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PROTECTING PATIENT'S RIGHTS IN A POST-TRADITIONAL LEGAL SYSTEM: COMPARING LATVIAN AND JAPANESE MEDICAL JURISPRUDENCE

Litigation concerning the violation of patient's rights, which are associated with informed consent, confidentiality, right to information and medical records, as well as occasionally with end-of-life decision-making are quite frequent in common law and civil law jurisdictions, and has lasted for over a century in issues concerning malpractice, or unauthorized medical interventions and breaches of medical confidentiality. However, what could we say about medical law-related litigation in Japan? Technically, the legal system of Japan is a civil law one, but is practically post-traditional, which is reflected in extreme paternalism in healthcare and patient-physician relationships, which could be observed before the recent decades and which still has some impact on the modern Japanese medical law, despite the number of medical law-related litigation is becoming more frequent nowadays. The Japanese legislation does not have a specific "patient's rights law" in contrast to European states, and most of the principles relating to medical malpractice derive from case law – the practice of the Supreme Court and of the lower courts. Each of the decisions strongly depends upon the factual circumstances, and the post-traditional features of the legal system may have some impact on it.

Key-words: patient's rights, medical law of Japan, medical law of Latvia, informed consent, data protection, withdrawal of treatment, euthanasia, treatment of cancer, traditional legal systems.

Background and research methods. The protection of patient's rights is a core issue of medical law, alongside with discussing specific rights, or solving complicated legal problems originating from patient-physician relationships, frequently in relation with intensive care and the limits of providing medical

assistance, which is closely connected with state control (usually by the courts and auxiliary institutions), or with informing patients on their state of health, and apparently, with potential civil and criminal liability of medical practitioners, which can be avoided in case appropriate legal requirements are met. Such legal requirements are frequently not codified, or the provisions are general in their nature. Therefore, detailed principles of their application are elaborated by the courts in their respective judgments. In this paper, I am going to compare the existing rights of the patients in the Republic of Latvia, as a civil law jurisdiction, and in Japan, which is technically a civil law jurisdiction, though a post-traditional one, which still has some certain impact on the functioning of the said legal system.

The given paper represents two research methods: the historical-legal as well as the comparative one. The former is used to describe the origination of medical law in both compared states from the very beginning of the 20th century till nowadays, while the latter is a conventional research method utilized in comparative jurisprudence. A considerable legacy is given to academic scholarship in respect with the evolvement of medical law in Japan from the works of R. Leflar (1996, 1997), Higuchi (2002), and a number of other scholars. The judgments used in the research paper are reviewed and described upon original court reports, translated from Latvian and Japanese languages. Whereas Latvian medical law was more imperatively-oriented in the First Period of Independence, it became more oriented on the fulfillment of patient's rights since the adoption of the Patient's Rights Law in 2009. Japanese medical law bore substantial traditionalistic legacy, illustrated by hyperpaternalistic patient-physician relationships nearly excluding any patient's rights before the 1980s, but such practice ceased in the late 1990s, and many patient's rights were developed in the case law of the courts, not a specific patient's rights law. The comparison of both jurisdictions with reviewing the most outstanding cases, finding similarities and divergences is the foremost aim of the given paper. Both states have an emerging body of medical jurisprudence, despite the approaches to expounding patient's rights may considerably vary. At the same time, the Latvian legislature and jurisprudence may definitely benefit from Japanese legacy, especially in the sphere of the patient's right to refusal of medical treatment, and the end-of-life issues, which still are yet to be resolved by the legislator and the courts.

We may notice that a number of medical law scholars have repeatedly compared medical law issues of Japan to United States, or United Kingdom [1, p. 357 ff.] [2, p. 251] [3, p. 10-14], however I chose to discuss the patient's rights limited to the Republic of Latvia and Japan, finding that the comparison of the medical jurisprudence of Latvia and/or Japan is not appropriate to be compared to United States. Firstly, the United States is a federal common-law state with quite a complicated system of courts with state and federal jurisdiction (so-called United States courts of appeal), the latter involving federal district and federal circuit courts and the Supreme Court, which is

the higher judiciary instance in this state. The legislation and jurisprudence in all the states concerning medical or healthcare law may be very diverse and not uniform. What is next, Latvian medical law does not seem to have its historical routes in United States law by borrowing any principles or judgments from there – instead, the Latvian historical-legal doctrine [4, p. 8–15] [5, p. 116–118] and historical jurisprudence of the First Senate* (i.e. concerning an action for damages deriving from contract) have routes in German civil and criminal** law, as well as Austrian civil and criminal law to a certain extent [4, p. 9–18]. Historically, the lands of contemporary Latvian Republic were under different jurisdictions, and thus, various legal systems operated throughout it, including even the Swedish ones. Nor does the Japanese law bear American routes, having a firm traditionalist legacy. At the same time, the basic principles of medical law, which were germinated in the common-law jurisdictions, frequently have analogous precedents in civil law ones. For instance, the concept of informed consent, that is regarded as one of the key principles in protecting the right of the patient in the shape of “free and informed consent”, has its parallel origins in French law, namely the cases of *Chavonin* (1935–1937), which was adjudicated by the Civil Court of Seine (first-instance) and the Court of Appeal of Paris (appeal)***.

The paper consists of four chapters with a heading one (*background*), and the other are designated with Roman letters. The first one is the introductory chapter, and the further ones are prepared to discuss separate rights of the patients, which constitute his right to self-determination.

The routes and current state of Latvian and Japanese Medical Law.

Foremostly, I have to state that researching Japanese law and jurisprudence, or at least legal scholarship, is often complexified by a restricted possibility to find the necessary judgments. Since Japanese law bears a substantial legacy of traditionalism, the explanation of some issues could not be sometimes

* 1924 g. 22 okt. Spr. Nr. 60, Jazepa Megna lūgums par Liepjas Apgabaltiesas sprieduma atcelšanu Vija Klajuma prasība pret Jazepu Megni un Vila Klajuma pas-kaidrojums., 1924 Senata CKD Spr., p. 146–148 (or Klajuma v. Megna (1924)).

** Reichsgericht, III Strafsenat, Urt. v. 31 Mai 1894 g. W. Rep. 1406/94 = ERG St. Bd. 25, S. 375, 376–377; 380–384 (Sache No. 127).

*** Consorts Chavonin c. K., Admin. d'assistance Publique et soc., des labora-toires Thorande, Trib. civ. de la Seine (1 Chambre), 16 mai 1935, Dall. Heb. 1935.390, 390–392; Dall. Per. 1936 II 9 (first instance); L. c. Consorts Chavonin et Cie des produits chimiques de la Sorbonne, Cour d'Appel de Paris, 1 Chambre, 11 mai 1937, Dall. Hebd. 1937.340, 340–431 (appeal). From the heading of the trial court we read: “A doctor, who experiments with a remedy or a treatment without necessity for the patient, and without the free and informed consent of the patient, commits a certain professional fault. He commits a particularly serious fault by summoning a patient under a pretext which was not entirely correct, and with a view to carrying out on him – without his knowledge and without his consent – an intervention; that this doctor knew to be in reality only an experiment intended to facilitate the scientific research of two interns” (p. 390).

deduced in a court decision – occasional scholarly papers, as, for instance, the work of *R. Leflar* on informed consent in Japan (1996) [6], as well as a number of works by Japanese lawyers and the Western scholars, may substantially assist in conceiving the real gist of how are the patient's rights protected in this country, and do they virtually exist, or they do not.

The legal systems, which may be defined as civil law ones, could have a very different past, or could have quite peculiar public-legal, or private-legal relationship regulation, which may also affect litigation relating to what is commonly referred as “*medical law*” nowadays – that is, all the disputes relating to malpractice in provision of healthcare and violations of the patient's rights. If we take Latvia in its 1st Period of Independence (1919–1940), we may find that medical malpractice litigation did exist*. For instance, in 1937 a man named Vaclav Grzibovsky managed to recover damages from the city of Riga for his loss of working capacity for failing to provide him medical assistance after his leg was overrun by a bus (refusing to hospitalize the patient finding his condition to be quite satisfactory, and examining the plaintiff only superficially), which subsequently caused a deterioration of his health condition, finishing up with the amputation of the leg. Plaintiff succeeded in his claim only against the city (despite, in fact, apart from the city, he sued the physicians and the university, which employed them), and the Senate held the city of Riga to be liable, since *the city* had an obligation to provide such medical treatment, not a subordinate entity did (i.e. the university which governed the said hospital, where malpractice took place)**.

A private veterinarian could also be sued for negligent treatment, if the patient (comically, or tragically – as the reader wishes) was a horse, and the plaintiff won the lawsuit against him upon breach of contract, as the veterinarian's “care” caused the poor horse die***. Another interesting

* The First Latvian Senate (1919–1940) has handed down around 65 thousand judgments (see. Universitas, Nr. 37, 01.04.1976), whilst only several thousands of them were digitized, the other ones are mainly kept in the libraries, so the access to such court reports is quite restricted for a non-Latvian researcher.

