0)
"#4 type" means	46 (6)	82 (107)	44 (4)
"#6 type" means	54 (7)	17 (22)	56 (5)

Table 9. Relation of the doctors' own point of view to "omission type" euthanasia

	Should be punished	Should not be punished	Do not know
	100% (13)	100% (131)	100% (9)
Continue	69 (9)	50 (65)	33 (3)
Discontinue	23 (3)	47 (61)	23 (2)
No Answer	8 (1)	4 (5)	44 (4)

13) Dr. Eugene G. Laforet, who is giving jointly a seminar course called "Moral & Philosophic Problems of Modern Medicine" at B. U., said in the reply that "[i]n the end, I guess, it all comes down to one's personal philosophy of nature of man, his destiny, and his role in the world."

doctors who think he should. It must be mentioned, however, that even among the doctors who advocate the performer, opinions on "omission type" euthanasia are evenly divided unlike in the case of "necessity type" euthanasia, which 82% of the doctors perform it [See Table 8]. This indicates a very important conclusion, which is also supported by the results in ⑫ that at least half of the doctors who believe in the "high risk-necessity" type of euthanasia try to prolong the patient's life as long as possible so far as the patient's pain is relieved.

⑳ Among the doctors who think that the performer of "necessity type" of euthanasia would not be punished under the present criminal law, 92 per cent (73) answered that he should not be punished in their own opinion, either. On the other hand only 56 per cent of the doctors who replied that "he should not be punished," think that "he would not be punished" under the present law, either, but the rest of 44% (15 per cent answered that "he would be punished" and 29 per cent replied that "I do not know") showed a conflict between their legal judgement and their own opinion as to the performer of "necessity type" euthanasia. See Table 10. Table 11, in which the percentages of each combination of their legal judgement and their own belief are presented, clearly reveals the fact that only 52 per cent out of the total 160 doctors are consistent in them [See ⑩].

Table 10. Relation of the doctors' own belief to their legal judgement.

	Should be punished	Should not punished	Do not know
	100% (13)	100% (131)	100% (9)
Would be punished	69 (9)	15 (19)	1 (1)
Would not be punished	23 (3)	56 (73)	23 (2)
Do not know	8 (1)	29 (38)	67 (6)
No Answer	0 (0)	1 (1)	0 (0)

Table 11. Combination between the doctors' own belief and their legal judgement.

Legal Assessments	Their Own Opinion	100% (160)
"Would be punished" &	"Should be punished"	6 (9)
"Would Not be" &	"Should Not be"	46 (73)
"Would be punished" BUT	"Should Not be"	12 (19)
"Would Not be" BUT	"Should be punished"	2 (3)
"Do not know" BUT	"Should Not be"	24 (38)
Other	Buts	2 (3)
"Do not know"	"Do not know"	4 (6)
No Answers		4 (7)

②① As to the legislation of euthanasia, a great difference was seen according to the differences in their legal judgements. See Table 12. The doctors who think the performer of "necessity type" euthanasia would be punished under the present law took a very positive position on the legalization of euthanasia through the form of legislation. Fifty-nine per cent of them supported a bill. In contrast with them, the doctors who think he would not be punished under the present law showed a very negative attitude; only 23 per cent agreed, and 61 per cent were opposed to it. As far as "necessity type" euthanasia is concerned, it may be assumed that 3 out of 5 among the former think that the legislation of euthanasia is necessary because the performer could be punished under the present law, while among the latter also 3 out of 5 think, on the contrary, that the legislation of euthanasia is unnecessary because under the present law he is not punished now. Consequently it is crucially important for lawyers to clarify whether "necessity type" euthanasia is permissible under the present law or not.

②② By the differences in their own opinions as to "necessity type" euthanasia a great difference was also seen in the attitude toward the legislation. Look at Table 13. It may be natural that the doctors who took the stand against "necessity type" euthanasia from their own point of view were also opposed to the legislation of euthanasia, but a considerable divergency of views was seen among those who approved of the performer of "necessity type" euthanasia.

Table 12. Doctors' legal judgements and their attitudes toward the legalization of euthanasia.

	Would be punished	Would not be punished	Do not know
	100% (29)	100% (79)	100% (47)
Support a bill	59 (17)	23 (18)	30 (14)
Do not support	38 (10)	61 (48)	51 (24)
Do not know	7 (2)	16 (13)	19 (9)

Table 13. Doctors's own opinions on "necessity type" euthanasia and their attitudes toward the legislation of euthanasia.

	Should be punished	Should not be punished	Do not know
	100% (13)	100% (131)	100% (9)
Support a bill	15 (2)	34 (45)	33 (3)
Do not support	85 (11)	48 (63)	56 (5)
Do not know	0 (0)	18 (23)	1 (1)

F. Differences According to the Various Attitudes Toward the Legislation of Euthanasia

The following differences were observed between the doctors who supported a bill of euthanasia and the doctors who did not.

②③ It might easily be imagined that the doctors who supported the legislation of euthanasia must be positive toward euthanasia. As it was, 88 per cent answered that they would perform "high risk-necessity type" euthanasia. The doctors over the majority of them answered also that they would perform "omission type" euthanasia; and 90 per cent said that the performer of "necessity type" euthanasia should not be punished.

On the other hand the doctors who were opposed to the legislation of euthanasia certainly showed the negative attitude toward euthanasia compared with the above-mentioned "supporters", but it was not decisive. Thirty-five per cent answered that they would not perform "high risk-necessity type" euthanasia, but at the same time there were still 63 per cent who answered that they would perform "high risk-necessity type" euthanasia. Over the majority of them answered that they would continue life-prolonging and/or curative treatments, but at the same time 38 per cent answered that they would perform "omission type" euthanasia. Seventy-three per cent believed that the performer of "necessity type" euthanasia should not be punished. The reason why a clear negative attitude toward euthanasia could not be seen among the doctors who did not support a bill of euthanasia is probably because many doctors (56 per cent, 48 in sample number) who thought that they would not be punished under the present law were included in them.

②④ The opinions of the supporter upon the performer of "necessity type" euthanasia were divided into three; 34 per cent thought he would be punished under the present law, 36 per cent thought he would not be punished and 28 per cent said "I do not know". See Table 14. What does this variety mean? Perhaps it resulted from their different grounds for supporting a bill of euthanasia. The first 34 per cent are assumed to

Table 14. Percentages to the doctors' legal judgements according to the various attitudes toward the legislation of euthanasia.

	Support a bill 100% (50)	Do not support 100% (86)	Do not know 100% (24)
Would be punished	34 (17)	12 (10)	8 (2)
Would not be	36 (18)	56 (48)	54 (13)
Do not know	28 (14)	28 (24)	38 (9)
No answer	2 (1)	5 (4)	0 (0)

take the view that the legislation is necessary because the performer of "necessity type" euthanasia might be punished now; the next 36 per cent that though he might not be punished under the present law, the legislation for the euthanasia which is more progressive than the "necessity type" is necessary, and the last 28 per cent

that the legislation of euthanasia is necessary because it is not clear whether he might be punished under the present law. This is only my inference, but if it is correct I can say that 62 (34 + 28) % of the supporters of a bill seem to think that the legislation only for "necessity type" euthanasia is enough and that only 36% seem to think the legislation of further progressive type of euthanasia is needed.

IV. Comparative Results in Boston and in Tokyo

A. As to "confrontation" and "non-confrontation" with the hypothetical situation

The situation where "pain-relieving euthanasia" becomes an issue existed in reality in Boston [See ①]. In Tokyo, too, the same result was revealed; 73 per cent (96) among 131 total doctors had been confronted with such a situation. The percentage in Tokyo is 14% higher than in Boston. See Table 15. If these figures are literally taken, it is well assumed

Table 15. Comparative results as to "confrontation" and "non-confrontation".

	Boston	Tokyo
Have Been Confronted	(95) 59%	73% (96)
Have Not Been Confronted	(62) 39%	27% (24)

that the situations for euthanasia occur oftener in Tokyo than in Boston.

B. As to "pain-relieving means"

a) As far as pain-relieving means are concerned the figures astonishingly

Table 16. Comparative results as to pain-relieving means.

