WHEN BODY IS SOUL: THE PROPOSED JAPANESE BILL ON ORGAN TRANSPLANTATIONS FROM BRAIN-DEAD DONORS

David Forster

Abstract: Organ transplantations from brain-dead donors have been de facto prohibited in Japan since 1968. Buddhism, Shintoism, the Japanese concept of personhood, Japanese medical and hospital practices, the police, and the Patient's Rights Conference have all contributed to this situation. However, consensus has been growing in Japanese society and government that these operations should be legalized. The Diet began considering a proposed bill to this end on April 12, 1994. This comment argues that the bill ought to be passed. If passed, this bill will save the lives of many Japanese, it will end the difficulties Japanese currently encounter going overseas for organ transplantations, and it will end the possibility of Japan acquiring an unfavorable international reputation for taking from the international organ pool but not contributing to it.

I. INTRODUCTION

The medical and legal communities of the majority of industrialized nations accept the brain-death standard for establishing death.\(^1\) In Japan, however, there has been an ongoing debate over the subject, both in the medical and legal communities and in society at large. This debate has caused Japan to be one of the few industrialized countries that do not perform organ transplantations\(^2\) from brain-dead donors.\(^3\) On April 12, 1994, the Japanese Diet began considering a bill which will allow these operations to take place.\(^4\) This proposed bill legalizes the brain-death standard as a criterion for determining death in cases where organ transplantations from brain-dead donors are possible.\(^5\) In order to fulfill this purpose, the bill ad-

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2 The noun “transplantation” refers to the grafting of tissues or organs from one human to another. The noun “transplant” refers to the tissue or organ used in transplantation. TABER'S CYCLOPEDIC MEDICAL DICTIONARY 2026 (Clayton Thomas ed. 1993).
3 Michael C. Brannigan, A Chronicle of Organ Transplant Progress in Japan, 5 TRANSPLANT INT'L 180, 180 (1992). Israel is often mentioned as the other industrialized nation which does not accept the brain death standard. See, e.g., Brain-Death Consensus Must Be Reached, JAPAN TIMES, Apr. 17, 1994, at 16.
dresses many of the cultural and societal reasons which originally led to the disapproval of organ transplantations from brain-dead donors.

This comment has two major sections. The background section presents the reasons behind the disapproval of these operations in Japan since 1968 and the gradual change in public sentiment towards accepting them. The analysis section has two parts. First, it recommends that the Japanese Diet pass the proposed bill despite recent political turmoil. Passing the bill will save lives by allowing more Japanese to receive organ transplants, and will also end the problems arising from the fact that Japanese citizens must currently seek transplantations in foreign countries. Second, the analysis reviews the necessary features which the proposed bill does include, and also discusses certain features which the final bill should include.

The debate on organ transplantation is often conducted in very abstract and unemotional language even though it concerns death, one of the most difficult and emotional phenomenons of human existence. To the family member or nurse left to wash and prepare the body after the surgeon has removed the organs, abstract language supporting organ transplantation may sound very heartless. This dark side of brain death and organ transplantation has received much attention in Japan, and it should not be ignored. Both the death of the donor and the extended life of the recipient should be considered in philosophical and legal discussions of organ transplantation.

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6 Because of the current political turmoil in the Japanese Diet, political commentators believe it is unlikely the bill will pass by the Fall of 1994. Brain-Death Consensus Must Be Reached, supra note 3, at 16; Japan: Organ Transplant Debate Moves into Political Arena, Reuters, Apr. 18, 1994, available in LEXIS, News Library, Allwld File.


8 S.J. Younger, Organ Retrieval: Can We Ignore the Dark Side?, 22(3) TRANSPLANTATION PROC. 1014, 1015 (1990).

9 Id. at 1014.
II. BACKGROUND

A. Medical Description of Brain Death

To understand the legal and cultural issues surrounding brain death, an exploration of the medical definition of brain death is necessary. Before the 1960s, the cessation of breathing and the stopping of the heart were the accepted medical criteria for establishing death.\(^\text{1}\) In the 1960's, however, it became possible to use a respirator to sustain the heartbeat and breathing of a person even when the brain could no longer maintain these functions.\(^\text{12}\) As a result, medical practitioners developed the "brain criteria for death," or "brain death standard," as it is commonly known.\(^\text{13}\) Where the brain-death standard has been accepted, the doctor can use either the brain-death criteria or the cardiac-death criteria to establish that a person has died.\(^\text{14}\)

Brain death occurs when there is massive damage to the brain which destroys the brain's ability to regulate the respiratory function.\(^\text{15}\) The three most frequent causes of the irreversible damage leading to brain death are (1) direct trauma to the head, (2) massive hemorrhaging into the brain from an aneurysm, and (3) the lack of sufficient oxygen to the brain because of cardiac or respiratory arrest.\(^\text{16}\) Before the invention of the artificial respirator, cardiac death occurred soon after the brain suffered massive damage because the respiratory system no longer supplied oxygen to the heart.\(^\text{17}\) However, with artificial respirators and additional medical devices doctors can now maintain a patient's respiration and heartbeat even when the brain cannot do so.\(^\text{18}\)

"Brain death" in this comment refers to the whole-brain death standard, which has been adopted in Japan by the Japanese Medical

\(^{10}\) The term "brain criteria for death" is much more accurate than "brain death" or "the brain death standard." However, this comment uses the two latter terms because they are more common.


\(^{12}\) Albert Jonsen et al., Clinical Ethics 20 (1992).

\(^{13}\) Id. at 20-21.


\(^{15}\) Id. at 15.

\(^{16}\) Id. at 16.

\(^{17}\) Id. at 15.

\(^{18}\) Id. at 15-16.
Association\textsuperscript{19} and in America by the President's Commission on Defining Death.\textsuperscript{20} The human brain has three general anatomical divisions: The cerebrum, or higher brain; the cerebellum, or midbrain; and the brain stem, or lower brain.\textsuperscript{21} The higher brain controls consciousness, feeling, memory, and thought.\textsuperscript{22} The lower brain controls spontaneous functions such as respiration, yawning, and swallowing.\textsuperscript{23} Under the whole-brain death standard, death occurs when the functions of the higher brain, the midbrain, and the lower brain are all irretrievably lost.\textsuperscript{24} The patient is then permanently unconscious and the brain can no longer maintain respiration and a heartbeat.\textsuperscript{25} Only an artificial respirator can maintain these functions.\textsuperscript{26}

The general criteria doctors use in America to determine if a patient is brain dead were presented by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death.\textsuperscript{27} The Committee report listed three criteria necessary for establishing brain death: Unreceptivity and unresponsivity, absence of movements or breathing, and lack of reflexes.\textsuperscript{28}

The first criterion, unreceptivity and unresponsivity, is established when the patient shows a total unawareness of externally applied stimuli.\textsuperscript{29} The patient is unaware of the need to eat or to release waste, and exhibits no response even to intensely painful stimuli.\textsuperscript{30}

The second criterion is the absence of movements or breathing.\textsuperscript{31} All spontaneous and reflexive muscular movement is absent.\textsuperscript{32} It is established when the patient does not physically respond to stimuli such as pain, touch,

\begin{itemize}
\item \textsuperscript{19} Rihito Kimura, \textit{Anencephalic Organ Donation: A Japanese Case}, 14 J. MED. \& PHIL. 97, 100 (1989).
\item \textsuperscript{20} DEFINING DEATH, supra note 11, at 36.
\item \textsuperscript{21} Id. at 15.
\item \textsuperscript{22} Id.
\item \textsuperscript{23} Id.
\item \textsuperscript{24} See id. at 15-16, 32-38.
\item \textsuperscript{25} See id. at 15-16.
\item \textsuperscript{26} See id.
\item \textsuperscript{27} These criteria are presented in H.K. Beecher, \textit{A Definition of Irreversible Coma. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death}, 205 J: AMERICAN MED. ASS'N. 337 (1968).
\item \textsuperscript{28} Id. at 337-38; see DEFINING DEATH, supra note 11, at 25; see WALKER, supra note 1, at 168.
\item \textsuperscript{29} Beecher, supra note 27, at 337.
\item \textsuperscript{30} Id.
\item \textsuperscript{31} Id.
\item \textsuperscript{32} Id.
\end{itemize}
sound, or light. Apnea, the lack of spontaneous respiration, is present, necessitating the use of a respirator.

The third criterion is the lack of reflexes. This refers especially to cephalic reflexes, which are those mediated by the cranial nerves and brainstem. Indications of absent reflexes include fixed, dilated pupils which do not respond to a direct source of light and the lack of blinking or other movement in the eyes when the head is turned or ice water is placed in the ear.