** 1937 g. 25 nov. / 16 dec., Spr. N. 10., Senāts, Civilā kasācijas departamenta atklātā tiesas sēdē lū kojis cauri prasītāja Vacslava Gržibovska un atbildētājas Rīgas pilsē tas pilnvarnieku, zv. adv. J. Ķuzis un J. Volkova, kasācijas sūdzības par Tiesu palātas 1937. g. 22. februāra spriedumu Vacslava Gržibovska prasībā pret Rīgas pilsētu v. c. summā Ls 14.097, – darba spēju zaudējumu atlīdzības un Vaclava Gržibovska pilnvarnieka, zv. adv. A. Jakovļeva, un Latvijas universitātes pilnvarnieka zv. adv. P. Lejiņa un Rīgas pilsētas pilnvarnieka zv. adv. J. Volkova., Pašvaldības Balls, No. 7 (01.07.1939); Pašvaldību Darbinieks, Nr. 4 (01.04.1939) (in a more “common law” – shaped name, Vacslav Gržibovski v. City of Riga, Supreme Court of Latvia, 25 nov. & 16 dec. 1937, Case No. 10, reported in Pašvaldību Darbinieks, Nr. 4 (01.04.1939) and Pašvaldības Balls, No. 7 (01.07.1939).

*** 1924 g. 22 okt. Spr. Nr. 60, Jazepa Megna lūgums par Liepjas Apgabaltiesas sprieduma atcelšanu Vija Klajuma prasība pret Jazepu Megni un Vila Klajuma pas-kaidrojums., 1924 Senata CKD Spr., p. 146–148.

and unusual judgment was handed down by the Senate in the case of White Star Line and White Star Dominion v. City of Riga in 1930, where the town representatives* attempted to recover a certain amount of costs for treating the children of migrants within a scarlet fever epidemic, lasting from late 1924 to early 1925. The steamship company was the “representative” of the patients for unstated reasons, but the city lost, since the Riga town regulation of 1922 prescribed to treat patients suffering from contagious diseases free of charge, and the reimbursement of the costs had been previously contracted with the ministry of internal affairs**. In 1929, two doctors were prosecuted for allegedly not providing any medical assistance for the patient in a private clinic; however, there was no evidence that the patient’s condition was so serious that non-administering medical assistance would ultimately constitute a crime under that situation***. Abortions then were illegal, unless it was justified by medical reasons, however the doctors usually had a certain degree of discretion to decide upon the situation. The indictment for illegal abortion could happen in case it was proved, that the extracted fetus was *alive* at the moment when the operation took place, which apparently required an expert opinion upon which the court may adjudicate the case (for instance, the judgment of *Sternbergs*, 1928)****. The Latvian Senate had adjudicated a multitude of criminal cases concerning abortions those days, and not only doctors could be prosecuted for an abortion, but the patients or the people inducing them to undergo an abortion as well*****. Occasional cases on

* In the appeal in cassation, the town of Riga was represented by an outstanding Latvian lawyer and sworn advocate Janis Ķūzis (1881–1952). Besides, he represented the defendant in the case of Vacslav Gržibovski v. City of Riga (1937) as well.

** 1930 g. 30 apr., Spr. N. 25, Pilnvarotās Rīgas pilsētas zvans adv. Kuzu pieteikums atcelt Tiesu palātas lēmumus Baltās zvaigznes līnijas un Baltās zvaigznes dominēšanas līnijas lietā pret Rīgas pilsētu un iesniedzēja pilnvarnieka Magnusa paskaidrojums, 1930 Senata CKD Spr. (L. Nr. 94), p. 20-21. In an “English” shape, the court decision would be shaped as White Star Line & White Star Dominion Line v. City of Riga (1930), as provided in the text above.

*** 1929 g. 30 apr. spr. Betaka u. c. l. Nr. 168, Latvijas Senata Kriminālā Kasācijas Departamenta spriedumi tezes. 1928–1930. g., Lieta Nr. 1906 (497 pantu), p. 75. See additionally: 1924 g. 16 febr. Spr. Goldringa l. Nr. 34, Latvijas Senata Kriminālā Kasācijas Departamenta spriedumu tezu pilnīgs kopojums, no. 1919 g. līdz 1928 g. 31 decembrim (1928) // F. Kamradziuss, Lieta Nr. 648, p.p. 338–339. (hereinafter – “1919–1928 Kopojums”).

**** 1928 g. 30 marta. Sternbergs l. Spr. No 124, Lieta Nr. 592, p. 310–311.

***** 1922 g. 21 marta spr. Lendes n. c. l. Nr. 166, 1919–1928 Kopojums, Lieta No. 585, p. 304–305; 1923 g. 16 okt. Lidke l. Nr. 405, 1919–1928 Kopojums, Lieta No. 586, p. 305; 1924 g. 29 nov. spr. Bekera l. Nr. 544, 1919–1928 Kopojums, Lieta Nr. 587, p. 305; 1924 g. 29 nov. spr. Davja l. Nr. 454, 1919–1928 Kopojums, Lieta Nr. 588, p. 305–306; 1926 g. 28 sept. spr. Londenberga l. Nr. 537, 1919–1928 Kopojums, Lieta No. 589, p. 306–309; 1927 g. 28 janv. spr. Cerbula n. c. l. Nr. 30, 1919–1928 Ko-

illegal practice of medicine existed in the jurisprudence of the First Senate, which were criminally punished*.

Contemporary Latvian legal system is a civil law one, and patient's rights are protected by the Patient's Rights Law, enacted in 2009** – similar laws are widespread in Eastern European states, such as Poland, Czech Republic and Estonia. These include informed consent, confidentiality of medical data, access to medical records and the right to refuse medical treatment. Most of these have already been reflected in case law of the Senate of Latvian Republic, which is the Supreme Court of the state. A number of such judgments were laid down in the last several years, especially in 2020. As an example, the Senate has ruled on a variety of issues relating to medical law, holding that: transferring patient's data to the State Police upon the own initiative of the hospital representatives (suspecting he has committed a crime, as he consumed drugs before hospitalization) is not legal***; the doctors are obliged to inform the patient that would constitute informed consent, as well as check all the contraindications regardless of the fact that the patient volunteers the operation himself****; that a plaintiff suing to expunge medical data (blood samples) of his deceased father, stored for a forensic examination for many years, has such a right*****. Expungement of medical records was also a subject of dispute before lower courts*****. Such wrongs, as an unconsented surgery, incur civil liability – just the same as it is in, for instance, Lithuania, where the Supreme Court has handed down a number of similar judgments in the last two decades*****. Refusal of treatment in Latvia not yet featured in case law, but it is seemingly bounded by life-threatening situations. Euthanasia is not legal

pojums, Lieta Nr. 590, p. 309–310; 1927 g. 27 sept. spr. Šaršums l. Nr. 626, 1919–1928 Kopojums, Lieta Nr. 591, p. 310.

* 1929 g. 15 nov. spr. Bitlera l. Nr. 873, Latvijas Senata Kriminālā Kasācijas Departamenta spriedumi tezes. 1928–1930. g., Lieta Nr. 1867 (272), p. 41; See also, P. Mincs & J. Lauva, *Sodu Likums* (1936 g. izd.) ad komentariem, p. 116–118 (para. 217–220).

** Pacientu tiesību likums, Latvijas Vēstnesis, 205, 30.12.2009.

*** Senata Administratīvo lietu departamenta, 2020 g. 6 novembra, Lieta Nr. A420305915, SKA-41/2020, para. 11–17.

**** A. pret. AS «EZRA-SK Rīgas slimnīca „BIKUR HOLIM”», Senata Administratīvo lietu departamenta, 2020 g. 24 marta, Lieta Nr. A420172018, SKA – 790/2020, p. 9–10 (para. 12–13).

***** A pret. Veselības ministrija, Latvijas Republikas Augstākās tiesas, Senāta Administratīvo lietu departamenta, 2020 gada. 30.septembrī, Lieta Nr. A420260716, SKA-166/2020, para. 15–17.

***** Administratīvā apgabaltiesa, 2020.gada 2. decembri, Lieta Nr. A420209619; Lietas arhīva Nr. AA43-0874–20/10, para. 2–4.6.

***** See, for instance: J. R. ir Z. R. v. VšĮ „Vilniaus universiteto Santariškių klinikos“, Lietuvos Aukščiausioji Teisma, 30.03.2005, Civilinė byla Nr. 3K-3-206/2005, Section II, IV; V.

in any way in Latvia – either in active form (i.e. administering a lethal drug), or in passive (i.e. discontinuation of treatment by terminating life-support) – in contrast with the Japanese legal realms, wherein this subject is not directly regulated by legislation, some principles of its correct application could be found in case law: basically, most of the patient's rights in Japan originate and are anchored in case law, not legislation. Even such unclear issue as euthanasia, which is balancing on the edge of crime, is not regulated by legislation at all. Instead, the courts came up with a solution by elaborating principles when it may be applicable in respect with terminally-ill patients*, but at the same time, a full absence of sources of law regulating such complicated questions, leaves more questions than answers, to which we'll turn below.