	Boston		Tokyo	
	(160)	100%	100%	(131)
Immediate death	(2)	1	3	(4)
"#4 type" means	(119)	74	73	(96)
"#6 type" means	(37)	24	24	(31)
No Answers	(2)	1	0	(0)

similar to those in Boston were found in the results in Tokyo. See Table 16. In Tokyo among 131 total doctors, 73 per cent (only 1% less than in Boston) will administer narcotics or other pain-relieving drugs even if there is a high risk or a certainty of causing a patient to die therefrom, while 24 per cent (just the same percentage as in Boston) will not

give such narcotics or other pain-relieving drugs as to cause a patient to die, and only 3 per cent will employ the means which will result in immediate death.

b) In contrast with the pain-relieving means, as far as curative and/or life-prolonging treatments are concerned, the doctors' attitudes are incredibly divergent between in Boston and in Tokyo. See Table 17. In

Table 17. Comparative results as to curative and/or life-prolonging means ("#3 type" doctors are included in No answer).

	"#4 type" doctors				"#6 type" doctors				Total doctors			
	Boston		Tokyo		Boston		Tokyo		Boston		Tokyo	
	(119)	100%	100%	(96)	(37)	100%	100%	(31)	(160)	100%	100%	(131)
Continue	(57)	48	89	(85)	(22)	59	87	(27)	(80)	50	86	(112)
Discontinue	(57)	48	11	(11)	(11)	30	13	(4)	(68)	43	11	(15)
No Answer	(5)	4	0	(0)	(4)	11	0	(0)	(12)	7	3	(4)

Tokyo 89 per cent among "#4 type" doctors and 87 per cent among "#6 type" doctors continue to give treatment for the disease and/or treatment designed to prolong the patient's life; while only 11 per cent and 13 per cent discontinue both kinds of treatment. These figures present two features as compared with the results in Boston. First, in Tokyo the percentage of the doctors who continue one or both of the treatments is

extremely high. Second, in Tokyo we can not see any differences between “#4 type” doctors and “#6 type” doctors in the way of dealing with curative and/or life-prolonging treatments.

c) Table 18 shows the comparative percentages of the doctors in Tokyo and in Boston as to what type of euthanasia they will actually perform under the present legal systems.

Table 18. Percentage as to what kind of euthanasia can actually be performed by doctors.

	Boston		Tokyo	
	(160)	100%	100%	(131)
“Murder type”	(2)	1	3	(4)
“High risk-Necessity type” & “Omission type”	(57)	36	8	(11)
“High risk-Necessity type” alone	(57)	36	65	(85)
“Omission type” alone	(11)	7	3	(4)
Perform Neither	(22)	14	21	(27)
Others	(11)	7	0	(0)

Now let us suppose a patient request euthanasia:

Thirty-six per cent of the doctors in Boston and only 8 per cent in Tokyo (less than one-fourth of Boston) will give narcotics or other drugs necessary for the relief of pain even if it is attended with a high risk or a certainty of causing death at the final stage and at the same time will discontinue to give the treatments for

the disease and for prolonging the patient's life.

Another 36% in Boston and 65% in Tokyo will employ the same pain-relieving means, but until the final stage comes they will continue to give one or both of the treatments for the disease and for prolonging life to keep the patient alive as long as possible.

Seven per cent in Boston and 3 per cent in Tokyo will discontinue life-prolonging and curative treatments, but they will not give such narcotics or other drugs that will result in death even if it is necessary for the relief of pain at the final stage.

Fourteen per cent in Boston and 21 per cent in Tokyo will not employ the above-mentioned, dangerous or fatal pain-relieving means at all and will continue other treatments.

d) How can we explain the similarity presented in a) and the difference in b) and c) between the two cities?

I guess the similarity perhaps resulted from the fact that the standard of medical techniques generally applicable to patients was not so much different between the two cities. The homogeneity of the medical methods of the relief of pain brought the similarity of the doctors' choice of their pain-relieving means. It seems to me the difference presented in **b)** and **c)** is more significant than the similarity. Death will be caused faster and more definitely when the discontinuance of curative and life-prolonging treatments is added to the administration of narcotics or other pain-relieving means. The doctors who give narcotics or other pain-relieving drugs and at the same time discontinue the curative and life-prolonging means are far more in Boston than in Tokyo. This means that there are much more doctors in Boston than in Tokyo who hasten the patient's death by omission before the situation reaches the final stage where the dose necessary for the relief of pain is at the same time a fatal dose. In Tokyo the doctors (89% of the "#4 type" doctors, which is 65% of the total doctors) do not give up providing curative and/or life-prolonging treatments until the final stage comes, while in Boston 48% of the "#4 type" doctors, which is 36% of the total doctors, don't. Thus I can say that the doctors in Boston are more liberal in dealing with a terminal, incurable and painful disease and that the doctors in Tokyo are more conservative. Various explanations for this difference may be possible, but it seems to me that it resulted from the difference in the mental structure between the two nations. It is often pointed out that traditionally the Japanese people don't like to draw a definite line between black and white, while that the American people prefer to pass a judgement from the standpoint of rationalism which is considered there to be a self-evident approach when one does something. The doctors in Boston are more likely to count a hopeless case as really hopeless than those in Tokyo. In other words the former know how to give up a terminal, incurable and painful patient in despair—omission of providing with curative and life-prolonging treatments, while the latter try to do their best for a hopeless case without

giving it up.

e) Regarding the way of providing the pain-relieving means we could see differences in Tokyo between the doctors who had been confronted with the hypothetical situation and the doctors who had not. See Table 19. The doctors who will provide “#4 type” pain-relieving means among those who have never been confronted with the hypothetical situation are only 57% in contrast with 79% among those who have; while the doctors who will provide “#6 type” means are 40% of the “not-confronted” doctors in contrast with 18% of the “confronted” doctors. These figures show that in Tokyo the doctors who have been confronted are more positive to “high risk-necessity type” euthanasia and those who have not are more negative. In Boston we could not see such a difference.

C. As to the doctors' legal judgements on the hypothetical case

a) Among the doctors who think “he would not be punished”, 85 per cent chose “#4 type” means and only 15 per cent “#6 type” means; while among the doctors who think “he would be punished”, 55 per cent the former and 39 per cent the latter. See Table 20. In Boston these differences were not seen [See ⑰].

These results indicate that the doctors in Tokyo are more inclined to perform “high risk-necessity” type euthanasia because they believe that it is permissible under the present law, and on the other hand not to perform

Table 19. The differences in the way of providing treatments between “confronted” doctors and “not confronted” doctors in Tokyo.

	Have been confronted	Have not been confronted
	100% (96)	100% (35)
Cause immediate death	3 (3)	3 (1)
“#4 type” means	79 (76)	57 (20)
“#6 type” means	10 (17)	40 (14)

Table 20. Differences in pain-relieving means” according to the doctors' legal judgements in Tokyo.

	Would be punished 100% (33)	Would not be punished 100% (73)	Do not know 100% (25)
“#3 type” means	6 (2)	1 (1)	4 (1)
“#4 type” means	55 (18)	85 (61)	68 (17)
“#6 type” means	39 (13)	15 (11)	28 (7)

it because they consider it not permissible under the present law.

b) In Tokyo unlike in Boston, the different attitudes toward the legal judgements of the performer of "necessity type" euthanasia did not have significant influences over the doctors' tendency to euthanasia legislation.

D. As to the doctors' own opinion upon the performer of "necessity type" euthanasia

a) In Tokyo, as to this item, amazingly unanimous opinion was expressed; except for 5 doctors the rest of 126 doctors asserted that "he should not be punished". See Table 21.

From this result it may safely be said that already there is no split of opinions among the doctors in Tokyo on the performer of "necessity type" euthanasia. We lawyers can not develop the legal aspects of euthanasia properly without taking this consensus of the doctors' opinion into consideration. Smaller as the percentage is, the situation is the same in Boston, too [See ⑩].

b) As I observed above, 96 per cent of the total doctors in Tokyo said that the performer of "necessity type" euthanasia should not be punished in their own opinion, but it must be pointed out that among them there were still 42 [=23+19] per cent of the doctors who think "he would be punished under the present law" or "do not know whether he would be punished or not". This shows, as I have already mentioned in

⑩ and ⑳, that the same great gap exists in Tokyo, too, between doctors' own opinion and their legal judgement, as seen in Boston. See Table 22. Believing "he should not be punished", more than 40 per cent doctors both in Tokyo and in Boston lack confidence that "he would not be punished under the present law".

