

New Organ Transplant Policies in Japan, Including the Family-Oriented Priority Donation Clause

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The revised Organ Transplant Law in Japan that took effect in July 2010 allows organ procurement from brain-dead individuals, including children, only with family consent. The amended law also allows individuals to prioritize family members to receive their donated organs after death. This policy differs from the prioritization policy in Israel, which provides incentives to individuals who agree to help each other in society and rectifies the problem of free riders, individuals who are willing to accept an organ but refuse to donate. Despite these differences, however, the Japanese and Israeli policies have revealed new ethical dilemmas, including the fear of compromising fairness in organ allocation.

Keywords: Brain death, Organ donation, Prioritization policy, Israel, Japan.

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In the international community of transplantation, Japan was viewed as an unusual country. Japan's revised Organ Transplant Law, however, is intended to push the country somewhat closer to the laws of other countries' transplant operations. Two major revisions of the law, which took effect in July 2010, have made Japan's organ transplant policies similar to other countries. Now, in Japan, organ procurement is permissible with family consent, unless the brain-dead person previously refused to be a donor. In addition, brain-dead children less than the age of 15 years are allowed to be donors. These changes, although, required alterations to the country's definition of a "dead" individual. For these purposes, Japan legally, but not clinically, discarded its unique double standard definition of brain death, in which brain death constitutes death only when the patient has given prior written consent to be an organ donor and the family does not oppose the donation (1).

Enacted in 1997 and valid through June 2010, the original Organ Transplant Law had the double standard definition of brain death as a result of political compromise as a means of legalizing organ donation from brain-dead individuals. This was necessary because half of the Japanese population did not believe that brain death constitutes death. Public opinion has remained divided about recognizing brain death (2). This division, however, does not mean that the majority of the public is opposed to revising the transplant law to ease donation regulations. Changes were made to the old system,

because it resulted in a small number of brain-dead donors nationwide: 86 brain-dead donors for over a dozen years. Because of this, in July 2009, after a short but heated debate, the majority of lawmakers voted for the revisions to the law. Analysts and researchers believe that some lawmakers felt pressured because of the international community's previous statement that transplant tourism and organ trafficking should be prohibited (3). The revised law, which has the main purpose of increasing the number of brain-dead organ donors, has resulted in 16 brain-dead donors in 3 months, although none of these were children.

The revised law does not stipulate that brain death constitutes death, but the revisions presuppose that brain death constitutes legal death. Otherwise, procuring organs from brain-dead donors with only family consent would constitute murder. However, many physicians are believed to have maintained the double standard of the definition of brain death to permit them the decision of when to pronounce a patient deceased. For clinical physicians, the timing of this pronouncement often needs to consider the condition of the family who unexpectedly faces the difficult situation of a loved one suddenly passing away.

The clinical application of the double standard of brain death seems appropriate not only psychologically but also medically, in which the clinical and ethical validity of the whole-brain concept of death is questioned (4). With the advancement of intensive medical technology in the past few decades, inconsistencies inherent in the concept of whole-brain death adopted by the United States and other countries, including Japan, have become evident (5–7).

PRIORITIZATION POLICIES IN JAPAN AND ISRAEL: SAME PURPOSE, DIFFERENT APPROACH

However, it is unknown whether another legal revision to the Japanese law will serve the purpose, that is, allowing

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individuals to prioritize family members to receive their organs, should they donate organs after death including brain death. The newly introduced family-oriented priority donation policy took effect in January 2010, half a year earlier than the previous two revisions. As of September 2010, one priority donation under the new policy has been reported, in which a cornea was transplanted into the donor's wife, skipping the donation waiting list.

The family-oriented priority clause, which is rare in the international community, was almost outside the Japanese Legislature's debate focusing on whether brain death should be uniformly recognized as legal death. The legal revisions, including the priority clause, aimed at increasing organ donation from cadavers were proposed by a group of lawmakers, one of whom had personal experience with donating when he gave a portion of his liver to his father. Many analysts predict that the priority clause that allows direct organ donation between close relatives would not increase the number of brain-dead organ donors, particularly considering that the nature of such organ donation involves brain-dead donors. But a group of lawmakers added the clause in an attempt to make it more appealing to the public and specifically to make more Japanese individuals view organ donation positively.

The countries that first implemented nonmedical criteria in organ allocation were Japan and Israel. However, there are clear differences between the two countries' prioritization policies. The new Israeli law that also took effect in January 2010 in the hopes of increasing the number of brain-dead donors has the following three rules for organ allocation: (1) consent given by a person during his life to donate an organ after his death accords both the person and his first-degree relatives priority in organ allocation; (2) an organ donated by a person after his death accords his first-degree relatives priority in organ allocation; and (3) an organ donated by a person during his life not for a designated recipient accords him or his first-degree relatives priority in organ allocation (8). Before instituting the law, Israel conducted national surveys, appointed a special interdisciplinary committee to research and deliberate on the topic, and hosted a parliamentary debate. Israel's policy is designed to provide incentives to individuals who agree to help each other in society and rectify the problem of free riders, people who are willing to accept an organ but refuse to donate. There is a small but prominent portion of the Israeli population who oppose the idea of brain death and organ donation, yet they do not hesitate in becoming candidates for transplantation when in personal need of a donor's organ (8). In Israel, people are encouraged to help each other while helping themselves and their family. In Japan, however, the population is encouraged to first help the family members.