The rights of the patient in Japan are mainly originating from case law, not from a special law on the rights of the patient – it basically does not exist. The relationships between the patient and physician (despite the fact, that the Supreme Court has firmly recognized them to be contractual**) subsisted, and probably still subsist under a deep influence of paternalism from the side of the physicians, which does not presuppose a thing called “the right to autonomy”, and thus, even informed consent seems to be a Western influence on national law [7, p. 61–62]. One of the examples of such practices, upon the work of Leflar (1996) and especially Higuchi (1992) [6, p. 24][8, p. 455–474] is that physicians frequently do not tell cancer patients what real ailment the person has, usually declining that they have cancer, even if they do; moreover, the immediate family of the patient may be also deceived concerning this. Leflar (1996) also denotes that such deception may be consensual in the sense that all the parties of the given legal relationships are more or less aware it is a deception [6, p. 24]; even the Supreme Court denoted in its 1995 judgment that the practice of concealing a cancerous diagnosis was absolutely normal for doctors in the 1980s – when the facts of the case took place***. Higuchi, who wrote about the lower court judgment, brought before the Supreme Court later (upon his findings, the judgment was originally named as *Makino v. Red Cross Hospital*, heard before the trial court in 1989 [8, p. 458–461]), wittily mentioned that such a strong paternalism may bring to fatal consequences – the patient, who is deceived concerning his state of health, may find that it is not necessary to undergo any further treatment, as his condition sounds decent in the doctor's words, whom he trusts. Despite, as Higuchi held further, the physician may deceive his patient from good motives, taking care of his well-being, the result may be even worse than the patient hears the naked truth [6, p. 465–467]. Learned lawyers held that the

* See., e.g. Yokohama District Court, Judgment on March 28, 1995 (Judgment Hourly Report No. 1530, p. 28), Medsafe No. 68.

** Supreme Court of Japan, Judgment of 27 November 2001, 1998 (O) 576, Minshu Vol. 55 (6), 1154, Section 4(1).

*** Supreme Court of Japan, Judgment of 25 April 1995, 1991 (O) 168, Minshu Vol. 49 (4), 1163, Sec. II.

Makino case was arguably the first where the court recognized the patient's right to self-determination [9, p. 220–221].

In the 90s, it was still not uncommon to conceal diagnoses featuring a potentially fatal or fatal ailment, as the physicians did believe that had they disclosed such facts, the patient would either stop struggling for health and subsequently deace, or commit a suicide [2, p. 251], but this approach started to cease in the late 1990s [3, p. 11]. In 2003, a district court in Tokyo found a hospital liable for not recommending an elderly man to undergo medical examinations in order to detect lung cancer, who died from the said disease soon, despite the causal link between the failure of the defendant hospital to explain him the necessity of further examinations and the man's demise was not established*. Besides, if we reckon up the Yokohama District Court judgment of 28 march 1995 (originally – “*Euthanasia Tokai Hospital case*”), then the case facts revealed that the elder son of the victim (who was triply given various medications in order to shorten his life – absolutely internationally from the side of the accused doctor), had repeatedly avoided communicating the exact diagnosis of the ailment (multiple myeloma) to his father, and not only to him**. Even if we do not mention the dispute of whether such a concealment of diagnosis is actually legal (or at its least, ethically correct), the fact that the closest relatives of the patients may conceal the diagnoses from them is itself difficult to conceive from a Western scholar's point of view.

According to Leflar's further works (1997), he suggested that paternalism in the sphere of healthcare does not necessarily stop on the point of concealing the diagnosis of cancer, expanding withholding the patient's access to medical records, concealing the information concerning the drugs they prescribed and inducing patients to sign up they would not complain, go to the court etc., as a condition to receiving treatment [10, p. 707–711] (in fact, Leflar claimed it was quite an old practice in his 1996 work). However, the strong paternalism in Japanese healthcare, and subsequently, in medical law, has been not only a result of the legal system being a post-traditionalistic one. Leflar outlines that it is dictated by the fact that Japanese doctors used to consult quite a lot of patients per day, and detailed examination or explanation was virtually impossible (at least, at the moment of the late nineties), and they made profit from selling drugs [10, p. 707–709]. Concerning the paternalism, it is built upon the old traditionalist features, like the existence of the relationships in the society somewhat close to master and servant, or father and son [6, p. 31–32], and the strong role of the doctor in society himself, in contrast to a weakened position of the patient, both physically and psychologically [10, p. 707–709]. Meanwhile, a special court for leprosy patients functioned in Japan to hear cases for them in the 20th century, as the state regulations prescribe to isolate such people in sanatoria; a network of “special” courts was established by the

* Tokyo District Court, Judgment of 13 March 2003, Medsafe No. 37.

** Yokohama District Court, Judgment on March 28, 1995 (Judgment Hourly Report No. 1530, p. 28), Medsafe No. 68; Hey Vol. 4 (Wa), No. 1172, p. 2-3; 8.

Supreme Court in 1948 [11, p. 225–228]; no accurate information as to what was the end date of the operation of such courts, but the isolation policy towards leprosy patients ceased in 1996. In the 1990s, 13 plaintiffs sued the Minister of Health for their seclusion in the sanatoria, and the Kumamoto District Court handed down the judgment in favor of them in 2001. The Court held that the rules on isolation of the patients in a closed sanatorium (contained in Leprosy Prevention Act of 1953) violated Art. 13 and 22 (1) of the Constitution of Japan, and emphasized that the provisions of the said law were outdated and became unconstitutional in 1960 at latest*. A deadly example of people confined in a sanatorium for decades was a strong encroachment on human rights of such an atrocity that was hardly possible to express in the concept of “damages”, which was said by the court of Kumamoto**. Luckily, there is no place for such bewildering occasions after the abolishment of the Leprosy Prevention Act of 1953 in 1996.

Informed consent. Leflar (1996 and 1997) claimed that a prototype of informed consent was reviewed in the Japanese legal doctrine in the 1930s, upon which doctors had to provide the patients some explanation concerning the proposed treatment, or at least, to treatment, which may carry unusual risks; upon Leflar, this was the influence of German civil law; the first lawsuits featuring actions for unconsented surgery broke out in the 1970s***. At some point, it should be outlined, that the Latvian legal doctrine has also addressed the issue of informed consent to the legal society in the 1930s – for instance, an anonymous author named “K.V.”, who wrote about the right of patient’s body integrity, saying that it was not resolved in Latvian criminal law [12], or Jākobsons (1936), who wrote a short book concerning the criminal

* Kumamoto District Court, 11.03.2001, 1998 (wa) No. 764, No. 1000 & No. 1282, and 1999 (wa) No. 383, Section II (2) {2.1, 2.2}.

** See Kumamoto District Court judgment at Section II (2) {2.3}: “Looking squarely at the plaintiffs’ total sufferings, the damage should be extremely serious. However, this case is an unprecedented, very special large-scale lawsuit for damages regarding the harm resulting from the New Act and the isolation policy having relied on the act; their harm, even the shortest, lasted very long for 23 years from 1973 until around the abolition of the New Act; and if the content of their harm is taken up individually, the damage was caused to extend to entire aspects of social lives and to a wide variety of aspects indeed, such as body, property, honor, trust, and family relations.”

*** Leflar (1996), see [6, p.p. 46-47]. Here he quoted the treatise of a Japanese judge, who observed a judgment by the District Court from Nagasaki, originating from 1930, where a woman sued a hospital, or a surgeon (unclear who did she sue exactly) for removing her ovaries without her consent. I have never examined the content of it, and cannot give any comment in this regard (despite I would love to, having the text), but it was seemingly a civil claim for negligence. I reckon up the Canadian judgment of *Parnell v. Springle*, Superior Court of Quebec, Jan. 20, 1899, 5 Rev. du Jur. 74, 75-76 (1899), where a doctor was sued for removing plaintiff’s ovaries without consent, finding that she is in a dangerous situation and he, upon his conscience, acted to save the patient’s life, which was found to be justifiable by the court.

responsibility of physicians. Mostly he wrote concerning unconsented surgical interventions [4, p. 8–15], despite the name of the book did not reflect it; neither K. V. (1932), nor *Jākobsons* (1936) mentioned any Latvian cases on this topic – if they actually existed at all. Though it is not surprising – I do not know any periodical originating from the First Period of Independence of Latvia, which reported cases from first-instance or appellate courts those days, e.g. in a fashion of Poland – the “*Orzecznictwo Sądów Polskich*” (often abbreviated as “OSP” in Polish legal scholarship), may serve a good example. At the same time, both of the said authors cited the predecessor jurisdiction legacy in the shape of *Modlinskiy’s case* in 1902, in which a young woman (Chernova) came to defendant to remove a tumor in her neck, but within the examination, he found a cyst tumor near the abdomen, and he decided to act immediately, not asking the consent of the victim’s parents, conducting a laparotomy. During the extraction of the tumor, a part of the tumor’s content floated to the cavity of the abdomen*; the patient’s condition severely deteriorated in the next few days, and it was supposed that the patient has peritonitis; defendant conducted the second laparotomy, but the patient died the next day after the said operation owing to heart complexifications. The findings of the lower courts were that the demise was caused by the operation; there was no urgent need to conduct it; dangerous operations require consent, and the defendant was not called for doing this operation. Defendant was convicted, and the cassational court dismissed defendant’s appeal. The court said: “The right to body integrity, the same as the right to life, is a natural right of every person, which is protected by law, by means of various regulations, as well as the ones related to criminal law. The activity of physicians, at least the right to treat [patients], belongs explicitly to persons, having a medical education, and is governed under the same rules, which are adjusted for any kinds of legal activity. One of these basic rules bears the [principle], that the body integrity of the person may not be violated without [patient’s] consent. We consider it not as causing physical pain, or a slight modification of the body cover, but such a modification of the organism, which threatens the health, a loss of an organ or its ability to function, or demise”. Note, that defendant was not blamed to be negligent in respect with the unconsented operation**. The era where the case originated from, was deeply paternalistic in the questions of healthcare, when the doctors had substantial authority, and supposedly they

* It was not established by the medical experts, whether this fact caused or enhanced the deterioration of the patient’s condition, but the expert conclusion was unanimous that the patient’s death was caused by the unconsented operation, despite no negligence in performing the operation itself was found. The negligence Modlinskiy committed was not in the careless performance of the operation, but in not asking the patient’s consent, or the consent of the patient’s legal representatives.