Table 21. Comparative results as to the doctors' own opinions on the hypothetical case.

	Boston		Tokyo	
	(160)	100%	100%	(131)
Should be punished	(13)	8	3	(4)
Should not be punished	(131)	82	96	(126)
Do not know	(9)	6	1	(1)
No Answers	(7)	4	0	(0)

Table 22. Percentages of the doctors' legal judgements among those who think in their own opinion the performer should not be punished.

	Boston (131) 100%		Tokyo 100% (126)	
Would be punished	(19)	15	23	(29)
Would not be punished	(73)	56	58	(73)
Do not know	(38)	29	19	(24)

performing doctor should not be punished, but only about half of them hold their firm belief that he will not be punished under the present law and the other half do not have this belief. In Japan 99 per cent among the “#4 type” doctors believe that “he should not be punished”, but among them there are still 37 per cent who will perform it without such a belief. See Table 23.

Thus both in Boston and in Tokyo it is concluded that there are many doctors who seem to perform “high risk-necessity” type of euthanasia actually now feeling inner conflict between their own legal judgement and their own opinion. We lawyers must develop the legal theory of

Actual inner conflict of the doctors will probably take place when they perform “high risk-necessity” type of euthanasia by themselves. As I have already observed in ⑫ and ⑬, in Boston 90 per cent among the doctors who will actually perform this type of euthanasia believe in their own opinion that the per-

euthanasia taking this fact into consideration.

Table 23. “#4 type” doctors' legal judgements and their own opinion.

	Boston (119) 100%		Tokyo 100% (96)	
Be punished	(22)	18	19	(18)
Not be punished	(62)	52	64	(61)
Do not know	(34)	29	18	(17)
No Answers	((1)	1	0	(0)
Should be punished	(6)	5	0	(0)
Should not be punished	(107)	90	99	(95)
Do not know	(4)	3	1	(1)
No answers	(2)	2	0	(0)

E. As to the doctors' attitudes toward euthanasia legislation

In Boston 31 per cent in the negative and 15 per cent “I do not know” [See ⑪]. The differences in this attitude had relations to the differences in each Question-group except for Question-III-C regarding the legal judgement made by doctors

Table 24. Comparative results as to the doctors' attitudes toward the legislation.

	Boston		Tokyo	
	(160)	100%	100%	(131)
Support a bill	(50)	31	31	(41)
Do not support a bill	(86)	54	62	(80)
Do not know	(24)	15	5	(7)
No answers	(0)	0	2	(3)

[See ②②, ②③, ②④].

a) In Tokyo the following results shown in Table 24 came out. Thirty-one per cent among the total doctors answered in the affirmative for the legislation of euthanasia and 62 per cent in the negative and only 5 per cent answered "I do not know".

Compared with the results in Boston there are two characteristics worth noting: the percentage of the supporters of a bill of euthanasia is just the same in both, and less doctors in Tokyo answered "I do not know".

The percentage of the "supporters" between the two countries is strangely in accord. Thirty-one per cent among the total doctors in both cities expressed their affirmative attitude toward the legislation of euthanasia. Generally speaking, I can say that 1 out of 3 doctors are in the affirmative for some form of euthanasia law under certain conditions. I tried to analyze the doctors' reasons for the support of a bill and found that the majority (62%) of the supporters of a bill in Boston were concerned only that "necessity" type of euthanasia should be legislated [See ②③]. As to Tokyo it is a shame that I cannot make the inference in the same way because of the lack of statistics, but on the average, the similar tendency will be seen in Tokyo, too [See Table 23].

Under the present situation where only one-third of the doctors support the legislation of euthanasia, and moreover where over the majority of them only support the bill for "necessity type" euthanasia, there will be no possibility of a law regarding further progressive euthanasia being enacted in near future both in Boston and in Tokyo. Without active cooperation and support of doctors, we can not expect the legislation for euthanasia to be realized.

b) Much more doctors in Boston refrained from telling whether they

would support a bill or not than those in Tokyo. Among the total doctors there were 15 per cent in Boston and 5 per cent in Tokyo. This fact indicates to us that with the comparative result mentioned in **D- a)** in this Section, the doctors in Tokyo are maintaining clearer attitudes toward euthanasia regardless of whether they vote for or against it.

V. Doctors' Opinions on Euthanasia in Boston

The doctors were requested to describe their opinions as to euthanasia in Question V. Among 160 doctors who responded to the questionnaire, about 120 set forth their opinions as to euthanasia. Their opinions introduced here are not necessarily related to what kind of pain-relieving means they would give under the present law, beyond which they expressed themselves as to whether euthanasia, whatever it might mean, was required or not.

A. Doctors' Attitudes Against Euthanasia

There were thirty doctors who were definitely opposed to any kind of euthanasia. Some of them seem to display even so-called "physiological hostility" against euthanasia. Let me quote a letter from a family physician in Cambridge who was honored as the G. P. of 1938 for Middlesex County:

"Has the practice of medicine degraded so far as to even think that such unGodly questions should be sought? Yes, I do believe that a physician should do all within his power to allay human suffering. But, since when does God's will be altered by so-called progressive(?) elements. I believe in Neither 'mercy killing' Nor 'euthanasia'! You should be ashamed to seek such replies."

Setting aside from this extreme view, the doctors who are opposed to euthanasia resulting in death describe a variety of reasons against it.

1. Travesty of "respect for human life"

Some doctors believe that life is too holy to be taken away in any circumstances because "an individual has an inalienable right to live", or that "God alone has the right to give life and take away it". Thus it follows that "as a physician, I have no right to kill" or that "I refuse to play God". One doctor said:

"I would support the position that medication for anything beyond the relief of pain in such situations is a cruel travesty of 'respect for human life'."

2. Doctor's duty is not to end life.

"I believe a physician's duty is to save lives and not to end them," said one doctor, "therefore I am not in favor of euthanasia under any circumstances. We should not be expected to be executioners. " I can see doctors' professional pride when one doctor says as follows:

"Doctor's main function is not to judge who should live and who should die, but alleviate by any possible means pain and suffering without destroying a human being."

Another doctor said that if the authority to perform euthanasia was provided to doctors, "it might undermine patient's confidence in medical profession since patient will suspect he may be next or last receive 'lethal dose'", and thus it follows that "the medical profession would fall into disrepute."

3. Fallibility of prognosis and imperfection of medical treatment

Two doctors emphasized insufficiency of medical knowledge:

"No doctor or anyone else or any committee know enough to prescribe euthanasia."

"I don't believe that we have a good enough scientific background at this time to intelligently legislate 'euthanasia'. A misjudgement is too permanent."

As to in what point medical knowledge was insufficient, several doctors said that they could not give a precise judgement regarding whether the disease in question was fatal or not, and that they often saw patients survive after he was diagnosed as fatal:

"All experienced physicians realize they are not infallible and have been amazed at the recovery of patients whom they considered fatally ill."

One doctor said definitely that no disease could be considered incurable:

"No disease can be considered incurable until the patient is dead. There have been innumerable cases of so-called 'incurable disease' that have been cured—some at the eleventh hour. I have personally seen cases of 'incurable' cancer heal spontaneously and live for many years."

There were several other doctors who mentioned that there would be always the possibility of the appearance of new treatments:

"New chemicals, hormones, X Ray or radium techniques and surgical improvements are constantly on the horizon which can accomplish a good deal for any given patient. We see such examples regularly. I'm opposed."

4. Danger of Abuses

There were doctors who worried about the danger of abuses of euthanasia:

"No committee or Government bureau should be given the right as it would certainly be abused."

"I am concerned about possible abuse of medical '007' permit."

Some doctors referred to the notorious historical events of Hitler and asserted the danger of euthanasia being gradually extended:

"Definitely opposed. The Nazis used exactly this sort of case as a start. If you don't know you should know where it led."

"Euthanasia is usually a cover for economic or political purposes, such as, for instance, the Nazi regime tried to do away with 'useless eaters' or racially undesirables. It is against the very basic principles of medicine."

There were other doctors who worried about the abuse from the standpoint of man's nature of irresponsibility:

"Man unfortunately is irresponsible and often motivated by outside factors."

"The frailty of human weakness would make unbiased decisions unlikely."

