Voluntary Active Euthanasia and the Nurse: A Comparison of Japan and Australia

Running title: Japanese nurses and euthanasia

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Abstract

Although euthanasia has been a pressing ethical and public issue, empirical data are lacking in Japan. We aimed to explore Japanese nurses' attitudes to patients' requests for euthanasia and to estimate the proportion of nurses who have taken active steps to hasten death. Thus, postal survey was conducted among all nurse members of the Japanese Association of Palliative Medicine between October and December 1999, using a self-administered questionnaire based on the questionnaire used in a previous survey on Australian nurses in 1991. The response rate was 68%. A total of 53% of the respondents had been asked by patients to hasten death, of whom none had taken active steps to bring about death. Only 23% regarded voluntary active euthanasia as ethically right, and 14% would practice it if it were legal. Comparison with empirical data shown in the previous Australian study suggests significantly more conservative attitudes among Japanese nurses.

Key words: active euthanasia, nurses, questionnaire, Japan

Introduction

Japan has a long history of practicing euthanasia (1). The Bioethics Council of the Japanese Medical Association suggested allowing euthanasia in very exceptional occasions on acknowledging current practices of euthanasia (2). There are two court rulings on active euthanasia in Japan. In the latest decision, which concurred with the previous 1962 Nagoya High Court decision, the Yokohama District Court determined in 1995 that there were four criteria for euthanasia; 1) the patient suffers from unbearable physical pain; 2) the death of the patient is unavoidable and imminent; 3) all possible palliative care has been given and no alternatives to alleviate the patient's suffering exist; and 4) the patient explicitly requests physicians to help him or her hasten their death (3). Since the criteria were declared, no euthanasia case has been reported. Japanese physicians cannot be certain as to whether or not they can practice voluntary active euthanasia (VAE) without being prosecuted as a murderer, because those court decisions were not made by the Supreme Court whose decision could be regarded as written law. On the other hand, the Japanese criminal law explicitly prohibits anyone to either assist suicide or killing others on their requests. Thus, uncertainty and ambiguity in the legality of practicing VAE still remain. The uncertainty about VAE has been intensified because of the lack of information regarding VAE in Japan. Although one study reported that 20% of nurses thought that active euthanasia was permissible under certain circumstances (4), little is known about Japanese nurses' attitudes toward the ethics and legality of VAE. To the best of our knowledge, no study has ever asked them about their experiences of complying with or refusing patients' requests to directly hasten death. Neither do we know to what extent religion or law influences Japanese nurses' attitudes or practices. Therefore, we conducted a questionnaire survey of Japanese nurses in these regards. The forms of euthanasia in this study are characterized on the basis of the act of the health care professional (active or passive) and request by the patient (voluntary, non-voluntary and involuntary) (5). In our survey, we used a modified version of comprehensive questionnaire about VAE developed by Kuhse and

Singer and used in Victoria in 1987 (6); amended questionnaires have since been used in two other surveys conducted in Australia (7,8). Use of the questionnaire would enable us to compare Japanese nurses' attitudes toward and experiences of VAE with those of Australian nurses reported in the past (8). In this paper, therefore, we present a comparison between the two countries as well as the results provided by a survey on Japanese nurses.

Methods and Designs

Questionnaire: An original English questionnaire developed by Kuhse and Singer was first translated into Japanese by the Japanese authors and a native English speaker living in Japan translated it again into English. The back-translated English questionnaire was reviewed by one of the original authors (Kuhse H) and evaluated. According to suggestions made by the original author, the Japanese questionnaire was modified and finalized.

Thus, the Japanese questionnaire consisted of 22 items including questions about background profiles of respondents. We asked our subjects about their attitudes toward and experiences of VAE with the subjects' personal and professional background placed first. The essential parts of the questions are listed in Table 1. In certain questions, concise sentences were added to explain the definition and meaning of terms such as euthanasia and VAE. In the question regarding the Dutch experience, legal situation and practice of VAE in the Netherlands was introduced including the criteria of the Royal Dutch Medical Association for permission of VAE. Confidentiality was vital in such a study dealing with legal and ethical issues. Thus, the questionnaire was undertaken with a method to assure confidentiality to respondents in such a way that the researchers would separate the outer envelope from the inner anonymous envelope on arrival of replies. Accordingly, even the researchers could not breach the anonymity of respondents.

Subjects: A postal survey was conducted between October and December 1999. An initial mailing was sent to all 244 nurses listed in the members list (published in 1996) of the Japanese Association of Palliative Medicine. After 4 weeks, a reminder card was sent to all subjects. Twenty-seven were still undelivered, which made the effective number of 217 for this study.

Statistical analysis: The chi-square test was used to test differences in proportions among independent categorical variables. A p value of less than 0.05 was considered significant.