** 1902 g. 19 novembra, Po delu doktora meditsyny Petra Modlinskago, 1902 Senata Kriminālā Kasācijas Departamenta Spr. N. 33, 1902 KKD p. 84, 85-86, 89-90. The translation is adapted to modern English.

could believe (but the reason is not clear why), that they are immune from any liability in respect with malpractice in the exercise in their profession. I have not encountered a similar case within the Period of Latvian Republic's First Independence, but modern case law strictly imposes the duty (and a civil liability for its breach) to inform the patient enough that he could make an informed decision concerning medical interventions, regardless the condition he is eager to undergo an operation himself, or not*. The contemporary legal characteristics of informed consent in Latvian law, upon the Senate's judgment SKC-216/2013, which involved a lawsuit for involuntary psychiatric treatment, involves the following:

1) the treatment of the patient is legitimate with the patient's consent except for involuntary treatment, where the imperative nature of such treatment is apparent;

2) the consent the patient is conditional on basis of

a) ability of the patient to express his will;

b) the patient's awareness;

c) the patient's voluntary nature;

3) consent of the patient is not a sufficient condition for treatment (when it cannot be performed only upon the patient's subjective will)**.

According to Leflar (1996 and 1997), medical malpractice litigation in Japan was rare before 1970s, and patients frequently signed wayward declarations (remotely resembling informed consent forms), relieving their treating doctors from liability, regardless of the result of the operation, promising not to sue or complain for negative results of the operation [6, p. 32, 46–48]. It is quite hard to analyze, what actual legal consequences could such a “declaration” have in a post-traditional legal system, and especially in a time fragmenton, which is nearly undiscovered, and would a court really refuse to hear a case if such malpractice occurred and a “declaration” was signed, too. However, as I mentioned before – not telling the patient his diagnosis (or at least a suspicion in it) could have adverse consequences, as the patient, who trusts his doctor, may exit any treatment, finding that he is healthy and does not need it. Such a situation occurred in the case of *Makino* (1989–1995), which was later brought before the Supreme Court. The facts of this case were the following. In early 1983, a woman came to a hospital with a complaint for an upper abdominal pain. The doctor, who examined the woman, suspected a gallstone disease and instructed the patient to undergo an ultrasound examination. This said examination was conducted in ten days, and the radiologist suspected a gallbladder tumor. Upon the results of the ultrasound, a physician of

* A. pret. AS «EZRA-SK Rīgas slimnīca „BIKUR HOLIM”», Senata Administratīvo lietu departamenta, 2020 g. 24 marta, Lieta Nr. A420172018, SKA – 790/2020, page 9–10 (para. 12–13).

** G.D. pret Valsts sabiedrību ar ierobežotu atbildību „Strenču psihoneiroloģiskā slimnīca, Latvijas Republikas Augstākās tiesas, Senāta Civillietu departamenta, 2013. gada 18. oktobra, Lieta Nr. 216/2013, para. 8.5 (p. 11).

the department of internal medicine instructed her to undergo a computer tomography at the department of gastroenterology. In late February 1983, the radiologist performed the procedure, and diagnosed the patient to be ill with gallbladder cancer. The doctor occupied in the gastroenterological department, who examined the patient in early March 1983, had a considerable suspicion that the cancer was in an advanced stage, and found it necessary to make a final diagnosis and decide on the course of treatment. Being unaware of the patient's personality and family, the doctor chose not to inform her on the diagnosis. The only thing the physician told, that she has a "serious disease of the gallbladder", while the later turned out to be "deformed", and tried to persuade the patient to undergo an operation, but the patient refused and said she needs to travel to Singapore on her own affairs, and since she agreed to be hospitalized after returning from Singapore, the doctor consented as well. The patient negotiated to be hospitalized in mid-April of 1983, but two days later, she notified an assistant nurse that she has to postpone the treatment owing to family issues. After returning from Singapore, she never contacted the doctors who consulted and examined her in the said hospital, but in June of the same month, her health condition deteriorated, and she was admitted to the Aichi Cancer Center, where she was (quite apparently) diagnosed with gallbladder cancer. Despite all efforts, the treatment was unsuccessful, and the patient died in December 1983. The family of the patient sued the hospital*.

The lower courts (I credit these findings to *Higuchi* [8, p. 458–461]) found for defendant, in spite of the fact they truly recognized the patient's right to self-determination (and it was probably one of the first times that a Japanese court spoke about it directly), and they firmly stressed that doctors have a discretion concerning how much information they may provide the patient. What as to the findings of the Supreme Court, they were the following. The doctor knew nothing concerning the patient's personality (and so he could not predict how she would react on the suspected diagnosis), and it was quite common for physicians to give false diagnoses in the 1980s. Since the doctor refrained to communicate the alleged diagnosis in March 1983 out his of considerations it would insult the patient, and could cause adverse impact on her treatment, and he attempted to persuade the patient to be hospitalized, the Court found the doctor's acts could not be accounted as unreasonable. The Court admitted that communicating a "substitute" diagnosis could relieve the patient, who seemingly did not take her condition seriously and so refrained from the doctor's advice to receive inpatient treatment. The Court held that the doctors really have to be cautious to avoid situations, when the patient finds his condition moderate and becomes less eager to continue the necessary treatment. At the same time, the Court found that the doctor informed the patient that an operative intervention is needed,

* Supreme Court of Japan, Judgment of 25 April 1995, 1991 (O) 168, Minshu Vol. 49 (4), 1163 (facts, para. 1-6 (Sec. I)) – English version.

since she had a serious gallbladder ailment, and the patient had consented to be hospitalized, but later resigned her treatment and stopped visiting the hospital. Thus, the Court found that the doctor could not be blamed in failing to warn the patient of the seriousness of his condition*.

Next, the Court considered whether the doctor had to communicate the name of the disease to the patient's family. As mentioned above, he knew nothing about the patient's family (and in fact, the families play a substantial role in communicating with the doctors in Japan), and could not make a prognosis how cooperative they would be. His decision firstly to hospitalize the patient, and then speak to a person from the family concerning the diagnosis could not be unreasonable, said the court; and after the patient refrained from hospitalization and any further treatment, the doctor did not have any opportunities to inform the family concerning the health condition of the patient. Thus, he could not be blamed for this as well. Therefore, the court found for defendant, and added, that in case the patient is to receive the diagnosis from the doctor, he/she should follow his advice and be cooperative in the aspects coming out of his treatment**.

Analyzing this judgment from the time, which has passed, I should say that the defendant was lucky for the court to acknowledge that the tradition not to tell cancerous patients their true confirmed or suspected diagnosis was not stringently illegal. Here I have to agree with *Higuchi* (1992), who said that the concept of deceiving patients on their diagnosis (or not communicating it specifically – the doctor did not conceal that the patient suffered from an untold serious gallbladder disease, as actually cancer *was* a serious gallbladder disease) considerably failed in such a situation – it was bad not for the doctor himself (at least – in 1980s or 1990s), but rather for the patient [8, p. 465–467]. Let us think for a moment – would you, my reader, undergo an operation not knowing your diagnosis, blindly trusting your treating physician, who will conceal your diagnosis (a precise, or a suspected one), but will not tell you it just in order not to insult you? Let us even imagine, that he will do this way from good entirely motives. I honestly doubt you would. What used to be good practice may turn to malpractice one day. In fact, withholding a diagnosis or not communicating it to the patient may provoke a major lawsuit. Let us reckon up the case of *O'Keefe v. United States* (1980), where a US army veteran went for an examination suffering from pain in his left hip and leg in late 1972, and despite a tumor was found on his pelvic bone, it was never communicated to him or was written in the report of his attending physician. In four years, the tumor enlarged in several times, and in 1976, the plaintiff's entire leg and pelvis had to be amputated (*hemipelvectomy*) owing to the negligence of

* Supreme Court of Japan, Judgment of 25 April 1995, 1991 (O) 168, Minshu Vol. 49 (4), 1163, Sec. II.

** Supreme Court of Japan, Judgment of 25 April 1995, 1991 (O) 168, Minshu Vol. 49 (4), 1163, Sec. II-IV.

defendant; plaintiff recovered over 500 thousand USD*. This example shows how dangerous may be the withholding of the diagnosis from the patient, and what could be the legal consequences of it.