5. Patients never wish to die.

Some doctors said that voluntary euthanasia was too hypothetical because patients never wished to die:

"If you have seen the desperate resistance of many dying 'uncurable' patients against surrendering their last moment on this earth, you can't help but wonder whom you are putting out of their suffering—the patient or his family?"

"I have taken care of many terminal patients and have yet to hear a patient truly state he or she wanted to die as death approached—they tenaciously hold on to life!"

6. Others

Some other reasons against euthanasia were set forth by doctors. One doctor said, "It is not always necessary to attempt to bear pain, but living with it has meaning—sometimes otherwise unavailable values emerge". Another doctor said that "this culture" did not permit physician to take

direct steps to terminate another's life. The other doctor said that "I do not believe that pain has the right to kill under any circumstances".

B. Pain-relieving Means Never Causes Death.

There is a strong contention that euthanasia is unnecessary because pain-relieving means never result in death or hasten death. 17 doctors, all of whom chose #6 in the questionnaire II-A, took this position to object to euthanasia. This standpoint is well represented in the following view delivered by one of them:

"My opinion is that mercy killing is never necessary. People never die too slowly, even with all our modern life-prolonging aids, 'care is taken that the trees shall not grow into the sky'. If ordinary pain relief by standard dosages of drugs seems ineffective, I would then try to control the apparently intractable pain by hypnotic psychotherapy, then if necessary I would administer pain-relieving medication of varying type so that extreme increase of dosage would not be necessary, hence would not result in death before the patient's expected demise."

He admits that increasing dosages of drugs may result in death, but he tries to avoid it by using other pain-relieving measures. There were many other doctors who, criticizing the hypothetical case in the questionnaire, asserted that increasing dosages never resulted in death. One of them wrote to me:

"The hypothetical situation you posed is unrealistic—based upon an erroneous information. Increasing medication for pain as is often needed in such disease is well tolerated and will not in itself cause death."

C. Euthanasia Attended with the Risk of Causing Death

More than 30 doctors admitted the fact that pain-relieving means involved the risk of causing death. Here, unlike the above-mentioned B group, the crux of problem is focused upon pain-relieving acts probably

followed by death. This group must be also differentiated from the next groups D and E, where death results from the pain-relieving acts directly or where letting a person die is considered as a means of relieving pain. This standpoint is represented by the following view delivered by Assistant Professor of Surgery at Harvard Medical School:

"The overriding consideration would be provision of pain relief. Nowadays this can usually be done with the wide variety of medications available. If the accomplishment of pain relief results in shortened life, this would not cause me to withhold the indicated therapy."

Another doctor said that "resulting in shortened life" occurred "daily" and gave a following example:

"In the case in which death from malignancy is inevitable despite all possible treatment, the obligation is to keep the patient from pain. To accomplish this some patients die from side effects of narcotics (pneumonia, etc.)."

Then how do the doctors think of resulting in this side effect of death? Some of them take a position that they can not know exactly whether certain pain-relieving means causes death or not because of "notoriously poor accuracy of prognosis":

"I would give maximum narcotics to relieve pain with certain conviction that I cannot make an exact distinction as to whether the provided medicine is immediate cause of death."

Some doctors take a position that they are justified because they never kill a patient "deliberately", even if death is considered as a calculated risk. This point of view is revealed in the following expressions:

"I would never deliberately kill anyone. If death, though I did not intend,

follows an act to relieve suffering, ethically and morally there is no objection."

There were some other doctors who asserted that their act of relieving pain was justified because it was not a direct act to cause death but only an indirect act. Perhaps they accept the principle of "*actio duplicis effectus*", which has been long recognized in the ethics in the western countries.

One of them said:

"Euthanasia is a direct means or act which takes of human life. But the administration of drugs to primarily relieve pain, which may have deleterious side effects hastening death, is an indirect act."

"I don't believe we should 'kill' anyone. I think we should relieve pain and suffering regardless of outcome because our main purpose is to relieve pain."

D. Euthanasia Attended with Inevitable Death

Several doctors admit that there is a situation where the ordinary pain-relieving means is necessarily combined with the causation of death as a result of habituation to narcotics. In other words doctors will administer ordinary or minimum narcotics or other drugs necessary to relieve pain, knowing that this ordinary or minimum dose will be at the same time a fatal dose. When a patient is suffering from physical pain, the relief of pain is considered as a matter of course within the range of ordinary medical treatment. The question is this: What will happen when that pain-relieving treatment is clearly attended with the causation of death? Does it fall into generally established medical treatment or is it outside the range of medical treatment? One of the doctors said:

"I feel our society is properly giving individual patients more say over their medical care and this all important aspect should be as well. In the present situation although technically criminal there is an implicit consensus to leave the decision to the patient, his family and the doctor with any fanfare—this


practice should be put to the public to vote on."

Another doctor said that this did not trespass present medical belief as follows:

"To allow euthanasia or mercy killing might allow any 'physician' the right to dispose of a patient's 'suffering'. The assist to a degnified demise as in II-A-4 or III does not trespass present medical or religious belief and seems adequate."

There were two doctors who thought that they could justify themselves from the standpoint of the principle of "double effect". They said:

"I would not kill 'directly'. When from an indifferent act two effects follow, one good and the other evil (morally), I would perform the 'indifferent'

lethal drug— death
relief of intolerable pain

act, provided the good effect was of greater 'value' than the evil one, and followed at least as soon as the evil."

"In my opinion it is the physician's responsibility to maintain and prolong useful and meaningful life. He is under no legal or moral obligation (within the context of Judeo-Christian ethics) to prolong the process of death. A patient may be allowed to die with dignity and the absence of pain. If the necessary dosage of pain reliever is such that a side effect would be precipitation or acceleration of the dying process I believe it would be both legal and moral since the primary purpose of treatment was the relief of pain and not to cause death. I would continue narcotics until pain totally relieved: i. e., probably lethal dose."

Among the doctors who accept the concept of "necessity type" euthanasia, there are some doctors who emphasize the principle of "necessity", which means that the way of giving dosages must be judicious and that the very pain-relieving act must be the last resort available for pain relief

without hastening or causing death. One of them said:

"If patient and family are fully aware of all alternatives and there is no other option than a slow, painful death, then the physician may be allowed to provide with euthanasia."

Another doctor admits the possibility of fatal dose for the relief of pain, but fortunately he says, "I have never killed a patient yet and expect I never will." The same way of thinking as this is well revealed in the following doctor's opinion:

"Try new drugs that might change the course of the disease. Try to keep the patient free from as long and as much as possible. I believe that as long as there is life, there is hope. By keeping a patient alive, new methods of treatment would be tried to change the course of the disease, and at the same time the patient is made as comfortable as humanly possible with sedatives. At least it is worth a try."

It is not necessarily clear whether he will give the lethal dose necessary for the relief of pain at the final stage after he tried everything. Judging from the words, "At least it is worth a try", he will probably affirm the administration of the lethal dose for the relief of pain at the final stage. Then he may be counted as a typical doctor who performs the "necessity type" euthanasia.

E. Active Euthanasia

The doctors who fall into this group E affirm more active type of euthanasia than the above-mentioned "necessity type" euthanasia. Unlike the above-mentioned group D, the administration of a fatal dose is not considered as the last resort to relieve pain, but here doctors will give it to a patient with the intention to kill him, though otherwise ordinary pain-relieving means is still available. Death is not inevitably attended with ordinary pain-relieving acts but purposely intended to shorten his life.

Many doctors agreed to this "active euthanasia", suggesting various conditions under which they would support a bill of euthanasia, but only a few stated the grounds why they thought this active euthanasia should be allowed.

1. Voices for active euthanasia

First of all let me quote a letter from an old doctor saying he wished to but could not perform active euthanasia because of the present law.

"After 37 years in general practice, I have, all too often, felt like one with my hands shackled behind my back. Under the circumstances stated "Hypothetical Situation" I would follow 2-A-3, without hesitation for anyone of my own and I could do no less for my fellow man. However, because of present law, I am forced to obey the law and to protect my license."

One doctor urged that use of overdose should be allowed:

"It would have to be tightly written to allow far use of drugs beyond the usual dose range..."

Another doctor said about the future of euthanasia as follows:

"It is my feeling that euthanasia will be permissible within 20 years under proper legal, medical and family consultation."