Each of the three criteria must be present for the doctor to declare the patient brain dead. When these criteria are established through proper tests, they provide a very accurate diagnosis. As of 1981, no one had found a case in which these criteria were met and the patient later regained any brain functions.

In addition to the requirements above, the report recommends that an electroencephalogram (EEG) reading be flat (isoelectric), showing that there is no discernible electrical activity in the cerebral cortex. These tests should be repeated 24 hours after the first tests were performed for the patient to be declared dead. Also, the physician should exclude any patients in whom hypothermia or drug intoxication is possible before applying these criteria. Hypothermia and drug intoxication can create a recoverable condition indiscernible from brain death.

Brain death is different from a persistent vegetative state, in which the patient is in a coma but maintains respiration and a heart beat without mechanical aid. Under the brain-death standard as established by the Harvard Committee, a patient in a persistent vegetative state is alive.
It bears re-emphasizing that when a country or hospital adopts the brain death standard, it is added to the cardiac standard, so that death is established by the occurrence of either cardiac death or brain death. As a medical standard, with the technology available today, this is an easy addition for doctors to make. However, death is a social phenomenon as well as a medical phenomenon, and the social transition to including brain death as actual death can be difficult. A brain-dead patient is warm, her chest is moving, and she appears “alive,” especially to the eye of the lay observer. These differences between a brain-dead body and a cardiac-dead body are the cause of much of the controversy about brain death in Japan.

The distinction between the brain-death standard and the cardiac-death standard is important for organ transplantation. The heart, the pancreas, and the lungs can only be taken from a brain-dead donor. Upon cardiac death, these organs begin to suffer cellular deterioration due to lack of oxygen and therefore are not transplantable.

Until recently, liver transplantations also required a brain-dead donor. However, in 1993, Japanese doctors transplanted a liver from a brain-dead donor just after he suffered heart failure. Therefore, the donor was technically cardiac dead. Whether the operation can be considered a success is questionable, however, because the recipient died after seventy-nine days.

Corneas can be taken from both brain-dead and cardiac-dead donors. Kidneys are the most easily and the most commonly transplanted interior organ. Kidneys can be taken from brain-dead donors or cardiac-dead

higher-brain criteria for death, see generally DEFINING DEATH, supra note 11, at 38-41. See also John P. Lizza, Persons and Death: What's Metaphysically Wrong with Our Current Statutory Definition of Death?, 18 J. MED. & PHIL. 351 (1993) (arguing for adoption of the higher-brain criteria for death).

46 UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. (Supp. 1993); see also DEFINING DEATH, supra note 11, at 38.

47 Id. at 83.


49 Id.


51 Brannigan, supra note 3, at 185.

donors. They can also be taken from live donors, because there are two kidneys and only one is necessary for survival.

B. The Current Need for Organ Transplantation in Japan

The exact number of Japanese needing organ transplantations is difficult to estimate. By one account, in 1985 there were 1,000 potential heart recipients in Japan. Also, it is estimated that 1,500 patients a year need liver transplants. Of the patients on kidney dialysis in 1984, 11,895 were registered on the waiting list for kidneys. These numbers demonstrate that allowing organ transplantations from brain-dead donors would save lives. Passage of the bill being considered in the Diet would permit heart, liver, lung, and pancreas transplantations, and would increase the number of available kidneys.

A 1993 waiting list for liver transplants provides a good illustration of the organ transplantation situation in Japan. Seventy-eight people were on this waiting list. As of June 1993, twenty-two of them (30%) had already died. Eleven (14%) went overseas to receive livers from brain-dead donors. Twelve underwent partial liver transplants from living-donor relatives. One recovered; one was removed from the list. Thirty-one (40%) were still waiting for a liver transplant, but unless a relative donated a partial liver it is unlikely they received one. As a result, these individuals have probably died or will die soon.

The moratorium on organ transplantations from brain-dead donors has forced many Japanese to go overseas to seek these operations in foreign

54 See id.
59 Researchers: 30% die waiting for liver transplant, supra note 57.
60 Id.
61 Id.
62 Id.
63 Id.
countries. Only wealthy Japanese can afford to do this. Exact figures are difficult to obtain, allegedly because the Japan Transplant Society and other organizations want to avoid any controversy.\textsuperscript{64} Yet, as of April 1990, at least four Japanese are recorded as having received heart transplantations overseas.\textsuperscript{65} The actual number may be much higher. An organization has recently been established which helps Japanese going abroad for heart transplantations with the problems they encounter, such as the language barrier.\textsuperscript{66} Also, at least fifty Japanese have received liver transplantations overseas.\textsuperscript{67} In the first two months of 1994, one Japanese man received a liver transplantation in Sweden,\textsuperscript{68} and another received a lung transplantation in America.\textsuperscript{69}

The majority of organ transplantations performed to date in Japan were kidney transplantations from cardiac-dead or live donors.\textsuperscript{70} From 1964 to 1988, doctors in Japan transplanted 6,176 kidneys.\textsuperscript{71} 4,630 (approximately 70\%) of these kidneys came from living related donors. Parents donated 3,532, siblings donated 932, and other relatives donated 66. Only 100 came from unrelated living donors.\textsuperscript{72} The remaining 1,526 (approximately 30\%) of the kidneys were removed from cardiac-dead donors.\textsuperscript{73} The number of Japanese kidney donations from cardiac-dead donors is low by international standards.\textsuperscript{74} In 1990, Japanese donations numbered 2.1 per one million population, whereas in European countries they numbered from 28 to 57.6 per one million population.\textsuperscript{75} On average,

\textsuperscript{64} Irene Kunii, \textit{Japan Mulls Brain Death Definition for Transplant Donors}, Reuters, Apr. 9, 1990, \textit{available in LEXIS}, News Library, Allwld File. The author of this comment also found it very difficult to obtain the numbers of foreign nationals who have come to America for transplantations. The information is kept by separate transplantation centers, and if it has been compiled by the United Network for Organ Sharing (UNOS), this organization does not release it.

\textsuperscript{65} \textit{Id.}


\textsuperscript{67} Kunii, \textit{supra} note 64.


\textsuperscript{70} See Y. Iwasaki et al., \textit{supra} note 58, at 963.

\textsuperscript{71} \textit{Id.}

\textsuperscript{72} \textit{Id.}

\textsuperscript{73} Motoshi Takao, \textit{Brain-death and Transplantation in Japan}, 340 THE LANCET 1164 (1992); Iwasaki et al., \textit{supra} note 58, at 963.

\textsuperscript{74} \textit{Takao, supra} note 73.

\textsuperscript{75} \textit{Id.}
only 200 kidney transplants from cardiac-dead donors are performed per year in Japan.76

There remains a large unmet need for kidney donation in Japan. As of 1988, there were 88,534 persons undergoing dialysis in Japan.77 Although Japan has the capacity to maintain more than 100,000 patients on its 35,000 dialysis machines,78 with kidney transplantations these patients could be free of the need for dialysis.

C. Legal Issues Involving Brain Death and Organ Transplantation in Japan

The Diet should pass the proposed bill on organ transplantation because it will save lives. The current legal situation prevents doctors from performing these operations from brain-dead donors even though they are not explicitly illegal. This paradoxical legal situation arises from a combination of four factors: (1) Statutory law, (2) the political actions of the Patient's Rights Conference, (3) police and government policies, and (4) criminal law cases. Only transplantations of the kidney and cornea are explicitly legal under Japanese statutory law, pursuant to the Act Concerning the Transplantation of Cornea and Kidneys.79 The law is currently silent on organ transplantations which require a brain-dead donor, such as heart, liver (complete), lung, and pancreas transplantations.80 These transplantations are de facto prohibited, however, because the police refuse to declare potential brain-dead donors legally dead.81 Therefore, a doctor performing a transplantation from a brain-dead donor faces the possibility of criminal charges.82

Only two statutes concerning organ transplantation have been passed in Japan.83 The first, An Act Relating to Cornea Transplants, was passed in 1957 and involved only cornea transplantation.84 This Act allowed cornea

76 Iwasaki et al., supra note 58, at 963.
77 Id.
78 Id.
80 See Brannigan, supra note 3, at 182.
82 Japanese Transplant Patient Dies 79 Days after Operation, supra note 50.
83 Brannigan, supra note 3, at 180.
84 Id. This was replaced by the Kidney Transplant Act of 1979, see supra note 79.
transplantations under two conditions: (1) The donor's family had to consent to the cornea removal, and (2) doctors had to have already chosen a specific recipient.85 In 1979, this Act was amended to include kidney transplants as An Act Concerning the Transplantation of Cornea and Kidneys.86 This Act still held that the donor's family must agree to the organ removal, but dropped the requirement that there had to be a specific recipient.87

Commentators disagree on whether transplantations from brain-dead donors are legal in Japan.88 Statements range from "[t]here is no legal reason organ transplants could not be carried out if proper medical procedures were carried out"89 to "[n]ot only is there an absence of brain-death legislation, but heart and liver transplants are strictly prohibited."90 The situation actually seems to be one of legal limbo and de facto prohibition. There are no laws addressing either the brain-death standard or the transplantation of any organs other than kidneys and corneas. Therefore, transplantations from brain-dead donors are not by law illegal. On the other hand, neither is there any law supporting the brain-death standard nor transplantations from brain-dead donors.