From the previous Supreme Court judgment of 1995, we may find that despite the courts (I speak concerning the courts of all three instances) recognize the patient's right to self-determination (and so informed consent as one of its main legal features); it becomes apparent that the physician's duty to inform was rather *conditional* upon a number of circumstances. It could be explained by the traditional features of healthcare and legal system of Japan. At the same time, the 2001 judgment takes a different turn. The facts of this case were the following. Plaintiff, a 43-year-old woman, went for a medical examination to defendant, who was a physician and ran a clinic in Sano (Osaka Prefecture), which had several departments and was a full member of a research group on breast cancer. Plaintiff was diagnosed with breast cancer as a result of an operational biopsy in February 1991. The doctor decided that the most suitable way of treatment was to remove the breast while preserving the pectoral muscle. The doctor informed plaintiff that an operation was necessary, and explained in full, what was necessary – he neither concealed she had cancer, nor that the breast was going to be removed. And before the operation, which was scheduled on February 28, 1991, plaintiff read that a conservative method of treatment of breast cancer existed as well (though it was quite novel those days in Japan). Two days before the operation, plaintiff handed a letter to the doctor, expressing sentiments towards having a complicated “choice” between the pursuit of life and removal of the breast. The breast removal was conducted as it was scheduled. Later, she sued defendant, demanding a compensation, claiming that it was suitable to apply conservative treatment, and defendant performed the given operation without her will or explanation**.

The facts concerning the conservative treatment of breast cancer as of the time the proceedings took place were, to sum up, the following. Since the late 1980s, the conservative treatment of breast cancer was applied in Japan, however was quite novel for those times. Most of the patients were satisfied with the procedure. The efficiency of such treatment, however, remained questionable though the physicians who applied this method of treatment found such procedures to be positive. As of the early 1990s, the percentage of conservative treatment of breast cancer cases was not that high, but the doctor, who performed the breast removal, was definitely aware of the fact that the conservative treatment of breast cancer was already performed in many institutions throughout Japan. Moreover, the plaintiff's condition was suitable for implementing such treatment, as it fulfilled the requirements for the “Implementation Programme of the Conservative Treatment of Breast Cancer”

* O'Keefe v. United States, U.S. Dist. Ct. of West Dist. Oklahoma, 21.02.1980, No. CIV-78-0838-T; 490 F. Supp. 79, 81-82, 83-84 (1980).

** Supreme Court of Japan, Judgment of 27 November 2001, 1998 (O) 576, Minshu Vol. 55 (6), 1154 (facts upon the ruling of the Osaka High Court, Section 2, (1)-(5)).

by Kasumi Group. The court of second instance found for the defendant. The court did not deny, that the doctors had a duty to inform the patient concerning the fact of their cancerous condition, the alternative ways of treatment etc., but in short, the court found that since conservative method of breast cancer treatment was not widespread at the time of the operation, and the efficiency of it was still in the process of recognition, the situation had not reached the point upon which it could be intelligible to discuss such way of treatment. The letter which plaintiff wrote to the doctor also did not change the subject.

The Supreme Court overturned the decision of the court of appeals. The court examined the depth of the duty to inform that patient, which was well recognized as one of the contractual duties of the doctor before the patient. The gist of this duty is to assist the patient in considering whether to accept to the given treatment method by weighting the pros and cons of it; if there are alternative ways of treatment, which are established by the standards of medicine, then these are to be explained as well. The main point is whether a novel, yet-to-be-established method of treatment falls under the rule. The answer, upon the Supreme Court, is very complicated, but in the given case, the Supreme Court found that it does. The argument was clear: this method of treatment was already applied by many medical institutions and received much positive assessment from the treating physicians. At the same time, the fact (or presumption) that the doctor does not find this method of treatment to be efficient by himself, and has no intention to apply it himself, it does not relieve him from his obligation to inform the patient concerning this method of treatment, its swings and roundabouts, as well as to communicate the facts concerning the medical institutions, which apply it within the scope of his knowledge. The Supreme Court also considered that the loss of the breast, which is the symbol of femininity for a woman, is depressing for the patient and affects the quality of her life in an adverse way, the requirement to explain on alternative ways of treatment – especially, the conservative breast cancer treatment) is even stronger. The court also confirmed, that the defendant was apparently aware of the conservative method of treatment, and that it was performed by many medical institutions, and was surely aware that the plaintiff had a strong interest in preserving her breast upon the letter. The court concluded that the doctor did not fulfill his “duty to explain”, having remanded the case to the court of second instance*.

A legal right to refuse treatment. In some jurisdictions, a patient has a legal right to forego medical treatment, mainly by means of notifying the medical personnel by the given fact in writing. In Latvia, such right is provided by Art. 6 (4) of Patient's Rights Law**, however at present we do not have any case law both from lower courts and of the Senate in order to assess the boundaries of such right, especially in the light of the fact that euthanasia in

* Supreme Court of Japan, Judgment of 27 November 2001, 1998 (O) 576, Minshu Vol. 55 (6), 1154, Section 4(2) – 4(5).

** Pacientu tiesību likums, Latvijas Vēstnesis, 205, 30.12.2009.

Latvia is illegal in any form. Therefore, in order to figure out what could it be, we usually tend to seek the answer in neighboring jurisdictions. In 2018, a court from Sumy oblast in Ukraine handed down a decision recognizing the right to forego treatment, but aligning the boundaries of it, namely 1) urgent cases; 2) with an existence of a substantial threat to the patient's health; 3) impossibility to get the patient's consent out of objective reasons*. The local national doctrine does not recognize the right to active or passive euthanasia, as well as any documents that could serve as the evidence for the court, approving the patient's wish not to be treated in a severely deteriorated health condition**. In Poland, the Supreme Court approved the right of a patient to refuse blood transfusion on basis of her religious beliefs in 2005***. In the same fashion did the Supreme Court of Nation of Argentine in a judgment of 2012****; and in 2015, this court legalized passive euthanasia (the case of Marcelo Diaz), who was in a permanent vegetative state for around two decades*****. Despite refusal of treatment does not mean a desire of euthanasia by the patient itself, or legalizes it, in case the law authorizes the patient to refuse it, refusal of treatment may fluctuate into it at some point – this was called “orthothanasia” by a Brazilian court in the case of *Ferreira* (2013), or “death in due time”*****. However, it is not the necessary point of the right to refuse treatment. As I held in my recent paper concerning the patient's living will – the right to refuse medical treatment, unless it is otherwise provided by case law or legislation, does not legalize euthanasia in any way [13, p. 63]. So, let us see how the given issue is resolved in Japanese case law.

As it was previously mentioned, the physician's or the hospital's civil liability for negligence (including lack of consent, explanation to the patient concerning further medical treatment and examinations) derives from Art. 415 (breach of contract*****), or Art. 709 of the Civil Code (professional negligence)*****.

* Judgment of the District Court of Lypova Dolyna (Sumy Region), 14.11.2018, Case No. 581/625/18.

** Concerning the Ukrainian state of law in respect with euthanasia and refusal of treatment, including a comment on the judgment of the District Court of Lypova Dolyna, see. A. A. Lytvynenko (2021) [p. 13, p. 53-54].

*** Postanowienie Sądu Najwyższego z dnia 27 października 2005 r. III CK 155/05, OSNC 2006/7-8/137.

**** Albarracini Nieves, Jorge Washington s/ medidas precautorias, Corte Suprema de Justicia de la Nación, 01.06.2012 (A. 523. XLVIII).

***** D., M.A. s/Declaración de Incapacidad, Corte Suprema de Justicia de la Nación, 7 de julio de 2015, CSJ 376/2013 (49-D), see in particular para. 18-24.

***** Ministerio Publico c. Joao Carlos Ferreira, Tribunal da Justiça do Rio Grande do Sul, 20 de novembro 2013, Apelação Cível No. N° 70054988266 (N° CNJ: 0223453–79.2013.8.21.7000), p. 5-7.

***** Supreme Court of Japan, Judgment of 27 November 2001, 1998 (O) 576, Minshu Vol. 55 (6), 1154.

***** Supreme Court of Japan, Judgment of 29 February 2000, 1998 (O) 1081, Minshu Vol. 49 (2), 582.

so the room for withholding diagnosis or deceiving a patient ceases to exist. The same it could exist for the doctor who would not respect the patient's will to forego certain treatment. The facts of the Supreme Court's judgment concerning the physician's liability for unconsented blood transfusion were the following. The patient, aged 63 at the moment of her stay at the hospital, became a member of Jehovah's Witnesses religious group in 1963, and as it is common of the group's disciples, refused blood transfusion on basis of religious beliefs.; her husband, though not a member of the religious group mentioned above, respected her will not to receive any blood transfusions. The hospital, where the patient was operated, was known to deal with patients having such specific religious beliefs that would not allow blood transfusion. Upon their policy, they would avoid transfusion as much as possible, except for life-saving cases, where it would be performed without regard to the will of the patient.

In June 1992, the patient came to a different hospital, where she subsequently was diagnosed with malignant liver angioma, and her treating physician told her that it would not be possible to perform the operation without blood transfusion, so she left and went to look for a hospital where it was possible. Later, the representative of the patient conducted a physician in the second hospital (where she was operated upon), and told that she was suspected to suffer from liver cancer. The doctor, who was known to work with patients, who were JW members, accepted his request, and told him that it would be likely to conduct the operation without blood transfusion unless metastases already exist. The beliefs of the patient were communicated to the doctors, and the son and husband wrote a special letter to the hospital representatives affirming the patient would refuse blood transfusion and they would not blame the hospital staff for damage occurring from non-providing blood transfusion. During the operation, the physicians found out that the blood transfusion was necessary to save the patient's life, and they conducted it regardless the will of the patient. The patient survived, but died 5 years later (cause of death was not specified of the court report, and there were no facts that there could be a causal link between this operation and her demise). Before her demise, she lodged a lawsuit against the doctor, and the state of Japan, but died shortly after*, and the members of her family succeeded the action.