2. The grounds for "active euthanasia"

One of the doctors who adduced the reasons for "active euthanasia" asserted "a right to die as a basic human right". He said as follows:

"In death as in life, I strongly feel that a person should have a definitive say about under what conditions he is still willing to exist, and under what conditions—not to be alive—is the better fate.

I would not ask of my closest relatives, friends, or doctor to make this decision for me. It would be grossly unfair and humanly impossible. There is

an inherent horror of murder in human mind when it comes to people you know.

But I do wish I could, legally and as a part of my basic human rights, say under what conditions, I would want to be non-existent. I realize this wish could lead to legalization of 'Euthanasia'."

This opinion that a man should have a right to die with dignity was supported by several doctors, but some among them said that this right should be exercised by a patient himself: "he should have the right to take his own life painlessly if he desires to do so". This means that there are some doctors who admit what can be called "suicide type" euthanasia.

One of the doctors said that "to prolong life is distinctly wrong from a moral and economical point of view", but it is not necessarily clear what he means by the words "moral" and "economical".

As to "moral point of view" two other doctors supported euthanasia more clearly from the standpoint of failure in self-realization as follows:

"I would like the medical staff or a committee of the staff, to pass the judgement in (1) the incurability of the disease, and (2) the sense that the patient is no longer able to live in any functional way so as to desire pleasure or gratification from life because of his physical illness, then I would leave the decision of mercy killing to the physician."

"The way to terminate life should be found where life has no further meaning or value for the individual."

There was one doctor who referred to "mercy". He said:

"If death is inevitable shortly and the individual is suffering severely, an easy quick death is merciful."

3. Conditions for active euthanasia

"If tightly controlled under certain clear-cut conditions, euthanasia is sup-

portable legally and morally—main problem is to define the conditions as you did in your questionnaire so that mercy killing deaths are indeed just that and, confined only to absolutely hopeless cases.”

Many doctors referred to the conditions under which they would support a bill for active euthanasia. Their discussions were mainly focused upon two elements: patient's consent or desire and safeguards against abuse and misjudgement.

(a) Terminal, incurable and painful disease

Most of the doctors who supported a bill of euthanasia seemed to think that terminality, incurability and painfulness are “sine qua non” for the permission of euthanasia. The crux of these elements lies rather in the problem as to who decide these and whether the given prognosis is absolutely infallible or not. The discussions made by doctors who were opposed to euthanasia were focused upon these two problems as I already presented them. But few doctors among those who agreed to euthanasia referred to infallibility of prognosis.

In terms of the “imminence of death” two doctors suggested a specific period of weeks which is supposed to be left before the patient's natural demise from disease alone.

In terms of incurability one doctor emphasized “a definitely diagnosed incurable disease” as one of the conditions for euthanasia, but he did not tell whether it was possible or not. Another doctor, however, clearly mentioned that “the dying hulk could not be rehabilitated even by a miracle.”

(b) The desire of the patient and his family

Among 40 doctors who referred to conditions for euthanasia, 30 doctors listed patient's consent or desire as one of them. One of the doctors said:

“Euthanasia should be permitted if it is clearly the desire of the patient if he is in possession of his faculties—regardless of the wishes of his family.”

Some doctors said that written document was required for the consent of a patient:

"A properly witnessed document signed by the patient and spouse or next of kin and the doctor—would in my mind, constitute an appropriate application to the courts or judge—for a 'mercy killing'."

Many doctors claimed the necessity of the consent of the patient's family in addition to that of the patient. But some of them said that "the wishes of the family should weigh heavily with the attending physician only when the patient is not in possession of his faculties." By the way what does family mean? No doctors defined this, but some of them used the words "spouse" and "next of kin".

(c) Who is to decide the whole situation?

Many doctors showed a great interest in the problem as to who was to decide the whole situations under which euthanasia was permissible, and suggested various types of procedure. Roughly speaking their opinions are divided into the following four groups.

The first group insists that this problem should be decided by the attending doctor himself alone. But the number of these doctors was very small.

The second group consists of the doctors who insist that this problem should be decided after informal consultation with other doctors or persons. One of the doctors said as follows:

"Believe there should be a law authorizing physician after consultation to 2 other physicians to give treatment for pain, even a somewhat overdose and ceasing treatment which ought to prolong life for a short time."

Another doctor said that no law could change the present prevailing practice:

"In a hospital, etc., nurses, orderlies, volunteers as well as family and friends play a role in deciding and so law cannot change this."

The third group and the fourth group suggested to establish an official "review board" or "committee" to check the situations in order to decide whether euthanasia should be applied to that specific case. The doctors in the third group insisted that the committee should consist of doctors alone, while those in the fourth group insisted that it should consist of doctors and other people. The opinion of the third group is well represented by the following doctor's view:

"Despite permission from the family and patients, no single doctor should undertake this awesome responsibility by himself. Safeguards should be set up in such a way that the M. D.'s responsibility should be shared with other M. D.'s (in addition to family & patient). Perhaps an elite panel of professors from the medical schools could set in committee to review the facts and make a decision in cases submitted to others—no rubber-stamping of the original M. D.."

The fourth group designs a committee made up of not only doctors but also other people like clergymen, judges, lawyers, or laymen.

(d) Other conditions

There were two doctors who referred to the age limits as one of the conditions of legal euthanasia. One of them said that "euthanasia below age 65 should not be allowed".

One doctor suggested the special procedure to decide the performer of euthanasia by establishing a system in which the state appointed an anonymous physician to perform it.

F. Policy-oriented Euthanasia

There were three doctors who approved of what I define "policy-oriented" euthanasia, whose subjects to whom euthanasia would be per-

formed were not suffering from physical pain. They insist that euthanasia should be performed to the person who has lost its function as a human being.

Strictly speaking the subjects of so-called "policy-oriented" euthanasia will not be limited only to those who have lost their functions as a human being. The key criterion which differentiates "policy-oriented" euthanasia from "pain-relieving" euthanasia lies in whether a subject is suffering from physical pain or not. Consequently a person who is suffering from terminal but not painful disease will subject to the range of "policy-oriented" euthanasia. In this sense some of those whom I classified into the above-mentioned "active euthanasia" might be brought into "policy-oriented" euthanasia. But since it was not necessarily certain whether they took patient's pain into consideration or not when they said, "Where life has not further meaning or value for the individual...", I classified into this group only the doctors who explicitly claimed the euthanasia beyond the purpose of the relief of pain. One of the doctors said:

"Yes, you pose only one situation a human being may find himself in and very legitimately or not want to get out. There are many others. The cerebral 'accident' that makes him or her into a 'vegetable'—not in pain—just nonfunctional as a human being."

Another doctor said as follows to the effect that the real problem of euthanasia came with stuporous, unconscious or mentally incapacitated patients:

"The problem is not with patients who can communicate a wish to die. They usually can kill themselves or (by demands for excess narcotics) get someone else to do it. It is with stuporous, unconscious or mentally incapacitated patients that the problem comes. Is it possible for doctors to be protected by law if he seeks some other end—in dealing with such patients—other than securing for that patient the longest possible life? I would hope so."

The other doctor complains that "I am kinder to my dogs than this community is to its humans":

"Prolonged coma, all IQ's < 50 and many others. Look at that article in Life magazine about Feb. 72 regarding hospital in N. Y. for mental defectives and you will see a whole picture of where we need euthanasia. I am kinder to my dogs than this community is to its humans."

G. "Omission Type" Euthanasia

As I have already mentioned, 43 per cent among the total doctors in Boston area replied that they would perform "omission type" euthanasia. Many affirmative opinions on euthanasia by omission were also written to me. Even among the doctors who were opposed to "necessity type" euthanasia there were many doctors who said that they would perform this. First of all let me quote a letter from an old doctor:

"35 years ago as an interne I was on duty at night. A very old patient terminal with cancer was comatose. I did not keep up the intravenous fluids, withdrawn the tubes and the patient died, possibly a coincidence. I was sharply reprimanded. I was asked if I would do that to my sister. I kept silent, but I thought I would do the same. No guilt."

One of the doctors described "omission type" euthanasia in detail. It seems to me he is well representing the other doctors' opinions. First he gives the grounds why he supports "omission type" euthanasia as follows:

"I feel it is inhumane and unjust to permit a person to suffer from terminal illness for a prolonged period. Since physicians are entrusted with the authority and responsibility over patient's lives in disease, then they should be expected to respond to the victim's situation with compassion, understanding and reasonableness."