An important factor in the de facto prohibition on organ transplantations is the Patient's Rights Conference.91 A group of doctors, mostly from Tokyo University Hospital, formed the Conference in 1983.92 The goal of the Conference is to protect the rights of patients in all fields of medicine, but most of its energy has been focused on its adamant opposition to transplantations from brain-dead donors.93 The Conference position is that the rights of both donors and recipients are unacceptably endangered by these operations for several reasons. First, the members fear that overzealous transplant surgeons may not provide donors and recipients with medically indicated treatment in the interest of performing an organ transplantation.94 Second, they fear that doctors might declare the donor brain dead prema-

85 Brannigan, supra note 3, at 180.
86 Kidney Transplant Act of 1979, supra note 79.
87 Id.
89 Ichiro, supra note 88, at 55.
90 Brannigan, supra note 3, at 180.
91 See generally KATSUNORI HONDA & HYROYUKI ANDOH, BRAIN DEATH AND PATIENT RIGHTS (1986).
92 Id. at 1; Brannigan, supra note 3, at 182-83.
93 HONDA & ANDOH, supra note 91, at 9.
94 See, e.g., Brannigan, supra note 3, at 183.
turely or without sufficiently establishing the presence of brain death.\(^9\)

Third, they worry that the doctors may not properly obtain the informed consent of both the donors and recipients.\(^9\) The Conference, together with various prosecutors,\(^9\) advocates legal action in order to protect the rights of patients whenever a doctor performs such an operation.\(^9\)

Police and government policies are the third factor in the de facto prohibition on transplantations from brain-dead donors. The police currently refuse to declare a patient in a brain-dead state officially dead.\(^9\)

Instead, they rely upon the medical standard of cardiac death as the only indication of death.\(^10\) The National Police Agency issued a directive that no examinations to confirm death can be performed until the heart has stopped beating.\(^10\)

An example of how this prevented a transplantation from a brain-dead donor occurred in January 1992, in Osaka Prefecture. A motorcycle-accident victim who had previously indicated his desire to donate his organs was declared brain dead.\(^10\)

Doctors summoned police to the medical center to conduct a postmortem.\(^10\) The police, however, would not do so until the patient's heart stopped beating and he was formally dead.\(^10\) The doctors therefore abandoned their plan to remove the patient's heart and liver, although they did remove his kidneys and corneas after his heart stopped.\(^10\)

Health officials also have prevented organ transplantations from brain-dead donors. On October 22, 1993, a 14-member team led by Dr.  

\(^{95}\) See, e.g., id.  
\(^{96}\) See, e.g., id.  
\(^{97}\) Prosecutors in Japan have a great deal of freedom in initiating legal action. They normally prosecute cases begun by the police, but they also can conduct criminal investigations completely separate from the police. Furthermore, prosecutors can directly receive, as can the police, complaints and accusations by the public. A complaint (kokuso) can be filed with the prosecutor by the victim or by the victim's family or legal representative. An accusation (kokuhatsu) can be filed by anyone who believes that an offense has been committed. In this manner, the Patient's Rights Conference and other groups are able to initiate a legal investigation if they find a sympathetic prosecutor. B.J. George, Jr., Discretionary Authority of Public Prosecutors in Japan, in LAW AND SOCIETY IN CONTEMPORARY JAPAN: AMERICAN PERSPECTIVES 263, 267-69 (John O. Haley ed. 1988); JOHN O. HALEY, AUTHORITY WITHOUT POWER. 125-29 (1991).  
\(^{98}\) See, e.g., Brannigan, supra note 3, at 181.  
\(^{100}\) Id.  
\(^{101}\) Organ Transplants Still On Hold Despite Panel Recommendation, supra note 81.  
\(^{102}\) Brain Death Dispute Delays Organ Removal, JAPAN TIMES, Feb. 1, 1992, at 2; Organ Transplants Still On Hold Despite Panel Recommendation, supra note 81.  
\(^{103}\) Id.  
\(^{104}\) Id.  
\(^{105}\) Brain Death Dispute Delays Organ Removal, supra note 102.
Keizo Sugimachi at Kyushu University Hospital transplanted a liver from a cardiac-dead donor.106 Originally the team had planned to take the liver from the donor while he was brain dead.107 However, the head of the health department of the Osaka prefectural government warned the doctors to be prudent.108 As a result, the doctors waited until the donor was dead by the cardiac standard.109 They removed the donor from the life-support system, and then waited for his heart to stop beating.110 Although the doctors were optimistic that the liver was removed in a near brain-dead state with little damage,111 the recipient died after seventy-nine days.112

Several times over the past twenty-six years, doctors who performed transplantations from brain-dead donors have faced legal charges based on the theory that they caused the cardiac death of the donor by removing the organs. Dr. Wada's 1968 heart transplant, the first and only one performed in Japan, marked the beginning of the national debate on brain death and resulted in a legal investigation.113 The debate eventually died down, but smouldered until 1984, when a team of Tsukuba doctors reignited it by transplanting organs from a brain-dead donor.114 The Patient's Rights Conference instigated legal proceedings against the doctors. This pattern repeated itself in 1988 and again in 1989, when a Niigata Prefecture hospital group performed kidney transplantations from brain-dead donors115 and the Patient's Rights Conference again instigated legal action.116 As recently as 1992, a citizen's group proposed legal action against doctors who did not perform sufficient tests to determine if a kidney donor was cardiac dead.117

The Tsukuba case provides a good example of how these cases proceed. In 1984, doctors at Tsukuba University performed a multiple-

108 Id.; Transplant Done After Brain-Dead Donor’s Heart Stops, supra note 108.
109 Doctors Say Liver Transplant Patient Stable, supra note 48; Transplant Done After Brain-Dead Donor's Heart Stops, supra note 108.
111 Id.
112 Japanese Transplant Patient Dies 79 Days after Operation, supra note 50.
113 See infra notes 183-99 and accompanying text.
115 Brannigan, supra note 3, at 183.
116 Id.
recipient transplantation of kidneys, pancreas, and corneas. The two corneas each went to different people, as did one of the kidneys. The donor was a 43-year-old female neuropsychiatric patient who had gone into a deep coma because of a stroke.

The Patient's Rights Conference asked that murder charges be filed for several reasons. First, they felt that necessary treatment for the brain-dead donor had been abandoned. Second, they argued that brain-death criteria were not properly established before the physicians removed the organs. Third, they challenged the donor's competence to consent to donate her organs because of her mental illness. Finally, they questioned the validity of the donor's husband's consent to remove the organs. As of 1992, the case was still under consideration. The threat of this type of legal action has deterred Japanese doctors from performing organ transplantations from brain-dead donors even though no statute prohibits these operations and no doctor has yet been found guilty of malpractice, manslaughter, or murder.

The Patient's Rights Conference, the police, and government officials have all contributed to creating a de facto prohibition of organ transplantations from brain-dead donors. However, these groups are not the cause of the societal controversy concerning these operations. The controversy has roots deep in Japanese culture.

