Brain Death, Organ Transplantation and the Ethics of Relationships in Japan: 1968-2000

Takanobu Kinjo

Follow this and additional works at: http://scholarsrepository.llu.edu/etd

Part of the Bioethics and Medical Ethics Commons

Recommended Citation
http://scholarsrepository.llu.edu/etd/454
Brain Death, Organ Transplantation and the Ethics of Relationships in Japan: 1968-2000

by

Takanobu Kinjo

A Thesis submitted in partial satisfaction of the requirements for the degree of Master of Arts in Biomedical and Clinical Ethics

September 2000
Each person whose signature appears below certifies that this thesis in their opinion is adequate, in scope and quality, as a thesis for the degree of Master of Arts in Biomedical and Clinical Ethics.

David R. Larson, Professor of Religion

Mark Carr, Assistant Professor of Religion

Robert D. Orr, Professor of Family Medicine

Louis Vanden, Professor of Religion

James W. Walters, Professor of Religion

Gerald R. Winslow, Dean and Professor of Religion
ACKNOWLEDGEMENTS

I would like to express my appreciation to the individuals who helped me complete this thesis. I am especially grateful to David R. Larson, my advisor, for his utmost dedication, encouragement, patience, and understanding. His example of great enthusiasm for helping students is what I will always strive to follow. I am indebted to the members of the review committee, Mark F. Carr, Robert D. Orr, Louis Venden, James W. Walters, and Gerald R. Winslow for their advice, comments, and above all, warm support. I am thankful to Johnny Ramiréz and Genie Sample for their help and guidance.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval Page</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>v</td>
</tr>
<tr>
<td>Abstract</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter I The Controversy in Japan: Review</td>
<td>1</td>
</tr>
<tr>
<td>From 1968 to 1982: The Wada Heart Transplantation</td>
<td>2</td>
</tr>
<tr>
<td>From 1982 to 1992: Unproductive Controversy</td>
<td>7</td>
</tr>
<tr>
<td>From &quot;1992 to 2000: Legislation and Implementation&quot;</td>
<td>17</td>
</tr>
<tr>
<td>Summary</td>
<td>20</td>
</tr>
<tr>
<td>Chapter II The Controversy in Japan: Analysis</td>
<td>22</td>
</tr>
<tr>
<td>Medicine and Society</td>
<td>22</td>
</tr>
<tr>
<td>The Absence of Consensus</td>
<td>24</td>
</tr>
<tr>
<td>Japanese Views of Death</td>
<td>31</td>
</tr>
<tr>
<td>The Japanese Ethics of Relationships</td>
<td>42</td>
</tr>
<tr>
<td>Summary</td>
<td>55</td>
</tr>
<tr>
<td>Chapter III The Ethics of Relationships: Exposition</td>
<td>56</td>
</tr>
<tr>
<td>A Missing Element in the Japanese Controversy</td>
<td>56</td>
</tr>
<tr>
<td>The Ethics of Relationships: Conceptual Analysis</td>
<td>59</td>
</tr>
<tr>
<td>The &quot;Wall&quot; Between Donors and Recipients in Japan</td>
<td>65</td>
</tr>
<tr>
<td>Overcoming the &quot;Wall&quot; Between Donors and Recipients</td>
<td>68</td>
</tr>
<tr>
<td>Summary</td>
<td>79</td>
</tr>
<tr>
<td>Chapter IV Implications for North American Bioethics: Reflections</td>
<td>81</td>
</tr>
<tr>
<td>Ethics of Organ Donation and Transplantation in North America</td>
<td>82</td>
</tr>
<tr>
<td>The Ethics of Relationships and North American Culture</td>
<td>87</td>
</tr>
<tr>
<td>Whole Brain-Death in North America</td>
<td>93</td>
</tr>
<tr>
<td>Summary</td>
<td>96</td>
</tr>
<tr>
<td>References</td>
<td>99</td>
</tr>
<tr>
<td>Selected Bibliography</td>
<td>105</td>
</tr>
<tr>
<td>Appendix: The Diagram of Organ Transplantation in Japan</td>
<td>107</td>
</tr>
</tbody>
</table>
ABSTRACT OF THE THESIS

Brain Death, Organ Transplantation and the Ethics of Relationships in Japan: 1968-2000

by

Takanobu Kinjo

Master of Arts, Graduate Program in Biomedical and Clinical Ethics
Loma Linda University, September 2000
Dr. David R. Larson, Chairperson

The center of the brain-death and organ transplantation debate in Japan has always been whether whole brain-death should be regarded as the death of a person. However, the debate has not yet been settled in Japanese society.