Then he explains how to withdraw life-supporting measures:

"It follows that alleviation of pain and agony are vital, and only the minimal supportive measures are to be done. Administration of analgesia and tranquilizers is to be encouraged, and use of anti-tumor drugs, respiratory assistance, and even intra-venous fluids should be diminished and eventually stopped. The patient can be placed in stupor."

And then he explains the difference between active euthanasia and omission type euthanasia:

"Hence, I could not strictly support a measure authorizing willful "mercy killing", such as injecting morphine to deliberately stop life, but withdrawal of life-supporting or life-prolonging forces, complied with heavy analgesia and sedation is perfectly compatible with my approach to this critical problem."

Lastly he claims that the decision of omission to use life-supporting forces must be made by the doctor:

"The point at which this decision is made on the part of the physician is arbitrary and hopefully will reflect good judgement."

Summarizing this doctor's view, he says that he places his patient in stupor by analgesia to alleviate pain and gradually withdraws life-supporting measures and finally stop even intravenous fluids. But he is absolutely opposed to active euthanasia. This seems to be a typical opinion of the doctors who support "omission type" euthanasia.

Another doctor stated, however, that "ordinary" (e. g. IV fluid, etc.) and "extra ordinary" (e. g. chemical therapy, etc.) therapy must be clearly distinguished and said:

"Doctors should not be allowed to kill patients legally but already has the option to discontinue "extra ordinary" therapy if it is merely prolonging a hopeless situation."

VI. Concepts of Euthanasia and Discussions —In Place of Conclusion

A. The Concepts of Euthanasia

Many doctors referred to the historical event of the Nazi regime in order to object to the legalization of euthanasia. I am sure nobody will approve of any type of euthanasia whose purpose is in political and racial discrimination. Even the doctors who referred to the Nazi program will not worry about the actual possibility of such a progressive type of euthanasia being legislated at present. They seem rather worried about the possibility of some type of euthanasia, which is considered appropriate at the beginning to be legislated, being gradually extended to more progressive types of euthanasia and in the end being utilized for the political purposes.

Whatever it may mean, the concept of euthanasia implies the artificial extinction of human life. Why is this artificial extinction of human life needed? Why is it justified? What type of euthanasia satisfies the need? Does it have any possibility of being abused? Before these questions are answered, the concept of euthanasia must be clarified.

The first scholar who classified the concept of euthanasia into various types was a German scholar, Karl Engisch, who wrote "Euthanasia and the extinction of not-worth-living life from the standpoint of criminal law"¹⁴⁾ in 1948. In this book he classified the concept of euthanasia into five groups: (1) "Pure euthanasia" in which pain-relieving means provided to a patient suffering from terminal and painful disease is not attended with the causation of death; (2) Euthanasia in which pain-relieving means is attended with death as an undesirable side-effect; (3) Euthanasia by omission; (4) "Active euthanasia" in which a patient suffering from a terminal and painful disease is killed for the purpose of putting an end to his suffering; (5) "The extinction of not-worth-living life" in which persons, such as

¹⁴⁾ K. Engisch, *Euthanasie und Vernichtung Lebensunwerten Lebens im Strafrechtlicher Beleuchtung* (1948).

idiots, incurable insanes, who would be burdens for the society are killed from the standpoint of social rationality.¹⁵⁾ This classification by Engisch was followed by many scholars thereafter.¹⁶⁾ In Japan too this was adopted by several scholars¹⁷⁾ recently. It seems to me, however, this classification is vague and confused from the point of view that the euthanasia for the relief of pain and the euthanasia for other purposes are not clearly distinguished.

In Anglo-American society G. Williams suggested another type of classification,¹⁸⁾ according to which he developed his detailed discussion. He divided euthanasia into four groups as follows: (1) euthanasia in the sense of giving a patient a fatal injection with the intention of killing him; (2) euthanasia in the sense of helping a patient to commit suicide; (3) euthanasia in which the necessary dose of drugs for the relief of pain is at the same time a fatal dose and (4) "mercy killing" by omission. The greatest characteristics of Williams' classification lies in the establishment of the concept of the third type of euthanasia, which, I think, contributed greatly to clarifying the concept of euthanasia in the sense that he made clear the last stage where the pain-relieving means would be diverted from medical treatment and step into euthanasia.

Another type of classification of euthanasia which is very popular is made from the standpoint of the voluntariness of a patient—voluntary euthanasia or involuntary euthanasia. This classification seems to me inappropriate because the emphasis of voluntariness itself involves a very dangerous possibility of opening a way to broad abuses because there is a risk of "voluntary euthanasia" being performed easily according to the

15) Ibid., pp. 4-5.

16) See Goetzeler, *Zum Problem der Euthanasie*, 65 *Schweizerische Zeitschrift für Strafrecht* 403 et seq. (1950); E. Schmidt, *Der Arzt im Strafrecht*, in: Ponsold, *Lehrbuch der gerichtlichen Medizin*, p. 11 et seq. (2d ed. 1957); Maurach, *Deutsches Strafrecht*, Bes. Teil, p. 14 et seq. (4th ed.)

17) R. Hirano, *Seimei to Keiho—Tokuni Anrakushi ni Tsuite* (Life and Criminal Law—Especially as to Euthanasia), *Keiho no Kiso* (The Basis of Criminal Law) 176 (1966); F. Kanazawa, *Anrakushi no Mondai* (The Problem of Euthanasia), *Hogaku*, Vol. 25, No. 1, p. 120 (1961); Y. Inoue, *Anrakushi no Yoken* (The Conditions of Euthanasia), *Horitsu no Hiroba*, Vol. 19, No. 6, p. 49 (1966).

18) G. Williams, *Euthanasia, The Sanctity of Life and the Criminal Law*, pp. 319-326 (1957).

patient's "voluntary" request even in the case where he has no physical pain. Here the need for euthanasia is shifted from the relief of pain to a patient's voluntary will to die.

"What is the need for euthanasia" in the world? "It is only to ease pain."¹⁹ Then euthanasia must first be divided into two categories according to whether the person to whom euthanasia is performed is suffering from pain or not. H. Silving says, "Euthanasia in the sense of killing of an incurably ill person for the purpose of putting an end to his suffering must be clearly distinguished from euthanasia in the sense of the destruction of life which is 'not worth living' because it is socially useless."²⁰

With reference to the classifications made by Engisch and Williams, I classify the concepts of euthanasia as follows:

I. "Pain-relieving" euthanasia

- (1) "Medical treatment type" euthanasia in which an ordinary pain-relieving means is not attended with the causation of death.
- (2) "Risk type" euthanasia in which an ordinary pain-relieving means is attended with the probability of causing death.
- (3) "Necessity type" euthanasia in which an ordinary pain-relieving means is attended with the certainty of causing death.
- (4) "Active" euthanasia in which letting a person die is considered as a pain-relieving means.
- (5) "Omission type" euthanasia in which artificial life-prolonging measures or curative treatment causing, increasing or prolonging physical pain are discontinued as a pain-relieving means.

II. "Policy-oriented" euthanasia

- (6) Voluntary euthanasia which is performed according to the desire of a person suffering from incurable disease or an old person.

19) Kamisar, Some Non-religious Views Against Proposed "Mercy-Killing" Legislation, 42 Minn. L. Rev. 969, 1007 (1958).

20) Silving, Euthanasia, 103 University of Pennsylvania Law Review 350, 351 (1954).

- (7) Extinction of not-worth-living persons such as defective or degenerate persons, including the mentally ill, the retarded, those with gross physical defects, and old people suffering from senility.²¹⁾
- (8) Extinction of mongoloid children

“Pain-relieving” euthanasia is performed solely for the purpose of relieving pain. It is further broken down into six groups according to how the pain-relieving means is related to death. “Policy-oriented” euthanasia consists of the persons, to whom euthanasia is performed, who are not suffering from physical pain, and hence it is performed for the other purposes than the relief of physical pain.

B. Discussions

(1) Physical pain and spiritual pain

It seems very significant to me to emphasize the importance of the distinction between physical pain and spiritual pain. Euthanasia for the relief of physical pain must be ruled by the different principles from what apply to the other types of euthanasia.