An additional example of the different focus of the Japanese and Israeli laws is the incentives they provide donors. The Japanese prioritization policy grants donor card holders no priority in organ allocation, whereas the Israeli policy grants twice as many points to donor card holders than their first-degree relatives. When considering the purpose of the prioritization policies in the two countries, both of which have segments of their population opposed to the idea of brain death, one could argue that Israel has taken a more logical approach to the issue that is believed to have some chance to increase the number of donors, whereas Japan has

taken an emotional approach that is believed to have a slim chance to serve its stated purpose.

A NEW ETHICAL DILEMMA EMERGES—DO THESE LAWS COMPROMISE FAIRNESS?

The Israeli policy creates ethical problems, such as the potential of putting individuals with fewer or no family members and living donors who have donated to a chosen recipient at a disadvantage. Some experts find it hard to accept that people whose first-degree relatives have made an unenforceable agreement to donate by donor cards would be prioritized over those who have assumed the risk during their lifetime by donating an organ (9). Such a policy seems to ignore the value of donation and the incidental benefit that a living directed donor confers on the waiting list by removing one candidate. Other experts fear that the Israel's policy may contravene the deceased's decisions regarding organ donation (10).

Japan's revised law has maintained a fairness clause that was present in the original law, as one of the fundamental principles of organ transplantation, stating that organ distribution and transplant operations should be conducted in a fair manner. This clause is in line with one of basic principles in organ transplantation in the world (11). Under the law, the Japan Organ Transplant Network, a government-affiliated entity, has taken measures aimed at ensuring fair opportunities for organ transplants strictly based on medical need. These measures are often referred to as the "fair-opportunity rules." Some Japanese domestic critics have voiced concerns that the family-oriented priority clause would violate the fair-opportunity rules, but the issue never drew much public attention. Furthermore, the issue was not on the agenda of the health ministry's working group, which consisted of experts and was tasked with identifying the preparations necessary to enact the revised law. Instead, the group discussed which family members are eligible for donation under the priority clause and concluded that the priority is limited to blood-related parents and children and legally married couples. Adopted children are eligible only when they have cut all legal ties with their biologic parents. The priority is realized when the deceased has left a written statement of his wishes regarding his organs.

The priority clause has not caused major conflict in Japan, suggesting that setting the priority would not morally offend the sense of rightness of the Japanese people. The lack of conflict, although, does not explain why the average Japanese citizen accepts the family-oriented priority clause under the guise of fairness. There seems to be no easy explanation for this, but there is a possible argument that acceptance of the fairness of the clause is due to the Japanese concept of the boundary of self. For the average Japanese individual, persons who fall within the boundary of self are first-degree relatives, just as the government panel concluded. In other words, it seems natural for the majority of the Japanese to consider their closest relatives as inseparable parts of themselves.

THE THEORY OF RELATIVE ETHICS BASED ON RELATIONSHIPS

The boundary of self and the sense of fairness of the Japanese population may be explained by the theory of rela-

tive ethics based on relationships, conceptualized by Shimizu (12), a Japanese philosopher, in which ethical codes could vary depending on the closeness of the relationship between the parties. The Harm Principle, made widely known by J.S. Mill in *On Liberty*, resides at one side of the Shimizu's theory. Shimizu proposes the corresponding principle of mutual help at the other side of the theory. The Mutual Help Principle works most powerfully among people having the closest relationship, whereas the Harm Principle works most predominantly among those with the remotest relationship. The Mutual Help Principle is associated with the unity and dependence of persons. According to Shimizu, people sharing a strong sense of closeness would like, feel required, or are pressured to do everything they can for family members. Watching the relationship-based relative ethics theory in action in Japanese families, there is little question about why the population accepts the family-oriented priority clause under the slogan of fairness. In Japan, the prevalence of this type of relationship has led to the country having the highest number of living donor liver transplants in the world. One of the characteristics of the Mutual Help Principle could also be found in the familial interdependency particularly between the mother and child described by Doi (13), a Japanese psychiatrist.

Moreover, in response to public concern that the family-oriented priority clause would invite suicides of people who desperately wish to save members of their family even at the cost of their own lives, the Japanese government revised its guidelines accompanying the revised law to state that individuals who committed suicide to provide organs for family members are unable to serve as organ donors. Among who voiced the concerns were the Japanese Circulation Society, consisting of 22,000 members including more than 10,000 heart specialists. Although these members understand that it would be almost impossible to intentionally become brain dead from the medical point of view, they were still concerned of the possible risk (14).

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