The Supreme Court found, that the intention of the doctors to remove the liver tumor had no tort as such – it was their duty. But when a patient stringently opposes blood transfusion (which was highly likely to be necessary in the patient's situation), it is a different thing. The patient's will was clearly communicated, and his right to self-determination should be respected. Since the doctors did not deny the possibility that the blood transfusion manipulation should be necessary at some point, they should have told it to the patient. Then, they should have left it for the choice of the patient, whether to leave

* This fact was not mentioned precisely in the English version of the court report. An alternate court report could be found in Waseda Bulletin of Comparative Law, Vol. 20 (2000) [14, p. 155].

the said hospital, or to remain in it (and apparently, accept the situation she would require a blood transfusion, if it is necessary to save her life). Despite the fact the doctors were well aware that a blood transfusion may be necessary a month before the operation, they did not communicate this fact to the patient. Thus, patient was deprived from her right to determine whether she accepts an operation with the possibility of a blood transfusion, or not, by the omission of the doctors, who failed to communicate the said conditions to her. Both appellants – the doctors and the state of Japan were held liable to the plaintiff (or plaintiff's successors, if to be more precise); the state of Japan was also liable to plaintiff as the employer of the said doctors, under Art. 715 of the Civil Code*. According to the court report in *Waseda Bulletin of Comparative Law*, the name of the case brought before the Supreme Court was *Japan v. Takeda*. The authors of the case note also denoted (and I would agree with them), that the said case was a major precedent in respect with the patient's right to self-determination [14, p. 154; 157]. I have to agree to this with a certain remark. When a highest instance of the judicature declares the acts of the doctors have breached their duty to inform the patient on the features of future treatment in such a case – this is a significant step in favor of contemporary concepts of the patient's rights and respect for autonomy.

I should denote that refusal of treatment is a right upon which different legal (and far not only legal) attitudes do exist. The Japanese law, upon the judgment of *Japan v. Takeda* made a substantial move from paternalistic patient-physician relationships to the Western counterparts of modern medical law. This case could be also useful for the legislature and judicature of the Republic of Latvia. Despite the legislation (Art. 6 (4) of the Patient's Rights Law) specifies such a right, there is a multitude of cases from real life, when such provision could not be easily applicable, as the sense of the legal provisions I referred above is quite general, probably assuming that it is up to the courts to decide concerning each situation. For instance, imagine a situation, where a patient is brought to a hospital after a work accident, and refuses blood transfusion, despite it is obvious for the doctors he would die without it within a day or two, if not lesser? Yes, the hospital may petition the court to receive an emergency writ – such mechanism is well established in this respect, for instance, in the United States**. However, what should the doctors do in case they do not have the time I mentioned above, and death is imminent, unless you perform blood transfusion, and the patient refuses it? I guess that nobody has a precise answer in this respect. But it would be wise to conclude that the last thing a medical practitioner wants is to be sued or prosecuted. Moreover, it is always better to be a defendant in civil proceedings, rather than a suspect or an accused in criminal ones. Since such paradigm is likely

* Supreme Court of Japan, Judgment of 29 February 2000, 1998 (O) 1081, Minshu Vol. 49 (2), 582; *Waseda Bulletin of Comparative Law*, Vol. 20 (2000) [14, p. 155–157].

** Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1006–1010 (1964).

to be true, I believe it is more up to the national law to adjust the boundaries of such “borderline” situations, when matters of “life and death” exist. Still, this right may perfectly exist within sensible limits. “The right of the person to forego medical interventions at the day of the call for medical care, or for the future, with an exception of the exemptions mentioned above, upon the informed consent [of the person concerned], is subject to a boundless application by the medical personnel after the clarification of the consequences of such acts, without any complementary conditions and restrictions” – said the Regional court of Lypova Dolyna in respect with the patient’s rights to forego medical treatment*.

Tanaka and Kodama (2020) report a medical case occurring at a public hospital in Tokyo in August 2018. A dialysis patient, a 44-year-old woman, died at the hospital after she decided to terminate her dialysis. Her condition was not terminal upon the findings of the doctors, and the treating physicians proposed a number of alternative treatments. However, she refused, signed a consent form to authorize terminating the dialysis procedures and died a week after [15, p. 52-53]. I possess no information concerning if a criminal investigation was commenced on basis of the patient’s death, and the authors did not provide any information concerning this. At the same time, I agree with them in terms of the emphasis that there is no sufficient legal basis to claim that such acts are legitimate. Moreover, prosecution on basis of failure (omission) to provide medical assistance is doesn’t seem to be unreal. I have found no precedent where a court has directly approved that the doctors are allowed to let a non-terminally-ill patient decease by terminating a life-supporting treatment (which has already started) upon his request, and die in the premises of the hospital. The case of *Japan v. Takeda* is considerably different from the medical case at stake – the transfusion procedure was nevertheless performed, and plaintiff was not informed that the hospital’s policy did not withdraw the possibility of its performance in case of stringent necessity.

Euthanasia and withdrawal of life-supporting treatment. There is no actual legislation or official guidelines for conducting active or passive euthanasia in Japan. The only law (in the actual meaning of the word) could be the criminal code charging for murder or assisted suicide, as well as the existing case law, where the courts have elaborated a number of principles upon which euthanasia may be found legal. In one of my recent works, I have outlined the problem of the role of court in respect with the termination of life-support from dying (and mostly comatose) patients, holding that the resolution of such cases in courts would be the most suitable variant. From the legal point of view, it is apparently necessary to avoid potential criminal liability of the medical practitioners and the legal guardians of the patient, as well as to cassate any fraudulent intentions from the ones interested in the subsequent death of their relative [16, p. 147–148]. In some countries, as, for instance, United

* Judgment of the District Court of Lypova Dolyna (Sumy Region), 14.11.2018, Case No. 581/625/18.

Kingdom, medical institutions elaborate guidance concerning termination of life-support, especially for minor patients, but such are not binding for the courts*, which come up with the decision based upon the assessment of factual circumstances of each case and after having considered the existing evidence, expert and non-expert witness testimony. Moreover, a court may rule against a petition of a hospital to withdraw life-support in case the judge finds there are circumstances that show such decision is not justifiable, finding it is not in the best interests of the child – such assessment is very complicated and unique in each case, which requires substantial judicial scrutiny**. As it may be deduced from the position adopted by the English courts, such extraordinary medical measures, like termination of life support, which will result in the demise of the patient, are not medical, but rather legal decisions. The Italian case of *Welby*, who committed a suicide (though an assisted one), after he lost his lawsuit in the city Court of Rome, desiring his ventilator to be switched off in order for him to die, as the court refused to authorize it***, is an indecent example of a “bad” death of a patient, who did not desire to appeal, but to die regardless of the court’s judgment, probably having lost his trust and belief in the judicial system. By far, should we “respect the will” of the patient? And do patients, facing unbearable pain, suffering and consequences of their ailments (in case they are conscious and relatively mobile) would like to litigate for asking the court to allow to die? All of these questions are sound, but the gist is that nobody should get charges for the patient’s actions, and not because the patient’s guardian would promise a doctor, that he would not communicate the prosecutor’s office what had happened. This is a matter of criminal law, and there must be no jokes with the justice. So, let us see what is the current state of affairs in Japan concerning this.

To begin with, not only any legislation concerning the regulation of any kind of euthanasia does not exist in Japan, but also even any legal definition of it does not. That is why, several scholars attempted to create their own [17, p. 44]. There are guidelines in respect with terminating treatment of terminally-ill patients (though it could not be said they equate to euthanasia-like procedures), but these, according to Tanaka & Kodama (2020), do not possess a sufficient legal basis [16, p. 54–56], and thus could not be relied upon as a source of law. Matters of life and death are a very sensitive thing – not only ethically, but foremostly legally. Letting a person die is walking on the edge of crime in any way, and thus requires a sufficient regulation, either by law, or by judicial precedent. I have explored the role of the courts within the

* See, for instance, *Re: A (A Child)*, Court of Appeal (Civ. Div.), 13.07.2016, [2016] EWCA Civ. 759, para. 40-42.

** *An NHS Trust v. MB & Anor.*, High Court of Justice (Fam. Div.), 15.03.2006, [2006] EWHC 507 (Fam), para. 58-87; 88-105; 106-109.

*** *Piergiorgio Welby c. Associazione Onlus ed il. Dott. Giuseppe Casale*, Trib. di Roma, Sezione I Civile, Ordinanza 16 dicembre 2006 No. N.R.G. 78506/2006, p. 7–10.

end-of-life decision-making process earlier this year [15, p. 140-148]; despite the attitude to this question is variable in different jurisdictions, it seems that the best thing to regulate is that no doctor or legal guardian should suffer of the legal consequences of the patient's wish to die.