Suppose here is an old man who is suffering from terminal and painful disease and miserably bedridden without any hope further to enjoy pleasure or gratification from life, wishing to die as soon as possible.

First of all, if the element of pain is taken away from this situation, why and for what purpose is euthanasia justifiable? Because he has the right to die with dignity? Because he cannot enjoy his life further? Because he is going to die sooner or later? Because he is wishing to die? Because he is imposing economical and physical burdens on his family or society? None of them will justify euthanasia by itself alone. If there is any rationale, perhaps it is because he is considered in all accounts to be no use in his living. But this standard “no use in living” is so vague that it

21) These expressions were borrowed from the article by J. Sanders, *Euthanasia: None Dare Call It Murder*, 60 J. Crim. L. C. & P. S. 351, 352 (1969).

will easily make a road to abuses. Whether he is suffering from physical pain or not is more objective standard.

Second, the differentiation of physical pain from spiritual pain has another meaning; that is, the spiritual pain is always possible to be eased by religion or love without resort to the last means of causing death.

Third, in the case of the euthanasia for spiritual pain never occurs the problem of pain-relieving means resulting in death, because to give narcotics is not a usually established practice to remove spiritual pain.

Thus the different principles as to purpose, necessity, and means must be established between pain-relieving euthanasia and the other types of euthanasia. It follows that even if a patient is suffering from terminal disease and miserably bedridden without any hope further to enjoy pleasure or gratification from life, wishing to die as soon as possible, euthanasia which is performed to this patient falls into "policy-oriented" euthanasia unless he is suffering from physical pain.

(2) Active euthanasia

What must be questioned next is then whether it is permissible to kill him at once for the purpose of relieving pain in the above-mentioned situation. The doctors who fall into the group E answered in the affirmative to this question; they supported "active euthanasia". I am afraid, however, their rationales on which they support this type of euthanasia are not persuasive. It is true that the standard of euthanasia becomes the more objective by the element of physical pain being added to the permissible conditions, and it is also true that the added element of physical pain intensifies the uselessness of a patient's life. But still I doubt whether a patient should be provided with the right to die. When a patient is going to die sooner or later from terminal disease, writhing in agony of physical pain and wishing to die, it is quite natural as a human being to say that his agony of pain must be alleviated or eased, but I do not think it is reasonable to say, "So, he has no meaning to live further and is entitled to be terminated at once by the hands of some others."

a. The right to die

In terms of the right to die one of the doctors asserted definitely that a man should have "a right to die as a basic human right". What is the nature of this right? Does this mean a doctor or any other person have a "duty" to terminate the person who claims his death under certain conditions? How is a doctor obliged to terminate a person under the specific situation? Through the contract between a doctor and a patient? Then if the doctor did not carry out this contract, would the patient, who *unfortunately* survived because of the doctor's breach of the contract, or the family of the deceased have a right to bring a suit for compensation? If not, would the doctors be imposed any sanction upon by a law? I can not imagine that this kind of right and duty will be introduced into our legal systems²²⁾. It is and will be merely an individual person's request at best.

b. Patient's request and "suicide type" euthanasia

"Should a doctor who complies with a patient's request to let him die and terminates him be punished as a murderer?" Under the present law this doctor is a common law murderer because a consent or a request of the patient is not a defense²³⁾. While in Japan we have a special provision²⁴⁾ as to "murder upon request,"²⁵⁾ which is punishable less severely than ordinary murder; hence the performer of euthanasia upon the request of a patient can avail himself of the benefit of this article, as we have seen an example in the case of *Government v. Yamauchi*. But since this article itself is not concerned with the reasons why the request is made and with what the motives of the actor are, the performer of euthanasia may be punished on the same principles which apply to the other actors of "murder upon request". The argument that all the murders on the ground of request should be excluded from criminal codes will not be accepted by

22) Silving, *op. cit.*, p. 378.

23) Williams, *op. cit.*, p. 319.

24) See footnote 3.

25) Silving's explanation on "murder upon request" of Japanese Criminal Code is not correct. In the old criminal code it contained the same provision as in the present code. See Silving, *op. cit.*, p. 377.

anybody²⁶⁾. Consequently even the sincere request of a patient does not immunize the doctor as a performer from the responsibility of murder.

Then does a patient have a right to commit suicide? Under the present law a doctor who furnishes poison (for example, an overdose of sleeping tablets) for the purpose of enabling the patient to commit suicide, again becomes guilty of murder as an abettor, if the patient takes the poison and dies.²⁷⁾ In Japan this doctor might be also punished under the same provision as murder upon request²⁸⁾. In Germany they have the special provision as to "murder upon request"²⁸⁾ but the accomplice in suicide is not punishable. But isn't it too technical if a doctor who injects poison to a patient suffering from cancer on the tongue and unable to eat anything is a murderer, while a doctor who brings a cup filled with poison to the lips of a patient capable of taking it, is only an accomplice in suicide and not punishable.²⁹⁾ At least in Germany "suicide type" euthanasia, which is also suggested by some of the doctors in Boston,³⁰⁾ is legally performed under the present law, but it does not cover all the cases which need the similar treatment. Moreover it seems to me that the attitude to try to solve the problem of euthanasia by the form of suicide is too easy and palliative. Euthanasia is to kill a person in its nature. Then it will be very dangerous to shift the problem of murder to that of suicide, because it makes us impossible to discuss openly and furnish the necessary safeguards against abuses. If euthanasia is required and necessary in the world, it must be pulled into the light and must be legalized under the necessary safeguards.

26) See Silving, *op. cit.*, p. 378.

27) Williams, *op. cit.*, p. 319.

28) Article 216 of German Penal Code provides as follows:

(1) Where a person has been induced to kill another by the express and earnest of the deceased, imprisonment for not less than three years shall be imposed.

(2) Where there are extenuating circumstances, the punishment shall be imprisonment for not less than six months.

(3) The attempt is punishable.

29) See the discussions developed by Engisch, *op. cit.*, pp. 11—12.

30) See page 58.

c. The motive

Does any special element attendant to the circumstances of euthanasia have the force to justify the performer's act? I mean by the special element the motive of the performer—mercy upon or sympathy for the patient's excruciating pain. H. Silving discussed well this problem of the actor's motive of providing euthanasia and concluded as follows:

"There is no evidence that the majority of the American people approve of euthanasia, but it is reasonable to assume that most people consider a killing motivated by mercy less reprehensible than killing for a base motive. Thus, a specific statutory reduction of penalty for mercy killing would seem to be the most appropriate solution."³¹⁾

The contention that the motive of actors should be introduced into criminal law is quite a correct attitude, because the basic principle of criminal responsibility is based upon the freedom to choose the alternative courses. If the patient's agony of pain is so strong that people in general are unbearable to watch him suffering, law can not expect a person to motivate himself to choose the other conduct. The stronger mercy or sympathy is, the less law expects a person to choose the other conduct. If law imposes sanction or punishment upon a person against what is considered moral by people in general, then criminal law will lose its underpinning force upon which criminal responsibility is based. In this sense Anglo-American criminal law ought to be reexamined because it does not allow for judges or jurors to take the motive of the accused into consideration in deciding his guilt or innocence of the crime in question. This is why in many cases, such as the Sander case, the Paget case³²⁾, etc., the jurors

31) Silving, *op. cit.* p. 388.

32) Miss Carol Paget shot his father, who had been suffering from cancer of the stomach and was indicted for second degree murder, but she was acquitted by reason of temporary insanity. *N. Y. Times*, Feb. 8, 1950, p. 1, col. 2.

Dr. Herman Sander injected ten c. c. of air intravenously four times, which resulted in the patient's death. But he was acquitted of murder on the ground that she had been already dead when he injected them. *N. Y. Times*, March 7, 1950, p. 1, col. 1.

could not help relying upon far-fetched grounds for the acquittal of the accused only to avoid the contradiction between generally recognized ethics and the strictness of law.

In Japan judges are authorized to exercise vast discretion for justification; hence the motive of an actor may be easily taken into consideration at least for mitigation. This may be one of the reasons why the movement for the legislation of euthanasia is not seen in Japan³³⁾. In almost every text book of criminal law in Japan active euthanasia is counted as one of the justifications as well as self-defence, necessity, etc. The scholars³⁴⁾ of criminal law generally support active euthanasia from the standpoint of mercy upon or sympathy for the terminal patient attended with excruciating pain.