Results

A total of 145 nurses returned a completed questionnaire (response rate, 68%). Characteristics of responding nurses as well as respondents in the previous survey conducted in Australia using the same questions are shown in Table 2. Japanese respondents were significantly less religious than their Australian counterparts. Nursing experiences were the same between the two groups.

Table 3 shows comparison of answers in the affirmative to questions regarding VAE among nurses surveyed in Japan and Australia. In terms of attitudes towards VAE, our respondents were significantly less affirmative of VAE than their Australian counterparts in answering most questions. Compared to Australian respondents, Japanese tended to discuss what should be done with the patient's relatives more often, and religious counselors were considered less often. The frequency with which Japanese respondents were asked to hasten death was not different from that in Australia. But the number of nurses who felt the patient's request was rational was significantly smaller in Japan than in Australia. In response to the hypothetical question, only 14% of Japanese nurses would practice VAE if it were legal, a significantly smaller number compared

with their Australian counterparts. The illegality of VAE affected the decision of the majority of Japanese nurses.

The majority of our respondents (85%) answered that their view regarding the morality of VAE is based primarily on secular ethical views while only 3% based their view on ethical views derived from religious belief. Particular illnesses that might prompt patients to ask to hasten their death were identified by 56 % of our respondents. One of the questions asked the respondents to rank several different reasons why they were asked to hasten death. "Persistent and irreversible pain (57%)" was ranked first most often, followed by "Terminal illness (20%)," and "Incurable condition (20%)." "Not wanting to be a burden on others (8%)," "Being afraid of a slow decline whilst dying (7%)," and "Infirmities of old age (1%)" followed. "Persistent and irreversible pain" was ranked first more frequently than their Australian counterparts. Age and religion were not related to the attitudes of our respondents.

As for experiences or practicing VAE (Table 4), entirely different behavior of Japanese nurses as compared to their Australian counterparts was evident: none of the Japanese nurses answered that they had complied with a patient's request to directly hasten their death and none had witnessed other nurses practicing it.

Discussion

The ethics of voluntary active euthanasia (VAE) is one of the most controversial issues in clinical settings. Prohibitions of assistance to patient's death have long been cardinal in professional medical ethics since the implementation of Hippocratic medical morality (9). Medical professionals are concerned that the act of VAE undermines the core moral commitment of medicine and the trust between patients and medical professionals. Bioethicists, health care workers, and laypersons disagree as to the ethical legitimacy of VAE. And debates continue with a wide range of discordant opinions about the moral distinction between VAE and the act of forgoing life-sustaining

treatments, the validity of the doctrine of double effect, and slippery slope arguments suggesting that legally permitting VAE would lead to ethically unacceptable killing such as non-voluntary active euthanasia. Whether or not individual autonomy can justify VE, and whether or not patient's subjective quality of life judgments that continuing life is intolerable should override religious and non-religious beliefs about the sanctity of life have not been resolved (5,9). However, circumstances surrounding euthanasia are gradually changing and there are now some exceptions. For instance, physicians can openly practice VAE in a certain situation in Netherlands (10) where legislation to permit that practice has been completed; physicians can legally prescribe a lethal dose of drugs to terminally ill patients who desire to terminate their own lives in the state of Oregon in the US (11). Between July 24, 1996 and March 25, 1997, the Northern Territory, Australia was the first place in the world where practicing VAE was legalized under the Rights of the Terminally Ill Act (12).

Nurses working in critical care and/or terminal care frequently encounter the request for euthanasia by the patient and family. We believe that the members of the association we targeted were the most appropriate subjects to ask questions about VAE because they were likely to care for more terminally or incurably ill patients than any other nurses in Japan. It has been reported that some nurses in Western countries have complied with such requests (8,13). The present study was intended to disclose the situation of Japanese nurses' attitudes and experiences of VAE. Although the response rate was lower than 70% and our results cannot avoid non-respondent bias like most questionnaire surveys, affirmative figure toward VAE of some 20% was very similar to the previous results (4,14). These consistent figures seem to suggest the reliability of the present study. When comparing our results to the previous Australian study (8), there exists a time lag and differences in sampling and sample size. More importantly, there are differences in the social context in terms of views of life and death, religion and the autonomy principle, so on. Furthermore, at the time of this survey, Japanese nurses were placed under tight supervision by the doctor in the context of the Health

nurse/Midwife/Nurse Law. Australian nurses could act more independently than Japanese counterparts, although Australian nurses too had to follow doctor's orders from historical doctor/nurse relationship (but not by law). Our respondents were working at the terminal setting, whereas Australian nurses were those practicing in one particular state. We need to see these differences between the two groups of nurses. However, we think it is still worthwhile to compare the two groups to give more insight into the cross-cultural difference in nursing practice.