D. Cultural and Religious Issues Affecting the Brain-Death Standard and Organ Transplantation in Japan

Commentators attribute the widespread Japanese disapproval of the brain-death standard and organ transplantation to a variety of sources. It is difficult to sort out which sources cause opposition to brain death and which cause opposition to organ transplantation. The two issues intersect in a
"bed-rock" of philosophical, cultural, Buddhist, Shinto, and Confucian perspectives.126

1. The Concept of Personhood — Body is Soul, and this Whole Is Part of the Family

The Japanese view of the relationship of body and soul, which is quite different from the American view, understandably leads to the Japanese aversion to accepting the brain-death standard. Traditionally, people in the West have believed that the body and soul of a person are separable, following Christianity and Cartesian dualism.127 By these models, the soul presumably resides in the brain and departs once the person (or brain) has died.128 Because of this philosophy, most Westerners easily accept removing organs from a body after the person has died, even if death is determined by brain criteria.129 Most Japanese, on the other hand, do not believe the body is an entity distinct from the mind or soul.130 Rather, they view individuals as "completely integrated mind-body units."131 This integration is not disturbed by death, and therefore many Japanese believe that removing an organ disturbs this unity of body and soul.132 Furthermore, the word for "spirit" is kokoro, which is written with the character for "heart."133 The kokoro is located in the chest.134 The reluctance to consider a person with a beating heart to be dead is therefore understandable.135

The Japanese concept of the individual's relation to his or her family is also different from that in Western society.136 In the West, the individual is the basic unit of society, possessing inherent legal and moral rights and

126 Id.
129 Id.
130 Feldman, supra note 114, at 24.
132 Kimura, supra note 131, at 125.
133 Lock & Honde, supra note 7, at 109.
134 Id.
135 Id. Also, Japanese regard the belly or the gut as the master organ rather than the brain. Haruko Akatsu, The Heart, the Gut, and Brain Death in Japan, 20(2) HASTINGS CENTER REP. 2 (1990).
living and dying as an individual.\textsuperscript{137} In Japan, in contrast, the individual is a social being who is regarded as part of a collective reality.\textsuperscript{138} The importance of communal identity is demonstrated by, for example, traditional birth and funeral rituals.\textsuperscript{139} Babies were not given names or considered part of the family until community rituals were performed.\textsuperscript{140} Likewise, the community had to complete certain activities before a person was recognized as dead.\textsuperscript{141} Death is regarded as much more than a physical event occurring in the body;\textsuperscript{142} it is also a familial event.\textsuperscript{143} The body of the deceased is seen to belong as much to the family as to the deceased, and therefore taking organs for transplantation without the family's approval is often unacceptable to the family.\textsuperscript{144} The concept of personhood both as an individual and as part of the family affects Japanese views on organ transplantation from brain-dead donors.

2. \textit{Religious Sources}

The Japanese concept of personhood is intricately intertwined with Buddhism and Shintoism. Many Japanese are followers of both religions,\textsuperscript{145} and both of them affect beliefs and rituals about death. Buddhism helps form the Japanese belief that a person is not dead until there is cardiac death.\textsuperscript{146} One reason is that Buddhist beliefs strongly emphasize "being natural," and "it seems 'unnatural' to pronounce someone dead when his or her chest is still moving."\textsuperscript{147} Furthermore, brain death is incompatible with the Buddhist notion of the "oneness of birth and death."\textsuperscript{148} Buddhists believe that under the brain-death standard the body is viewed simply an assemblage of organs, the most important of which is the brain.\textsuperscript{149}

\begin{thebibliography}{99}
\item\textsuperscript{137} Id. at 1063.
\item\textsuperscript{138} Id. at 1064; Lock \& Honde, supra note 7, at 109.
\item\textsuperscript{139} Nudeshima, supra note 136, at 1064.
\item\textsuperscript{140} Id.
\item\textsuperscript{141} Id.
\item\textsuperscript{142} Handa, supra note 127, at 439.
\item\textsuperscript{143} Lock \& Honde, supra note 7, at 111.
\item\textsuperscript{144} Id.
\item\textsuperscript{145} AGENCY FOR CULTURAL AFFAIRS, JAPANESE RELIGION 12 (1972). For instance, in 1970, there were 84,442,000 Shinto followers and 84,899,000 Buddhist followers, while the total population was only 103,720,060. Obviously, there is a great deal of overlap.
\item\textsuperscript{146} Akatsu, supra note 135.
\item\textsuperscript{147} Id.
\item\textsuperscript{148} Masao Fujii, Buddhism and Bioethics, in BIOETHICS YEARBOOK 61, 67 (Baruch Brody et al. eds., 1991).
\item\textsuperscript{149} Id.
\end{thebibliography}
Buddhist, it is oxymoronic to take organs with living cells from a body, and still declare that the person is dead.\textsuperscript{150} For the Buddhist, until the body is wholly dead, there is no oneness of death.\textsuperscript{151}

However, Buddhism can affect beliefs about the appropriateness of organ transplantation either negatively or positively.\textsuperscript{152} Those who argue that Buddhism prohibits organ transplantation note that the spirit of a deceased is believed to remain in this world for forty-nine days after death before attaining a new life through reincarnation.\textsuperscript{153} In light of this, many families are hesitant to allow doctors to remove parts from the dead body for fear of disrespect to the spirit who is still present.\textsuperscript{154} Furthermore, receiving an organ transplantation denies the transitory nature of life and death by unnaturally fighting against it.\textsuperscript{155}

Other commentators cite Buddhism as a source of support for organ transplantation.\textsuperscript{156} They note that Buddhism supports True Offering, a gift of compassion which has no feelings of regret or self-praise attached.\textsuperscript{157} This act brings the giver pleasure. Organ donation is consistent with this view of compassion.\textsuperscript{158}

Shintoism, the folk religion of Japan, also informs the Japanese attitudes regarding brain death and organ transplantation.\textsuperscript{159} According to Shintoism, the spirit of a deceased will be content if the death was not violent to the body.\textsuperscript{160} If the death was violent, the spirit will suffer and may even cause bad luck for the living.\textsuperscript{161} Injuring a corpse is taboo, although in the past authorities or families sometimes did it intentionally to punish the dead person.\textsuperscript{162} As a result of these beliefs, many Japanese feel that taking an organ before there is cardiac death constitutes violence to the body of the

\textsuperscript{150} Id.
\textsuperscript{151} Id.
\textsuperscript{152} Id. at 66-67.
\textsuperscript{153} Lock & Honde, supra note 7, at 110; Makio Takemura, The Buddhist View of Death, 35(3) ASIAN MED. J. 127, 128 (1992). This belief seems irreconcilable with the belief that the body and soul are one. Perhaps they are compatible at some higher level of Japanese metaphysics.
\textsuperscript{154} Lock & Honde, supra note 7, at 110.
\textsuperscript{155} Fujii, supra note 148, at 66-67.
\textsuperscript{156} Iwasaki et al., supra note 58, at 963; Fujii, supra note 148, at 66.
\textsuperscript{157} Iwasaki et al., supra note 58, at 963.
\textsuperscript{158} Id.
\textsuperscript{159} E. Namihira, Shinto Concept Concerning the Dead Body, 22 TRANSPLANTATION PROC. 940, 940 (1990).
\textsuperscript{160} Id. at 941.
\textsuperscript{161} Id. at 940-41 (1990); Lock & Honde, supra note 7, at 110; ROBERT J. SMITH, ANCESTOR WORSHIP IN JAPAN, 39-50 (1975).
\textsuperscript{162} Namihira, supra note 159, at 940-41.
deceased, and therefore is incompatible with Shinto beliefs. Even when the patient has consented to give his or her organs for transplantation after death, the family will often refuse to give consent. Family members fear that injuring the corpse will make the soul more unhappy than would ignoring the patient's living will.

Ancestor worship is another religious tradition affecting organ transplantation and brain death in Japan. Ancestor worship derives from Shinto, Confucian, and Buddhist sources. By this belief the deceased enters the community of spirits and becomes an ancestor through a series of rituals lasting thirty-two years. The family performs these rituals in part through the use of memorial tablets and photographs of the deceased which are kept in the family altar. Thus, the image of the deceased is kept in the present and in human form, and during this time the living relatives have an obligation to make the spirit happy and comfortable. A 1983 questionnaire found that 66% of the respondents felt that cutting into dead bodies is repulsive, cruel, and shows lack of respect to the dead. Therefore, many families likely feel that organ transplantations from the deceased will cause the spirit to be unhappy contrary to their obligation. Although ancestor worship has declined in recent decades, the societal customs and beliefs surrounding it may continue to have an effect.