Probably the most influential court decision in this respect is the judgment of the Yokohama district court, featuring a trial against a doctor, who murdered a multiple myeloma patient by repeatedly injecting various drugs, the adverse effects of which, upon his calculations, would cause death. The peculiarity of the case is that there was no medical error in the doctor's actions; instead, he acted stringently to shorten the life of the patient, who was about to live several days more, had a severe and an intrusive therapy been commenced in order to prolong his life (literally, "at any cost"). Since I have the entire court report of the 1995 case, which, upon the original, is called "Tokai University Euthanasia Case", we will discuss it in more detail. So, the facts are below.

Defendant was a doctor working at Tokai University Hospital. The patient, a 52-year-old man, was factory worker. In March 1990, his blood examination was found to be suspicious. He was initially an outpatient, and later was suspected to suffer from a multiple myeloma. To establish the diagnosis, the man was hospitalized for further diagnostics and examination. The family (the wife and elder son) were told that he was likely to have multiple myeloma, but the patient was said he had a bone marrow failure. Later on, the patient's condition was stabilized, and he was released in June 1990, but was hospitalized again in December 1990, as his condition deteriorated. By the end of the year 1990, and in early 1991, it started to become clear that it is impossible to cease the deterioration of his condition; in February 1991, the patient started suffering from bone destruction and back pains owing to a compression fracture of the lumbar spine. In March, the prognosis of the patient became worse as he was predicted have a high risk of deceasing from such causes, as infectious diseases, a stroke or kidney failure. Despite his condition was stabilized in the first day of April, it continued to deteriorate until his demise. Within the first decade of April he started vomiting with blood and the vital functions were worsening. The last week of the patient's life (April 8-14, 1991) was described in the court report with great detail, but I will get through the main ones. The family had not once asked to stop the patient's treatment, but the physicians strived to save him; the discussions concerning the termination of any efforts between the family and doctors frequently involved disputes. Before the patient's last day, the dropper and catheter were removed. As of April, 14, the patient was still alive, but had difficulties with breathing and low level of consciousness. However, the prognosis held he would not survive a week of time. Finally, it was decided to "stop the suffering" of the patient. The patient was loudly snoring; the accused firstly injected 4ml of Horizon Diazepam, which had a side effect of respiratory depression, but it didn't "work". Next, he brought a medicine

named “Serenese” with similar side effects, and administered a double dose, but it didn’t “work” again. Then, the accused decided to use Verapamil, which had a side effect of a short heart failure, together with potassium chloride. At 20:46, the patient suffered a hyperkalemia, and died around 21:00*.

The doctor was prosecuted under Art. 199 of the Criminal Code (charges for a homicide), and the court went to discuss the situations, where an active termination of life is permissible under the law, given that neither the criminal code, nor other laws specified it. The court gave some legacy to the existence of the problem of euthanasia, claiming that it is wayward derivative of the patient’s right to self-determination, and recognized that euthanasia could be in some way permissible. The court asked a couple of phenomenology-like questions: 1) firstly, is it necessary to continue treatment in order to prolong life, in case the patient’s demise may not be averted?; 2) next, is it permissible to terminate futile treatment – which the court called “a problem of a so-called dignified death”.

The court held, that when the demise of the patient may not be averted, there is a boundary of the “obligation to treat”, wherein the obligation is not “obligatory” and is justifiable in case they find the further standard: 1) the condition of the patient must be terminal**; 2) there has to be a will of the patient to terminate such treatment, and it must exist at the time of the hypothetical moment of the termination of treatment***; 3) when it is impossible to alleviate pain****. Therefore, the court set up four criteria where euthanasia could be permissible:

* Yokohama District Court, Judgment on March 28, 1995 (Judgment Hourly Report No. 1530, p. 28), Medsafe No. 68; Hey Vol. 4 (Wa), No. 1172, p. 6–9; 10–14.

** Yokohama District Court, at p. 17: “It is considered, that the termination of treatment is permissible only in the case, when the condition is such, when death is unavoidable, as there are no chances to recover. Despite the termination of treatment derives from the patient’s right to self-determination, this right recognizes not the right to choose death, or the right to death, but the right to choose, how to approach death, or to the process, which brings towards death (...) Only when it becomes impossible to save the life, and it [the death] becomes unavoidable (...), such measures for the prolongation of life should be terminated, as they have to be observed concerning whether they are admissible, or not” (edited).

*** Ibid, at p. 17 “It is apparent, that it would be necessary that the patient would have a stringent will [to terminate the treatment] at the time, when the issue of terminating treatment is considered. Next, such intention is made (...) upon the request of the patient... (...), who has enough information concerning his state of health with precision, the content of the treatment [procedures], expected future situation etc...,” (edited). At some point, this phrase would go even better in respect with refusal of treatment. Later, at p. 18, the court acknowledged that it is impossible to know the exact will of the patient in every case, but there may be evidence of the presumed will of the patient.

**** Ibid, at p. 18–20.

The patient suffers from unbearable pain and is in a terminal condition;
It is impossible to avert death;

It is an elimination of the patient's physical pain – there is no other variant to alleviate it;

There is a will of the patient, who would choose to shorten his life*.

Assessing the facts, the court concluded the following in respect to the acts of the doctor and the condition of the patient in the case: 1) the patient was in a terminal condition and was apparently suffering; 2) the patient was not fully informed on his state of health and his prognosis – the existing information was not enough to conclude on the presumed will of the patient; 3) similar cases of “euthanasia” could considerably undermine the trust in healthcare in respect with people, who are at the terminal stage of their illness, as it may seem, that a life of a dying person could be neglected, which is impermissible; 4) the court recognized, that the Japanese healthcare system in respect with the care for dying persons (i.e. palliative care, as it is called now) ought to be better; 5) at the same time, the hospital, where the accused was employed, was known to have high standards of treatment. Verdict: guilty**.

Now, let me introduce a few thoughts concerning this judgment. The criteria, which the court outlined for euthanasia to be permissible, are quite sound, and are well known in medical law. Nearly the same criteria were announced by an expert witness in the trial of Truus Postma (1973) in the Netherlands, adjudicated by the town court of Leeuwarden, who claimed that average Dutch physicians do not consider as correct to prolong the patient's life at any cost in a number of situations***. It was a bit obscure for the expert witness to say, that an early 1970s doctor from the Netherlands would not consider to struggle for a patient's life when he does not necessitate. But would a public prosecutor ask him, what does he consider, and what sense does it make, in case such actions are prohibited by the Criminal Code? Euthanasia was not legitimized

* Ibid, at p. 24.

** Ibid, p. 25–26; 27–30.

*** See. Truus Postma, *Rechtbank Leeuwarden*, 21.02.1973, NJ 1973, 183:

“1) firstly, it should be an incurable patient – owing to a progressive illness, or an accident having injured him (anyway, he should be considered medically incurable – at least such was the ethical background of around 1970)

2) secondly, his physical or mental suffering seems to be unbearable or severe for the patient;

3) the patient should have indicated, if necessary, in handwriting, that he does not want to suffer anymore, practically desiring to be alleviated from suffering by submitting to voluntary death;

4) the process of dying has commenced or it is apparent according to medical record;

5) the physicians accept the necessity to administer painkillers to mitigate the physical and mental suffering of patients for long. The administering of lethal doses of drugs in such cases seemingly is also accepted” (translation from Dutch from the original court report with minor editions by the author).

in this country before 2002. The situation with euthanasia in the Netherlands, where the doctors either were acquitted, or received conditional sentences for killing patients on their request* is rather a big exception from the civil law tradition. The criteria, set out by the court of Yokohama are likely to be examined by courts (and in fact, the court had precisely assessed the facts of the case in compliance with the said criteria), not doctors or any other medical personnel themselves – in order not to be prosecuted for homicide. Therefore, if such criteria should be used by courts, then it is logical that the hospital has to petition the court to permit euthanasia (and nothing does indicate that the patient's family or caregiver would not impugn the judgment) to avoid criminal liability of its employees. At this point, I think it would be sound to conclude that the said criteria should be based upon the established *facts*, which are established not by a doctor, a relative of the patient, a guardian, a nurse or any other party involved, but the judiciary. The will of the patient in the Yokohama case was not *established* – neither before a court (they did not petition the court), nor in fact, which caused the physician to be convicted of crime. Addressing the issue to the court is not problematic (despite occasionally American courts claimed it could be cumbersome to review each similar case**), and a medical decision to terminate the patient's life without an authority does not worth to be prosecuted for.

The final case we are going to observe here only approves this statement. The facts of the case were typical for a euthanasia case. The patient (hereinafter – the victim, as the charges were put for homicide, Art. 199 of the Criminal Code of Japan), aged 58, had a major bronchial asthma attack in early November 1998, and the victim was in a cardiopulmonary arrest, when he was delivered to the hospital. Though the victim's cardio-pulmonary functions were regained, he did not regain consciousness, and was put to the ICU unit, where he was hereinafter kept on a respirator and received further medical treatment. Owing to the hypoxemia during his cardiopulmonary arrest, the victim suffered from brain damage, and remained in coma until his demise (he was admitted to the hospital on November 2, 1998, and died owing to a homicide, which was committed by the doctor on November 16, 1998). The accused was a physician with sufficient skill, knowledge and experience working in hospitals, and was occupied as a director of the department of respiratory medicine, and directed the course of the victim's medical treatment. The doctor informed the family of the victim that it would be difficult for the patient to regain consciousness again and the victim is likely to fall into permanent vegetative state. On November, 6, 1998 the patient started spontaneous breathing, and the respirator was dislodged, though the endotracheal tube remained intact so as to avert glossoptosis and suck sputum. Two days later, the victims limbs

* See. Rechtbank Leeuwarden, 21.02.1973, NJ 1973, 183.; Rechtbank Rotterdam, 01.12.1981, NJ 1982, 63; Rechtbank Utrecht, 21.12.1982, NJ 1983, 264; Hof Amsterdam, 17.11.1983, NJ 1984, 43.