The present results show that requests for voluntary euthanasia are frequently made to nurses who practice palliative care or oncology in which they are likely to care for many dying patients. A sizable proportion of Japanese nurses, approximately half of our respondents, have been asked by patients for assistance to hasten death. This proportion is almost the same as the result in the Australian study (8). The top three reasons that patients ask to hasten death are also the same as those of Australian patients. It seems that the desires of patients suffering terminal or incurable illness are not significantly different from one another. The finding that "Persistent and irreversible pain" was ranked first more frequently than Australian nurses was presumably because of their experiences in insufficient pain control among Japanese cancer patients (15). The second finding was a negative attitude of our respondents towards the acceptance of VAE. Just over 20% of Japanese nurses think that VAE is acceptable under certain circumstances. This rate is much lower than that found in their Western counterparts, of whom 44 to 75% showed affirmative attitudes toward VAE (8,16). Regarding the practice of VAE: none of our respondents had taken active steps to bring about the death of a patient who asked them to do so. Furthermore, only 14% of them answered that they would practice VAE if it were legal. Such rates are significantly lower than those presented in the previous Australian study (8).

We think that it is worthwhile to deliberate what makes Japanese nurses significantly more reluctant to comply with a patient's wishes to hasten death. It is unlikely that Japanese nurses disregard a patient's desire to hasten death as always

merely temporal and not authentic, unreliable, or byproducts of a depressive mental state, because 85% of them answered that a desire for voluntary euthanasia can sometimes be rational. However, it should be pointed out that a significantly greater number of Japanese nurses disregarded the patient's desire as irrational than the Australian nurses (8). Such a nurses' attitude is probably in part derived from the Japanese tradition of not attaching importance to verbal expression (17). The illegality of VAE in current Japan could also not explain it because only 14% of our respondents would practice VAE if it were legal, and the proportion is significantly lower than that of Australian counterparts (8). For more than half of them, the illegality of VAE seems not a primary issue when they refused it. Moral beliefs derived from religions are probably not a primary factor that prevents them from performing VAE either: only 3% of our respondents answered that their overriding a patient's request for VAE was based on ethical views derived from religious belief. Although we did not ask our respondents directly, the respondents might have esteemed secular moral and ethical views derived from sanctity of life. They might object to VAE morally and ethically even if it were legalized.

It could be speculated that factors other than those discussed above play a major role in the moralities and behaviors of Japanese nurses. Our current study cannot tell what it is and more empirical studies focusing on nurses' ethical beliefs will be needed to adequately address this issue. It can be argued, however, that rather complicated trilateral relations among the physician and the nurse, the patient's family and the patient have played significant roles in medical decision-making and practice in the end-of-life care in Japanese clinical settings (15,18,19). Japanese nurses are rarely engaged in directly administering medication or operating medical devises. Treatment plans are usually determined solely by doctors and it is very rare for nurses to make independent medical decisions, where nursing is often considered subordinate to medicine (18,19). In this rigid hierarchy, Japanese nurses are placed in a difficult middle position between the patient and doctor, and the patient and family (15). Recent data

suggest that Japanese physicians still tend to treat terminally ill patients aggressively even if the patients explicitly desire otherwise (20). Considering that Japanese nurses are obedient to physicians and rarely question orders, it might not be unreasonable to hypothesize that Japanese nurses may think that they are meeting their professional obligations by aggressively prolonging life, in accordance with the doctor's and the family's wishes. It might also be argued that the Japanese way of thinking -what everybody does is right and what nobody does is wrong (3)- contributed significantly to the nurses' attitudes and experiences; they do not dare to be at the head of any action, even though court rulings and the Japan Medical Association favor euthanasia under certain circumstances (2,3). These speculations raise an important issue in nursing practice: can nurses practice VAE if it were legalized? The fact that only the doctor is allowed to practice VAE in countries where it is or was legalized suggests that this issue will bring out a fundamental issue of the nurse's role in the health care system, which is beyond the scope of this article.

In conclusion, this paper presented the view and practice of Japanese nurses who are involved in palliative care and cancer treatment. Although a sizable proportion of Japanese nurses have been asked by patients for assistance to hasten death, none has complied with such a request. It is mandatory for Japanese health care workers to deliberate and practice better palliative care and to rethink the implication of legal prohibitions of VAE for the welfare of terminally or incurably ill patients.

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Table 1. Questions regarding voluntary active euthanasia

1. Has any patient under your care expressed a desire to hasten his or her death, either by interrupting treatment or by taking active measures?