3. Hospital Practices

Current practices in Japanese hospitals also contribute to the disfavor of the brain-death standard and organ transplantation. Relatives play a more prominent role in the Japanese hospital than in the American hospital. They are often present at the bedside to perform nursing duties throughout the hospital stay, and upon the death of the patient the family usually

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163 Id. at 941; Lock & Honde, supra note 7, at 110. This concept is distinct from cremation, which is universally practiced in Japan due to Buddhist tradition and law. Clyde Haberman, A Transplant Trauma: Is Soul-searching Ending?, N.Y. TIMES, Feb. 10, 1987, at A4.
164 Namihira, supra note 159, at 941.
165 See generally SMITH, supra note 161.
166 Id. at 12-15; Lock & Honde, supra note 7, at 111.
167 Id. at 110.
168 Id.
169 Id.
170 Id.
171 SMITH, supra note 161, at 220-23.
172 Lock & Honde, supra note 7, at 112.
washes and lays out the corpse. The body is then taken to the family home for the beginning of the Buddhist ceremonies. As a result, Japanese doctors are hesitant to ask the families for permission to remove organs, especially when the brain-dead patient is still breathing and warm. Furthermore, in Japan the patients and family are kept outside of the medical decision-making process. There is no tradition of informed consent or of assisting in the psychological preparation for death. Rather, the patient and his or her family are left alone to handle the dying process without medical guidance, social workers, or counselors. Again, this situation does not lend itself to the doctor asking the family if organs may be removed from the brain-dead but still breathing donor.

4. Distrust of Doctors

Other commentators blame the public fear of brain death and organ transplantation on problems within the medical system and a distrust of doctors. The Japanese medical community has traditionally created policy and made decisions without public input. The public generally has accepted this paternalistic role of doctors. Japanese doctors began performing transplants in the late fifties and early sixties, as did doctors in other industrialized countries. The first kidney transplant was in 1956, and the first liver transplant was in 1964. These early operations did not attract any negative attention.

Then Dr. Juro Wada performed Japan's first and only heart transplant in 1968, at the Sapporo Medical College in Hokkaido. He transplanted the heart of an eighteen-year-old brain-dead drowning victim into a recipi-
ent who survived for eighty-three days after the operation. A societal furor erupted after the facts of the case became public, and the press and many in the public accused Dr. Wada of committing murder.

There were several factors that fueled the societal debate. First, the public discovered that brain-death in the donor may not have been properly established. Dr. Wada did not provide adequate documentation as to the specific brain death criteria used. Second, many people questioned the operation because of the lack of information concerning the recipient's medical history and diagnosis, and felt that he should not have been treated with a heart transplant. Third, Dr. Wada's medical team both declared the donor brain dead and performed the heart transplantation. Many felt that the medical team had compromised its decision to declare brain death because of its interest in performing the operation.

A Hokkaido prosecutor spent a year investigating evidence that the donor was still alive at the time of the operation, but he never formally indicted Dr. Wada nor filed formal criminal charges. Furthermore, the prosecutor never defined death in his decision, leaving the issue of organ transplantations from brain-dead donors hanging in legal limbo. However, from this point on the threat of similar legal investigation effectively curtailed organ transplantation from brain-dead donors.

Dr. Wada never made a public apology, and for the most part the medical community did not condemn the operation. In Japan, great weight is put on apology as a means of assuming moral responsibility for wrongdoing, even if the legal system does not prosecute. It is a way for

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184 Brannigan, supra note 3, at 182.
185 Haberman, supra note 163; Brannigan, supra note 3, at 182.
186 Bai, supra note 183, at 991; Brannigan, supra note 3, at 182.
187 Brannigan, supra note 3, at 182.
188 Id.
189 Lock & Honde, supra note 7, at 104.
192 Haberman, supra note 163. This is possible in Japan because of the principle of discretionary prosecution, by which a prosecutor may decide not to prosecute for a variety of reasons. The reason which probably applies in Dr. Wada's case is insufficiency of evidence. George, supra note 97, at 265-67.
193 Bai, supra note 183, at 991.
194 See id.
195 Kimura, supra note 131, at 124.
196 Id.
an individual involved in a social transgression to re-integrate him or herself into society. The public may have felt that Dr. Wada's refusal to apologize showed his unwillingness to assume responsibility for his errors. The end result is that the normal Japanese deference to medical authority was replaced by a distrust of the motives of any physician who wanted to do an organ transplant from a brain-dead donor.

E. The Gradual Formation of Support for Organ Transplantations from Brain-Dead Donors

Despite the disapproval of organ transplantations from brain-dead donors, public and governmental support for these operations has grown over the years. Generally, the Japanese feel it is important to reach consensus on an issue before changing the status quo because they have a stronger communitarian orientation than most Western countries. This is true both at a societal level and a governmental level. Support for organ transplantations from brain-dead donors has been slowly rising in both society in general and in the political arena. An integral part of this process at the societal level has been a series of newspaper polls which regularly report on the percentage of support for accepting the brain-death standard and allowing organ transplantations. At the political level, support for these operations has been formed through a series of advisory committees and ad hoc policy groups. The Diet's passage of a bill allowing organ transplantations from brain-dead donors will mark the point at which enough consensus has been formed for the government to change the status quo through legislation.

198 Brannigan, *supra* note 3, at 182.
199 Id.
200 Lock & Honde, *supra* note 7, at 104.
201 See generally HALEY, *supra* note 97.
202 Brannigan, *supra* note 3, at 184; See also Lock & Honde, *supra* note 7, at 104.
204 Lock & Honde, *supra* note 7, at 104-05.
1. The Rise of Social Consensus

Although in the West medical issues like brain death fall primarily into the province of bioethics, in Japan they are dealt with publicly through the creation of social consensus. The Japanese form this consensus in a slow, steady way that is often baffling to outsiders. The process often occurs through newspaper polls which allow the public to know how the rest of society feels about an issue. The newspaper polls on brain death have shown a gradual increase in the acceptance of the concept. The newspaper *Yomiuri Shimbun* conducted a long-running poll on the organ donation issue. The results are as follows:

This poll shows that the percentage of people willing to donate organs has risen, although not in a linear progression. Furthermore, it shows that the percentage that will not donate organs and the percentage that do not voice an opinion have gone down, but again the drop does not follow a smooth linear pattern.

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207 Haberman, supra note 163. Haberman describes it as, "the measured, often elusive way in which the Japanese form a consensus on delicate issues."

208 Lock & Honde, supra note 7, at 104-05.


210 Id.
NHK, the Japanese public broadcasting system, also has conducted polls on the issue of organ transplantations from brain-dead patients:

<table>
<thead>
<tr>
<th>Percentage of respondents who support organ transplantations from brain-dead patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-88</td>
</tr>
<tr>
<td>38%</td>
</tr>
</tbody>
</table>

These polls show a slow but significant increase in social consensus for allowing organ transplants from brain-dead donors. Medical anthropologists Margaret Lock and Christina Honde believe that the end result of this long public debate will be a well-informed public that feels comfortable using the brain-death standard. The public will have participated in building social consensus, and the newspapers will have played their established role in this uniquely Japanese method of forming public consent.

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211 Kimura, supra note 131, at 127.
212 On the other hand, at least one participant in the brain-death controversy, Kato Ichiro, believes that social consensus is a myth and an unfair means of equivocation. He contends that social consensus cannot be defined or ascertained, and therefore is only a mirage which allows people to remain undecided. Social consensus appeals to the "peculiarly Japanese sense of 'togetherness'" and acting with the approval of all. Furthermore, social consensus combines with the "strong tendency to see regulation as the norm; anything not specifically permitted by the state is regarded as forbidden." He argues that this combination is causing the brain-death standard not to be accepted in Japan without good reason. Ichiro, supra note 88, at 52-55.

Interestingly, both supporters and opponents of accepting brain death have accused the newspapers of manipulating the public to the other side's advantage. While Kato argues that the newspapers are preventing the acceptance of brain death by prolonging indecision, opponents argue that brain death supporters get more media publicity, thus maneuvering the public into support of the brain-death standard. Lock & Honde, supra note 7, at 105-08.

213 Id. at 114-15. The author's agree that: "[a]t the end of this prolonged cultural debate [on brain death] there will be, in contrast to North America, a public which is sensitive to the issue, many of whose members still believe (perhaps incorrectly) that they have participated in creating the new policy using the characteristic Japanese means of working towards consensus. The result will probably be that there will be few legal battles or disputes around this issue in the future."

214 Id.
2. **Political and Scientific Committees that Have Reported on Brain Death**

An important feature of the Japanese legislative process is the need to form political consensus before legislation is passed, which results in "an unusually large number of advisory committees, ad hoc policy groups, and similar vehicles for developing consensus."\(^{215}\) A series of political and scientific committees has debated on the appropriate legislative response to brain death since Dr. Wada's heart transplant in 1968. These committees have provided the groundwork necessary to creating and passing the proposed bill.