** Woods v. Commonwealth, 142 S.W.3d 24, 49–50 (Ky. Sup. Ct. 2004).

started showing contractures; the accused assumed that there was no hope to restore the brain functions of the victim, and when he met the immediate family of the victim, informed them the actual conditions of the victims and obtained their consent that the respirator would not be attached again in case the victim's respiratory functions would worsen, adding that the tube would not be removed (as it would pose the risk of the victim's suffocation). Five days later, it was time to change the endotracheal tube of the victim. The accused wondered if the victim could breathe without the said tube, and removed it in the presence of the victim's wife, however an immediate effect of the victim's breathing slowdown made the accused to intubate the victim again at once. On the next day, the victim was moved to the general ward, and the accused instructed the nurse to reduce the oxygen supply and transfusion, and told her that no CPR acts should be done in event the victim gets worse (it is strange to hear this was in some way permissible in a full absence of euthanasia/end-of-life legislation). During the last two weeks of the patient's life, no tests to determine a tentative life expectance were made; nor any facts concerning his will "to fight until the last breath", or "die in peace" were known (if they actually existed). On the patient's last day of life (November, 16), the wife of the victim spoke to the accused and asked to remove the endotracheal tube, claiming that "it was a decision of a family". The accused was told, that the family of the victim would arrive to the hospital by the evening. At around 6:00 PM, the accused came into the victim's room with a nurse, where the immediate family was waiting for him. The accused removed the endotracheal tube, being in full recognition that it may provoke death, and took no measures to assist the victim to breathe. The victim tried to gasp for breathe with some efforts, and the accused muscle relaxants for the victim. The victim died at 7:11 pm.

The doctor was prosecuted, and was found guilty of homicide. From the findings of the Supreme Court, I would like to outline the following ones:

No tests in regard with a tentative expectation of the patient's life were made during his stay at the hospital;

The termination of his life-support was performed after two weeks of his stay at the hospital, and it was impossible to determine the possibility of recovery or life expectancy;

The termination of treatment was performed upon the request of the family members, who were not informed concerning the victims health condition, the possibility of recovery etc. (*it was highly likely to look as an emotional decision* – A.L.);

The termination of treatment was not based upon a presumed (or real) will of the patient (*had it existed at all?* – A.L.).

Considering the given facts, the court found that the cessation of life-supporting treatment in this case could not be regarded, as a legitimate one. Verdict: guilty*. The judgment was also known as "*Kawasaki-Kyodo Hospital*

* Supreme Court of Japan, 12.07.2009, 2007 (A) 585, Keischu Vol. 63, No. 10, Section 1 (1)-(8); 2.

case”, which contributed to the body of Japanese medical-law jurisprudence in respect with end-of-life decision-making, anchoring the physician’s criminal liability for not complying with the rules (if they could be called as such) for conducting withdrawal of life-supporting treatment. This case is quite depressing from the point of civil law, as the doctor could easily avoid criminal liability, had the accused acted in a more legally prudent way. Firstly, the doctor should not have listened to the family of the victim. From the point of civil law, which is more or less the same in Eastern Europe’s legal tradition, the patient was, first of all, legally incompetent. Therefore, any decision could be made upon a legal representative (lat. *pilnvarniek*), more commonly, a legal guardian. Legal guardians are appointed by a court and in many civil law jurisdictions the guardian’s powers include managing very certain functions. In any case, the guardian reports the court on the acts in respect with maintaining the beneficiary’s health, and it is highly questionable of whether a civil law court would authorize removing life-support – even with providing sufficient evidence. Moreover, it is not uncommon to seek a court approval for a major medical intervention by the guardian according to the provisions of the civil code – it would obviously require the same for terminating life-support (for instance, see the wording of the Austrian Supreme Court in its 2012 judgment*). The situation with the case I mentioned above looks more like a relic of customary law, which turned into a conviction for the doctor. The family presented no court declaration approving the withdrawal of life-support, and no official legal guardian talked to the accused claiming he was planning to petition the court for such declaration; no signs that the homicide was committed under coercion also exist. The homicide elapsed from the thin air. Had the doctor not listened to the family of the patient – nothing would occur. The only thing the doctor had to blame himself for was legal nihilism. Therefore, as I have stated in my recent paper on the legal characteristics of the living will – it is a hazardous idea not to seek a court approval, but to attempt to decide matters of life or death on your own [13, p. 60–63]. If the patient’s representative firmly disregards the legal consequences of death of the patient, he at least should consider the legal consequences of such acts for the doctor.

The given paper discussed the emergence and development of the patient’s rights in Japanese law – a legal system with a traditional background, which could be considered a post-traditional one owing to the fact that customs and traditions still have impact on the legal system, though not as much now. As of the 1980s, the doctors frequently used to deceive their patients concerning the facts of them having cancerous conditions, which served bad primordially for the patients (judgment of the Supreme Court of 1995), but such practice became obsolete and ceased to be legal at around 2000 (the judgments of the Supreme Court of 2000 and 2001). According to the principles, set out in the said cases, paternalistic healthcare was no longer applicable in the Japanese legal

* Oberster Gerichtshof, 2012. 08.10, 9 Ob 68 / 11g, para. 2.4; 3.5.

system: the right to self-determination was well recognized, and the doctors could be found liable for not informing the patients on the future treatment and its main concerns. Japanese courts also coped with complicated issues on refusal of treatment (e.g. judgments of the Supreme Court of 2000), which still poses a legal problem for the courts in Eastern Europe owing to the disparities in elucidating the boundaries of this rights.

The medical law and jurisprudence of the Latvian Republic is relatively young, despite having some legacy in the interwar period (1919–1940) – the period of First Independence of Latvia, which also featured a number of outstanding litigation related to medical negligence and public-legal relationships in the sphere of healthcare. The current medical jurisprudence features judgments considering nearly every aspect of the rights of the patient (e.g. the recent Senate judgments No. 41/2020; 166/2020 and 790/2020), though the problem of refusal of treatment and end-of-life decision-making still remains unresolved, especially the latter one, as the national legal system does not recognize “a right to a dignified death”. At the same time, it is apparent that earlier or later, the legal system will face this problem – as dozens of other jurisdictions have. Since it is not possible to avoid the issue of euthanasia legality in the future, it would be better to be prepared to adopt the best worldwide practices. Upon the position of the author, “a right to a dignified death” has to be recognized to a certain extent, under the condition of state control, which requires sanctioning it by a court under convincing evidence, upon which it must be established that the condition of the patient is already irreversible, and his direct or presumed will was against “endless and futile treatment” (as an alternative, the parties must prove before the court, that it would be not in the patient’s best interests to undergo “endless and futile treatment”). The cases from Japan – both the one from Yokohama (1995), and the one adjudicated by the Supreme Court (2009), only affirm how dangerous it may be to disregard the law and act without an authority, and serve a good example that matters of life and death need legal regulation. The same is applicable to the limits of one’s refusal of treatment, especially in cases where the patient’s health condition is life threatening. Balancing between the public interest in preserving the patient’s life, and the private interest in the right to one’s self-determination, the former must prevail.

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Захист прав пацієнтів у посттрадиційній правовій системі: порівняння медичної юриспруденції Республіки Латвія та Японії

Проаналізовано випадки порушення прав пацієнта, зокрема здійснення медичних втручань без згоди пацієнта, порушення медичної таємниці чи інформаційних прав пацієнта, включно з питаннями припинення життя (end-of-life), які не є рідкісними в країнах англо-саксонської та континентальної систем права. «Найстаршим» судовим процесам у справах щодо аналогічних випадків значно більше, ніж століття: предметами позову, як у наші дні, так і в ті часи, ставали лікарська недбалість, проведення операцій без згоди пацієнта та розголошення медичної таємниці. Досліджено розвиток медичної юриспруденції в Японії. Зазначено, що правова

система Японії, також належить до континентальної системи права, але на практиці вона є посттрадиційною, що виражається у вкрай високому ступені патерналізму у правовідносинах лікарів і пацієнтів, який панував до останніх кількох десятиліть і «привид» якого все ще певною мірою впливає на медичне право сучасної Японії попри те що кількість позовів стосовно порушень прав пацієнта у цій державі в останні десятиліття суттєво зросла. Зазначено, що законодавство цієї держави також не містить закону про права пацієнта, що відрізняє її від більшості держав Європи, більшість принципів стосовно вирішення справ, у яких предметом позову є недбалість медичних працівників, походять з прецедентного права – практики Верхового суду та судів нижчих інстанцій. Кожне з таких судових рішень залежить від обставин конкретної справи, а особливості посттрадиційної системи права все ще впливають на ухвалення судом рішення в справі.

Ключові слова: права пацієнта, медичне право Японії, медичне право Латвії, інформована згода пацієнта, захист персональних даних, припинення життєзабезпечуючого лікування, евтаназія, лікування раку, традиційні правові системи.

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