2. What was the reason your patient asked you to hasten his or her death?

3. Were patients with certain conditions or diseases (cancer or AIDS, for instance) more likely to wish their death to be hastened? If you noticed such a tendency, please write the specific condition or disease.

4. When a patient asks you to hasten his or her death, would you consult with the following people (examples were given) as to how to deal with the case?

5. In your experience, have you ever thought a patient's request to have his or her death hastened was reasonable?

6. In Holland at present, a doctor is in practice allowed to terminate a patient's life when the following conditions are met (criteria were shown here). Do you think that, if the above conditions are met, it should not be considered a crime for a doctor in this country to perform active euthanasia, as is the case in Holland?

7. The Royal Dutch Medical Association thinks it is appropriate for a doctor to practice active euthanasia when the above-mentioned conditions are met. Do you think this country's most authoritative associations should allow it?

8. Do you think this country's law should be changed to allow active euthanasia by a doctor under certain conditions?

9. If the law allowed it, would you perform active euthanasia?

10. Have any patients in your care ever asked you to take direct measures to terminate their life?

11. Have you ever, at the patient's request and without the doctor's orders, taken direct, active measures to terminate the life of a patient under your care?

12. How many times have you, at the patient's request and without the doctor's orders, taken direct, active measures to terminate the life of a patient under your care?

13. Do you feel that you did the right thing when you, at the patient's request and without the doctor's orders, took direct, active measure to terminate the life of a patient under your care?

14. To your knowledge, have other nurses, at the patient's request and without the doctor's orders, taken direct, active measures to terminate the life of a patient under their care?

15. We would like to ask your reasons for refusing the patient's request to take direct, active measures to terminate his or her life. How much did the fact that "active euthanasia is against the law in this country" influence your decision not to perform active euthanasia?

16. Do you think it is sometimes right to take direct, active measures to terminate a patient's life at his or her request?

17. On which of the following is your answer to above question mainly based?

Table 2 Characteristics of the responding nurses in Japan and Australia

		Japan	Australia	
Number		145	943	
Response rate		68%	49%	
Sex	Female	95%	94%	
	Male	3%	6%	
Age (Mean +/-SD)		43 +/- 9	NA*	
	Less than 30	7%		
	30 – 39	36%	nearly 40%	
	40 – 49	31%	25%	
	50 – 59	24%		
	60 and over	2%		
Religious		21%	79%	p<0.0001
Experience in treating patients who are older than 12 years old with a terminal illness or untreatable disease?		98%	98%	

*NA; not available, but the age distribution appeared to be the same between the two groups as assessed from the proportions of their predominant age groups.

Table 3. Comparison of answers in the affirmative to questions relating to voluntary active euthanasia (VAE)

% of yes (95% confidence interval)

For all respondents	Japan (145)	Australia (943)	
Do other nurses sometimes practice VAE?	0	NA*	
Is VAE sometimes right?	23 (16-30)	NA*	
Should the Netherlands situation be introduced here?	21 (15-28)	75 (72 - 78)	p<0.0001
Should medical organizations approve VAE?	15 (9-21)	NA*	
Should the law be changed to allow VAE?	14 (8-19)	78 (75 - 81)	p<0.0001
Would you practice VAE if it were legal?	14 (8-19)	65 (62 - 68)	p<0.0001
Has a patient ever asked you to hasten his or her death?	53 (45-61)	55 (52 - 58)	
Of those who have been asked to hasten death	Japan (75)	Australia (502)	
Why were you asked to hasten death?			
Persistent and unrelievable pain	57 (46 – 69)	33 (29 – 37)	p<0.0001
Terminal illness	20 (11 – 29)	14 (11 – 17)	
If a patient asks you to hasten his or her death, do you discuss what should be done with:			
A colleague?	93 (88-99)	92 (90 - 94)	
Other medical staff?	95 (90-100)	90 (87 - 93)	
A family member, relative or very close friend of the patient?	93 (88-99)	68 (64 - 72)	p<0.0001
A religious counselor?	28 (18-38)	44 (40 - 48)	p=0.0087
Can patient's asking to hasten his or her death sometimes be rational?	85 (77-93)	95 (93 - 97)	p=0.0012

Table 4. Comparison of answers in the affirmative to questions relating to practice of voluntary active euthanasia (VAE)
% of yes (95% confidence interval)

	Japan (41)	Australia (333)
Have you ever taken active steps to bring about the death of a patient who asked you to do so? (without having been asked by a doctor to do so)	0	5 (3-7)
	Japan (0)	**Australia (16)**
If yes, has it happened more than once?	0	63 (39-86)
If yes, do you still feel you did the right thing?	0	100
	Japan (41)	**Victoria (317)**
If no, did you reject the patient's request of voluntary active euthanasia due to illegality of the action?	61 (46-76)	NA*