Two committees developed medical criteria for brain death over a period of seventeen years, from 1968 to 1985.\(^{216}\) The first group was the Ad Hoc Committee on Brain Death, formed by the Japanese EEG (electroencephalogram) Society shortly after the Dr. Wada case.\(^{217}\) This committee first put out a general statement on brain death, and then six years later, in 1974, reviewed this definition.\(^{218}\) It examined 200 brain death cases, and published the mandatory criteria to establish brain death as follows:

<table>
<thead>
<tr>
<th><strong>Prerequisite</strong></th>
<th>Only applied to cases of primary brain lesions.(^{219})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion</strong></td>
<td>Not strictly applied in cases of cerebral anoxia, hypothermia, acute intoxication, and cases in children.(^{220})</td>
</tr>
<tr>
<td><strong>Criteria</strong></td>
<td>Deep coma, apnea [lack of spontaneous respiration], dilated pupils, absent pupillary and corneal reflexes, abrupt fall in blood pressure [which persists], isoelectric [flat] EEG.(^{221})</td>
</tr>
<tr>
<td><strong>Duration of Observation</strong></td>
<td>All of the preceding had to be present for at least six hours.</td>
</tr>
</tbody>
</table>

In 1983 the Ministry of Health and Welfare formed the second group, the Special Task Force on Brain Death, headed by Dr. Takeuchi.\(^{222}\) Its goal

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\(^{216}\) Brannigan, *supra* note 3, at 183. These medical criteria are accepted by 70 percent of the larger Japanese hospitals and university medical centers. *Id.* at 184.

\(^{217}\) *Id.* at 183.

\(^{218}\) *Id.* at 181, 183.

\(^{219}\) *Id.* at 183. Primary lesions are the original injury or wound. Secondary lesions are the results of primary lesions, for example scars or ulcers. *Taber's Cyclopedic Medical Dictionary, 1098-99* (Clayton Thomas ed. 1989).

\(^{220}\) Brannigan, *supra* note 3, at 183.

\(^{221}\) *Id.*
was to reappraise the 1974 criteria through a study using over 700 cases of brain death from primary and secondary lesions. In 1985 the Task Force released its specific criteria, which differed little from the 1974 criteria:

<table>
<thead>
<tr>
<th>Prerequisite</th>
<th>Known irreparable organic brain lesion, whether primary or secondary, detected by computerized tomography (a special type of x-ray machine which displays an organ or tissue at a certain depth)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Children under six years of age, hypothermia, drug intoxication, endocrine and metabolic disorders.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Deep coma, 300 Japan coma scale, 3 Glasgow coma scale; apnea confirmed by apnea test; bilaterally fixed pupils larger than 4 mm in diameter; absence of the six cephalic reflexes, i.e., corneal, ciliospinal, oculocephalic, vestibular, pharyngeal, and cough reflexes; isoelectric electroencephalogram.</td>
</tr>
<tr>
<td>Duration of Observation</td>
<td>Six hours, or longer in cases of children over six years of age and those with secondary brain damage.</td>
</tr>
</tbody>
</table>

The new criteria differ from the 1974 criteria in four respects. First, the new criteria add cases which involve lack of oxygen to the brain. Second, the criteria require that there be absolutely no cephalic reflexes. Third, the new criteria no longer require an abrupt fall in blood pressure which persists. Fourth, cases involving secondary lesions will now be considered. These latter criteria are a strict version of the brain-death criteria presented by Harvard medical school and commonly used in the United States.

The Task Force also added two procedural requirements for the determination of brain death. First, the medical team must preserve a record of confirmed and accurate test results. Second, at least two physicians with sufficient experience in brain death determination must give their opinion.

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222 *Id.* at 183-84.
223 *Id.* at 183.
227 Igata, *supra* note 225, at 610.
228 Beecher, *supra* note 27, at 337.
and neither of them should participate in any subsequent transplantations from that donor.\textsuperscript{229}

The Task Force was very clear in stating that its report gave only a medical judgment of the state of brain death, and not a judgment on brain death as the death of the individual.\textsuperscript{230} Rather, they felt the latter philosophical question "should be discussed on other occasions by other groups."\textsuperscript{231}

In 1986, the Japan Medical Association (JMA) organized a committee, the Bioethics Discussion Group, soon after the Special Task Force on Brain Death released its criteria. The JMA committee investigated brain death and organ transplantation and took up the recommendation of the Task Force to create social consensus in favor of brain death as the death of the individual.\textsuperscript{232} The Discussion Group issued its "Final Report on Brain Death and Organ Transplants" on January 12, 1988, which stated that:\textsuperscript{233}

1. Brain Death (i.e., irreversible disfunction of the entire brain) would be recognized as the death of an individual in addition to the traditional [definition of death based on the] absence of heartbeat (circulation, pulsation, and respiration).

2. The minimum standard of brain death would be based on the standard adopted by the Special Task Force on Brain Death within the Ministry of Health and Welfare (whose chairperson is presently Dr. Kazuo Takeuchi).

3. The determination of Brain Death by brain-death criteria would be provided by physicians who respect the patient's and/or family member's wishes evidenced by a truly informed consent.

4. Determination of death by applying . . . brain-death criteria would be justified socially and legally if it (1) is grounded in the consent of the patient, (2) is determined by appropriate

\textsuperscript{229} Igata, supra note 225, at 609; Handa, supra note 127, at 438.
\textsuperscript{230} Bai, supra note 183, at 991.
\textsuperscript{231} Id.
\textsuperscript{232} Id.
\textsuperscript{233} Id.
methods, and (3) is carried out by a physician in accordance with the guidelines of the Japanese Medical Association.

5. The time of death would be recorded no more than 6 hours after the initial determination of brain death.

6. Organ transplantation would be performed according to the guidelines of the Japanese Transplantation Society, which requires providing a full explanation for a free, uncoerced, and informed consent by the donor, the recipient, and the recipient's family members.

In March 1990, the Japanese government became directly involved and announced the establishment of a Provisional Commission for the study of Brain Death and Organ Transplantation. The Commission gave a report in January 1992, which concluded that brain death is actual death and favors organ transplantation from brain-dead donors. It also proposed that a donor's wishes, if confirmed, should outweigh the wishes of family members, and "that doctors may assume a donor's consent if his or her close relatives confirm the wish to donate organs." However, its decision was not unanimous. A dissenting minority claimed that a person is alive as long as the heart is beating.

The work of all of these political and scientific committees has laid much of the groundwork necessary for the upcoming bill on transplantations from brain-dead donors. The committees have provided strict medical criteria and concrete proposals for the Diet to consider, and furthermore have established much of the necessary political consensus.

3. The Social and Political Role of the Bill

The Japanese government is now, theoretically, in a position to pass the proposed bill on organ transplantations from brain-dead donors. The role of the government in regulating social issues is much different in Japan

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234 Brannigan, supra note 3, at 181.
236 Brain-Death Accepted as Death, 5(1) JAPAN LAW J. 8 (Feb. 1992).
237 Bar Organization Wants Halt to Organ Transplant Bill, supra note 235.
238 Id.
and America.\textsuperscript{239} In America, the government can prohibit conduct as long as it does not unduly interfere with the rights of individuals. In contrast, the Japanese government has much more authority to intervene in society, but it often lacks the power to do so.\textsuperscript{240} In other words, the jurisdiction of the Japanese government is very broad, but its ability to coerce and compel is remarkably weak.\textsuperscript{241} Instead, the community controls behavior through the expression of disapproval backed by social sanctions.\textsuperscript{242} This is possible because Japan has maintained a strong communitarian orientation despite the transition from a predominantly agricultural to urban society.\textsuperscript{243} As a result, the government's role often is to provide legitimacy to social consensus.\textsuperscript{244} After a long period of societal debate on an issue, when it appears that public opinion has formed enough consensus, the government intervenes as a mediating influence by providing the legitimacy of its authority to the consensus.\textsuperscript{245}

The proposed bill on organ transplantations from brain-dead donors which the Diet is now considering is a typical example of this process. There has been a long period of debate during which public support for organ transplantations from brain-dead donors has slowly grown. At the same time, as is characteristic of the Japanese political system,\textsuperscript{246} many scientific, political, and private groups have attempted to create public consensus on the issue. The proposed bill is the government's move to help to end the societal stigma attached to organ transplantations from brain-dead donors.

\textsuperscript{239} See generally HALEY, supra note 97.