It seems to me, however, it is a leap in argument to allow a doctor to terminate a patient at once on the ground of the motive of mercy or sympathy however deep it may be. Does this mercy or sympathy have the force to justify euthanasia even in the case where pain can be relieved or softened without resort to the means to kill the patient at once?

(3) Necessity Type Euthanasia

Let us return to the most basic question: Why is euthanasia needed? Because a patient suffering from terminal disease shall not writhe in the agony of pain. Then why do we need to kill him at once in all cases? As long as the patient's pain is relieved, the purpose is attained and there is no need for us to go beyond it. When there is still a room for the pain to be relieved or eased, we can not allow any person to terminate a patient on any grounds, can we? It is beyond the range of the necessity of euthanasia. The ground or the purpose why euthanasia is requested is not to

According to Joseph Sanders, *op. cit.*, p. 356, in the cases of euthanasia including both types, Moxon was convicted of murder; but Mohr and Repouolle were convicted lesser degree homicide; Paget, Braunsdorf and Waski were acquitted on the ground of insanity; Sander, Greenfield and Wener were acquitted on other grounds; and Johnson was not indicted.

33) In Japan there is not such an organization to promote euthanasia legislation as the Voluntary Euthanasia Legislation Society in England and as the Euthanasia Educational Fund in New York.

34) Professor Tadashi Uematsu supports active euthanasia from the standpoint of rational humanism ("On the Conditions of Euthanasia", *Juristo*, March 1st, 1963) and Professor S. Ono also supports active euthanasia from the standpoint of deep mercy of human being (Euthanasia, in *About the Nature of Punishment*, p. 210, 1955). There are many other scholars who support active euthanasia, and most of them follows Uematsu and Ono.

kill a parson but to relieve pain from a person. As long as pain is relieved, life must be maintained as long as possible even if he is sleeping or losing consciousness. There may be an argument that it is more humane to terminate a patient at once if he has to die sooner or later than to let him continue his meaningless, weak and irritating life in the state of drugged torpor. G. Williams says:

"There is likely to be more disagreement on whether a patient, provided he is saved from the extreme of pain, is to be required to continue an artificial, twilight existence, in a state of terrible weakness, and subject perhaps to nausea, giddiness, and extreme restlessness, as well as the long hours of consciousness of a hopeless condition. Most people, however, especially those who have seen a friend or relative in this desperate plight, will think that such an existence is not to be imposed on a person who wishes to end it."³⁵⁾

Perhaps many doctors in the Boston area who supported active euthanasia would share the opinion with Williams. But I am afraid Williams' attitude is too easy. First of all we have to recognize that it depends upon the way of understanding of the existence in a state of drugged torpor whether we should not approve of "policy-oriented" euthanasia, especially the extinction of not-worth-living people. If this meaningless, weak and almost unfunctional existence in the state of drugged torpor is allowed to be terminated, why can't we admit the extinction of other not-worth-living existences, who are in the similar situation? Isn't it a natural and logical conclusion therefrom? We have to recognize, however, that once the standard of pain is taken away and other standards such as "no use in living", spiritual pain, economical burden, the burden of family, etc. are introduced to legalize euthanasia, the euthanasia which is considered good at the starting point will easily be abused. We can not set other effective boundaries against abuses than "physical pain", which ought not to be stepped over.

35) Williams, *op. cit.*, p. 325.

Second, how many doctors (48% in Boston and 89% in Tokyo) answered that, administering narcotics or other drugs in order to relieve pain, they would at the same time continue to provide life-prolonging and/or curative treatments! How many doctors are warning how fallible their prognosis is!

Thus the problem euthanasia emerges only when the pain-relieving means is inevitably related to the causation of death. This is the final stage where we can not relieve pain without giving lethal dose. In other words ordinary amount of narcotics or drugs necessary for the relief of pain is considered at the same time as a lethal dose. There are two questions left to be answered: (1) Is there such a final stage in practice? and (2) Why is "necessity type" euthanasia justifiable?

Many doctors suggested, as I have already mentioned in the former section, that the concept of euthanasia is unnecessary because pain-relieving means never causes death.³⁶⁾ If the preposition that "pain-relieving means never causes death" in all cases is true and generally recognized in the field of medicine, I am ready to admit my "erroneous information" and willing to take the position that the concept of euthanasia is unnecessary.

G. Williams says that after one month later the amount of narcotics must be increased eighteen times as much as the first one to alleviate pain because of the patient's habituation to narcotics.³⁷⁾ If this is true a patient will encounter the final stage sooner or later. On the other hand there is another argument that judicious use of narcotics with other pain-relieving means may not cause death. There were many doctors in Boston who expressed the view to the effect that pain-relieving means might have a possibility of causing death as a side-effect, but that it would be well tolerated and not necessarily lead to death.

Perhaps logically speaking, there must be a "final stage" but in practice it may be considered as a "high probability" or a "calculated risk". Then how is this pain-relieving act assessed from the standpoint of criminal law?

36) Kamisar, op. cit., p. 1009.

37) Williams, op. cit., p. 323.

When death from the pain-relieving means is definitely anticipated, it is sure that the doctor's act falls into murder unless there is any justification. Even when death is not definitely anticipated, if the doctor administers narcotics or other drugs knowing the high probability of causing death,³⁸⁾ it is also sure that his act falls into murder but for justification.

Pain-relieving act itself belongs to the well-established practice of medical treatment if it does not cause death. When it causes death it is outside the range of medical treatment. But on the other hand "it could be extremely artificial to say that this last dose which is administered upon the same principle as all the previous one, is alone unlawful."³⁹⁾ There were some of the doctors who asserted that their excuses would rest upon the doctrine of "double effect". But this theory is too artificial, because "a doctor who gives an overdose of narcotic having in the forefront of his mind the aim of ending his patient's existence is guilty of sin, while a doctor who gives the same overdose in the same circumstances in order to relieve pain is not guilty of sin, provided that he keeps his mind steadily off the consequence which his professional training teaches him is inevitable, namely the death of his patient."⁴⁰⁾

The doctors give the lethal dose because it is the last means to relieve pain. This means the legal problem of euthanasia is not the problem as to whether a doctor can terminate a patient suffering from terminal and painful disease, but the problem as to whether there have been no other ways ordinarily applicable for the relief of pain in question than the administration of lethal dose, which is simultaneously minimum amount necessary for the relief of the pain. Then the doctrine of necessity in the common law will justify the doctor's act⁴¹⁾, that is the causation of death. The extremity of pain and the fact that the doctor's act is the only means left to

38) A. Levisohn, *Voluntary Mercy Deaths, Socio-Legal Aspects of Euthanasia*, 8 J. For. Med., No. 2, p. 64 (1961); Williams, *op. cit.*, p. 322.

39) Williams, *op. cit.*, p. 324.

40) *Ibid.*, p. 321.

41) *Ibid.*, p. 322.

relieve it—these two elements are essential to the application of the doctrine of necessity. For the judgement of the reasonableness (adequacy) of necessity under the circumstances of the particular case, the incurability of the disease, the imminence of death and the consent of the patient will be required. As to the element of the patient's consent, however, it seems to me implicit consent is also enough for the justification; namely the doctor can not act against the patient's explicit will. As to the consent of the family the same principle will be applied, too.

(4) "Omission type" Euthanasia

Lastly I have to refer to "omission type" euthanasia. As I mentioned in the former section, one doctor clearly showed how "omission type" euthanasia was performed. He keeps his patient in stupor by a large amount of analgesia and withdraws life-supporting forces even such as intravenous fluid; nevertheless he is strongly opposed to active euthanasia and even to "necessity type" euthanasia.⁴²⁾

But if a patient is placed into stupor to be killed by the withdrawal of life-supporting forces, where can we find the difference between this way of causing death and active euthanasia? If doctors who support "omission type" euthanasia generally believe that: though active euthanasia should not be allowed, this kind of omission should be allowed, it is nothing more than their own excuse and *placebo*.

The existence of pain is also essential to "omission type" euthanasia. So long as a patient is placed in stupor, he does not have any pain. His life must be maintained as long as possible. Only when life-prolonging measures are prolonging, providing or increasing a patient's pain without any other means to relieve it, "omission type" euthanasia, namely the withdrawal of life-supporting systems, should be allowed.

42) See Section V, G at 63.