\textsuperscript{240} HALEY, supra note 97, at 24-32, 193. Authority is the legitimacy or socially recognized entitlement to command and be obeyed. Power is the capacity to coerce others to do something they would not otherwise do. As distinct from power, authority is widely understood to interrelate with notions of legitimacy, moral and legal right, willing obedience, and obligation. Power, on the other hand, can be viewed as both a capacity to influence as well as to coerce. \textit{Id.} at 13.

\textsuperscript{241} HALEY, supra note 97, at 14.

\textsuperscript{242} \textit{Id.} at 13, 170-75.

\textsuperscript{243} \textit{Id.} at 13, 169-75.

\textsuperscript{244} \textit{Id.} at 13, 186-87.

\textsuperscript{245} \textit{Id.}

\textsuperscript{246} JAPAN'S POSTWAR CIVIL SERVICE, supra note 203, at 9.
III. **Analysis**

**A. Introduction**

The Diet may begin considering the proposed bill on April 12, 1994, and it might pass by Fall 1994. The Diet should pass this bill because it will save the lives of many Japanese who under the current circumstances will die. The bill will save lives for two reasons. First, more Japanese will be able to afford organ transplantations because the travel and lodging costs involved with traveling overseas will be eliminated. Second, Japanese who need transplantations will not face the current difficulties in being accepted on a foreign nation's organ transplantation waiting list. Furthermore, the Diet should pass the bill because it will prevent the possibility of a damaging international opinion that Japanese citizens are taking too much of the limited supply of organs available in other countries.

However, the bill should also ease the worries of those Japanese who do not approve of organ transplantations from brain-dead donors. To this end, the bill should establish strict standards to ensure the protection of the rights of donors, recipients, their families, and those who do not wish to donate organs. With strict standards, the bill can both satisfy those currently opposed to adopting the brain-death standard and save lives.

**B. Description of the Proposed Bill**

The proposed bill, which explicitly allows organ transplantations from brain-dead donors and addresses the key problems surrounding organ transplantation in Japan, was presented to the Diet on April 12, 1994. However, the bill is unlikely to pass during the spring/summer session of the Diet, which ends June 29, because of political turmoil in the Diet.

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248 Brain Dead Donor Organ Transplant Bill Reaches Diet, supra note 4.

249 Id.

250 Japan: Organ Transplant Debate Moves into Political Arena, supra note 6. In the summer of 1993 the Liberal Democratic Party lost power for the first time since 1955. Prime Minister Morihiro Hosokawa then led a multi-party coalition for eight months before he resigned in a scandal on April 8. Tetsuo Jimbo, Prime Minister Quits over Money Scandal, Newsday, Apr. 9, 1994, available in LEXIS, News Library, Allwld File. On April 25, Tsutomu Hata became Prime Minister, but he leads a distinct
The bill is unusual in several respects. First, because the bill is socially very controversial, standard drafting procedures were not followed. Normally, cabinet and ministerial orders (seishō rei), which delineate the specific procedures of a bill, are not established until after a Diet Committee has drafted a bill. However, in this case both the draft legislation and the ministerial orders were concurrently drafted. Second, it is likely that voting on the bill will not follow party lines. A multi-partisan committee (kaku tō kyōgikai) introduced the proposed bill to the Diet, and committee members of all of the parties except the Communist Party signed the bill. However, in voting on the bill the parties are likely to follow the example of the Japan New Party, which has decided to allow its members to vote on the bill according to their conscience.

The proposed bill presented below represents only the draft legislation. The multi-partisan committee released this outline of the bill on December 2, 1993. It is divided into eleven parts.

Part I presents the purpose of the bill, which is to establish a basic ideology about the transplantation of organs. At the same time, it aims to contribute to the proper execution of organ transplantations.

Part II presents the basic ideology behind organ transplantation, part III describes the responsibility of the government, and part IV describes the responsibility of the medical practitioner.

Part V details how the organs will be extracted, and makes three very important statements. First, doctors are permitted to extract internal or-minority in the Diet and faces many critical issues of the economy, diplomacy, and politics. Pierre-Antoine Donnet, *Japanese Government at the Mercy of the Opposition*, Agence France Presse, May 1, 1994, available in LEXIS, News Library, Allwld File.

251 Asahi Summary, supra note 5.
252 Id.
253 Id.
254 Brain Dead Donor Organ Transplant Bill Reaches Diet, supra note 4.
255 Id.
256 Id.
258 Asahi Summary, supra note 5.
259 Id.
260 Id.
262 Asahi Summary, supra note 5.
gans for the purpose of organ transplantation from corpses, and the word corpse, dead body or any other description for the deceased will also include the brain dead. This sentence establishes the brain-death standard as a legal standard for death. Second, regarding the judgment of brain death, all necessary explanations must be made to the family of the patient so that they understand the term “brain death.” This provision helps to establish a protocol which will reassure those Japanese wary of the brain-death standard. Third, the judgment of the existence of brain death and the procedure for filing out a report of death shall be based on the opinion of a medical expert. This provision puts the decision in the hands of the doctor rather than the police or some other official.

Part VI is also very important. It defines the consent necessary for organ donation. Organs can be removed for the purpose of organ transplantation only in certain cases. The first case is when the donor indicated his consent to donate his organs in a written document, and when the donor's family does not refuse the removal of the organs, or there is no family. The second case is when there is no written consent by the donor, but the family members believe that the donor had made his willingness to donate his organs clear by previous words and conduct. In this second case, the family may still consent to donate the organs by providing a written document. This document must show the donor's consent by providing evidence that the donor had inquired about obtaining a donor card, had expressed an interest in donating other parts of his body, or had shown an interest in contributing to medical science. Furthermore, in this case the doctor responsible for removing the organ must explain the procedure to the family in the presence of another doctor or an attorney chosen by the family.

Organ removal for transplantation will not be permitted when there is no written consent by the donor, and family members either do not know

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263 Id.
264 Id.
265 Id.
266 Japan Economic Newspaper Summary, supra note 261.
267 Id.
268 Id.
270 Id.; Japan Economic Newspaper Summary, supra note 261.
271 Transplants May Be Allowed 'If Donor Would Have Wanted', supra note 269.
272 Asahi Summary, supra note 5.
the donor's intention concerning organ donation or know that he desired not
to contribute his organs. Part VI, by establishing strict rules of consent
determining the circumstances in which doctors can remove organs for
transplantation, should help to reassure those Japanese wary of the brain-
death standard.

Part VII of the bill concerns the handling of the body of the donor. First, if an investigation into the cause of death is necessary, a doctor may
not remove any organs until the inspection has been completed. Second, standard ethics for handling the body must be maintained.

Part VIII concerns the preparation and preservation of records. First, doctors who make decisions concerning brain-dead patients or who are involved with the removal or transplantation of organs must fill out necessary records as established by the Ministry of Health and Welfare. Hospitals must then maintain these records for five years. Second, the record keepers must cooperate with family members who wish to inspect these records, and may not charge a fee to the family or otherwise hinder their inspection.

Part IX of the bill prohibits the sales of organs. Part X gives the Ministry of Health and Welfare the responsibility for regulating organizations involved in the procurement and distribution of organs. Finally, part XI provides the penal regulations for transgressions of the bill and requires that the bill be examined five years after it is enacted. C. Reasons for Passing the Bill

The fundamental reason for passing the bill is that more lives will be
saved by organ transplantations. These operations can extend the life of the

273 Id.
274 Id.
275 Id.
276 Id.
277 Id.
278 Id.
279 Id.
280 Id.; Japan Economic Newspaper Summary, supra note 261.
282 Asahi Summary, supra note 5.
283 Japan Economic Newspaper Summary, supra note 261.
recipient for years and even for a lifetime in the case of children. The bill will save lives for several reasons.

First, it will be cheaper for Japanese to get organ transplantations if they do not have to go overseas. Yoko Hirokawa, a 19-year-old Japanese student, had to raise $99,000 through donations and loans to afford a liver transplant in Australia in 1993.284 Japanese National Health Insurance did not cover any of these costs.285 Another Japanese citizen, Masakuni Aoki, is trying to raise $700,000 to receive a heart transplantation in the United States.286 At the very least, the transportation cost to and the lodging costs in a foreign nation will be eliminated. Therefore, the cost will be lower even if National Health Insurance does not cover the cost of transplantation operations.

National Health Insurance has covered the cost of kidney transplantations from cardiac-dead donors since 1978,287 so it is possible that it will also cover organ transplantations from brain-dead donors. If National Health Insurance does cover the costs, the advantage to Japanese of modest means is obvious; they will be able to receive a treatment that is now prohibitively expensive.

The second reason the bill will save lives is that the difficulty of getting onto the waiting lists of transplant centers in foreign nations will be eliminated. The access of foreigners to organ transplantations in America provides a good example of this difficulty. The United Network for Organ Sharing (UNOS) allows foreigners to receive 10% of the organs transplanted at each transplant center in America.288 As a means of enforcement, an UNOS committee will audit and review a transplant center's activities and policies if more than 10% of the transplants at that center go to foreigners.289

Once a transplant center has accepted a foreign national onto its waiting list, he or she is subject to the same allocation system as American recipients...
citizens. A potential recipient receives points based mostly on medical criteria. These differ by organ, but generally points are received for the amount of time on the waiting list, the quality of antigen match, medical urgency, and logistical factors. The recipient with the most points will receive the organ, barring extraordinary circumstances.

However, for a foreign national to get onto an American transplant center's waiting list a personal referral must be made by the prospective recipient's doctor. If the foreigner's doctor does not have established contacts in America, or a means of obtaining them, the prospective recipient has little chance of getting an organ transplantation in America. Therefore, most foreigners cannot get the necessary physician referral and are excluded per se from organ transplantation in this country despite UNOS' 10% quota policy. Of course, some foreigners do gain access to transplants in America, but they are normally wealthy and lucky, and sometimes have contacts with government officials. Generally, foreigners receive only 2% to 3% of all organs transplanted in the United States.

The Japanese Diet should pass the upcoming bill so that more Japanese could receive organ transplantations in Japan, where they have easier access to transplant centers and doctors.

A final benefit to passing the bill is that it avoids the possibility of a negative international image arising because the Japanese receive organs overseas but do not donate organs themselves. Worldwide, there is a shortage of organs for transplantation. There are occasional references, both in Japan and abroad, that refer to Japanese traveling overseas for transplantations as a problem in light of this shortage. One government study from Canada reports worry that potential organ recipients from the Far East might

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290 Id. at § 6.2.1.
292 See, e.g., id. at 523.
293 Id. at 526.
294 UNOS, supra note 288, at § 6.2.4.
296 See id.
297 Id. at 166.
298 See, e.g., Katherine M. Detre et al., PITT-UNOS Liver Transplant Registry, in CLINICAL TRANSPLANTS 9, 12 (P. Terasaki ed. 1989).
overwhelm Canadian supplies. More often, however, this worry is expressed by Japanese, among them Dr. Hisao Manabe, president of Osaka's National Cardiovascular Center, and Dr. Kazuo Takeuchi, dean of Kyorin University Medical School and chair of the Ministry of Health and Welfare's Brain Death Study Group. In America, a bad image of the Japanese is unlikely to develop because, as mentioned above, foreigners receive only 2% to 3% of all organs transplanted in the United States. Although Japanese citizens travelling abroad for transplantations have not yet become a media or government issue, the potential for an unfavorable international news flurry certainly exists. If the bill passes, this potential will be averted.

D. Necessary Features Included in the Bill

The proposed bill addresses two important issues. First, it establishes brain death as a standard for death, although it does so in an indirect manner. Second, it clearly describes the donor and familial consent necessary before doctors may remove organs for transplantation.

The proposed bill states that the word corpse, dead body, or any other description for the deceased will also include the brain dead. This is the most important provision of the bill, because it gives statutory force to the legality of using brain-death criteria to establish death and removes brain death from the legal limbo which has surrounded it since 1968. Doctors will be able to perform organ transplantations from brain-dead donors without fear of criminal charges of murder, the police will no longer have to rely on the cardiac standard for declaring death, and government officials will no longer need to issue warnings about proposed transplantations from brain-dead donors.

In light of the importance of this provision, it is unfortunate that the bill writers did not state it more directly. Stating that brain-death criteria are now a legal standard for establishing death would be more forceful than the actual language stating that the word "corpse" now includes the brain dead.

301 Rubinfien, *supra* note 56.
302 Kunii, *supra* note 64; see also Kimura, *supra* note 131, at 128.
303 See, e.g., Dette et al., *supra* note 298, at 9, 12.
304 Asahi Summary, *supra* note 5.
305 *Id*.
306 *Id*.
Perhaps the writers felt that stating this provision weakly would make it less objectionable to that segment of the population which still feels that brain death is contrary to Japanese cultural and religious beliefs.

The second important issue the proposed bill addresses is the donor consent necessary before doctors can remove organs for transplantation. The bill requires that the donor consent in writing to donate, and that the family agree with his consent. It also allows a family to give consent on behalf of the donor if the family provides written consent showing that the donor wanted to donate his organs.

This is important for two reasons. First, consent was an issue in the Tsukuba cases when prosecutors pursued legal action against the doctors for performing transplantations from brain-dead donors. The proposed bill clarifies the consent required, and therefore it probably will not be an issue in any lawsuits arising from organ donation. Second, this clarification will help to ease the worries of those who do not wish to have organs removed against their will for traditional cultural and religious reasons. Because the requirements are strict, those who do not wish to donate organs will not do so mistakenly or against their will. This will help to form further social consensus for the bill and for organ transplantations from brain-dead donors, and will also help to restore public confidence in transplantation surgeons.

E. Necessary Features Which the Bill Should Include

The proposed bill should also include certain other features to help build public confidence and to avoid future legal problems. First, it should include strict medical criteria for determining brain death. Second, it should allow for future changes in the means of determining the medical criteria of brain death. Third, the bill should require that the determination of brain death be made by a physician who is not the transplant physician. Fourth, the bill should have strict procedures which will prohibit doctors from coercing families into giving consent to donate the organs of the deceased.

307 See supra note 268 and accompanying text.
308 See supra notes 269-72 and accompanying text.
309 Brannigan, supra note 3, at 182; Lock & Honde, supra note 7, at 104.
310 The Ministerial orders (seisho ret), as of yet unreleased, will probably address these features.
The first recommendation is that the bill should include the criteria for determining brain death put forth by the Ministry of Health and Welfare's Special Task Force on Brain Death. These are very strict criteria, and will insure that doctors do not misdiagnose brain death in a potential donor. This will create public trust in the medical procedures doctors use in determining brain death.

Second, the proposed bill should not be fixed to the present level of technology and tests for determining brain death. The bill should allow for future changes in the medical criteria by which doctors determine brain death. Almost certainly, new technology will arise which will allow a more accurate determination of brain death. The bill should be structured so that it can adopt this new technology and remain current.

Third, the bill should require that the physicians who make the determination of brain death in a potential donor be different from the transplant physicians. This requirement is in force in America and is recommended by the World Health Organization precisely to insure that a proper diagnosis of brain death is not compromised by a transplant physician's desire to perform a transplant. One of the major complaints against Dr. Wada in his 1968 heart transplant was that he both declared the donor brain dead and performed the transplantation. This provision will ensure that no doctor will be compromised in his declaration of brain death. Therefore, it will also help to gain the acceptance of those Japanese worried about the rights of potential organ donors.

Fourth, the bill should establish procedures which will prevent doctors from coercing a family into consenting to donate the organs of the deceased. Two recommendations to this end already have been proposed. First, doctors could be required to present the situation in a uniform manner, following legislated guidelines. Second, the number of times the doctors could ask about donating the organs could also be limited by guidelines. This would help to gain the acceptance of those Japanese

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311 See supra notes 222-31 and accompanying text.
313 WORLD HEALTH ORGANIZATION, supra note 190, at 8.
314 Lock & Hondo, supra note 7, at 104.
315 Japan Economic Newspaper Summary, supra note 261.
316 Id.
317 Id.
who do not wish to donate organs and who do not trust doctors to be uninterested in the fate of the organs.

If these four recommendations are included, the proposed bill will create greater public confidence and thus will further help to build consensus. Therefore, the Diet should include them in the bill.

IV. CONCLUSION

By passing the proposed bill, the Japanese Diet can save the lives of Japanese citizens and end the danger of a unfavorable international reputation arising from Japanese going overseas for organ transplantations. Newspaper polls show that societal consensus for performing transplantations from brain-dead donors has risen steadily. Various policy groups have formulated strict medical standards and policy guidelines which the bill can utilize. All of the political parties in the Diet except the Communist Party have members who support the proposed bill.318 Furthermore, the bill will protect the rights of those Japanese who do not wish to donate organs for cultural and societal reasons. Despite its current political turmoil, the Diet should determine that the ministerial orders will include the recommendations made above, and then pass the proposed bill. It is time to end the legal limbo that has surrounded organ transplantations in Japan since 1968, and let Japanese doctors perform these life-saving operations.

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