There are four main reasons why it is said that whole brain-death criteria are incompatible with Japanese society. First, they cannot establish a person’s death because the Japanese define it not according to medical facts but according to social relationships. Second, it is impossible to determine societal consensus in Japan on this issue. Third, traditional Japanese views toward life and death are incompatible with whole brain-death criteria. Fourth, whole brain-death criteria for the purpose of organ-transplantation is incompatible with the Japanese ethics that emphasizes relationships. The more ongoing and more intimate the relationships are between family members and the deceased, the more probable it is that family members will perceive him or her a living person and the less likely it is that they will accept whole brain-death criteria with respect to their beloved one.

The essential cause of these problems is the “wall” between the two sides
which implies insensitivity and indifference to the needs of those on the other side; What is missing in the controversy is a mutual understanding of these issues on the part of those on both the donor and the recipient sides. Because the Japanese people do not have a special ethics like Christian neighbor-love, one form of moral imagination which helps North Americans see strangers as if they are loved ones, and because the Japanese do not have the custom of giving gifts without reciprocity, it is unrealistic to expect them to donate organs to strangers. The most promising solution would be to abolish the ordinary practice of maintaining anonymity between those on the donor and the recipient sides so that each is finally able to become more realistic about the needs of those on the other side.
Chapter I
The Controversy in Japan: Review

In order to understand the whole brain-death and organ transplantation debate in contemporary Japan, it is necessary to review certain historical events. Such reviews offer good starting points, generate debates, and provide information from which inferences can be drawn and valuable lessons learned. In this study, a review of the historical background is very important in at least two ways. First, it will foster understanding of the unique, but at the same time, peculiar history of whole brain-death and organ transplantation in Japan. This is the history of the total prohibition of whole brain-death criteria and transplantation for almost 30 years. Second, an historical review will also help identify the central issues in the whole brain-death and organ transplantation debate in Japan. This is, therefore, an introductory chapter that provides factual information needed for the ethical analysis that follows.

The historical events can be categorized into three periods and reviewed in detail. The first period, from 1968 to 1982, was characterized by a total prohibition of whole brain-death criteria for organ transplantation in Japan. The most notable event in this period was the Wada heart transplantation in 1968. This event was so decisive in the Japanese history of organ transplantation that it will be closely reviewed in this chapter. The second period, from 1982 to 1992, was marked by the active organ transplantation movement along with the anti-whole brain-death movement. This period must be understood as a transitional
one that prompted many disputes regarding whole brain-death as a new definition of a person's death for organ transplantation. The third period, from 1992 to 2000, was a time in which whole brain-death criteria for organ transplantation was legislated and several brain-death organ transplantations were performed. In this period, Japan plunged into a new era of organ transplantation; however, it is not yet clear whether Japanese society has accepted it. A summary is provided at the end of this historical review.

From 1968 to 1982:
The Wada Heart Transplantation

On August 8, 1968, Asahi Shinbun, one of the major national newspapers in Japan, reported in its evening edition the first heart transplantation in Japan. Professor Wada at Sapporo Medical University Hospital transplanted "the heart from a young man who was killed by a fatal accident" to another young man who had suffered from mitral incompetence, tricuspid insufficiency, and aortostenosis. The donor was a 21 year old man who was found drowned around noon on August 7, 1968. Forty minutes after the donor was found, attempted resuscitation brought back spontaneous respiration while he was being transported to the nearest hospital. He was then transported to Sapporo Medical University Hospital in order for him to be put into an oxygen tank. On the same day around 10 p.m., the donor became brain dead. After about four hours he was medically declared dead. The team ceased to use a pump-oxygenator when the donor's heart condition reached the point of no return and began the transplantation for which the donor's family had given the consent.\(^1\) The recipient lived for 83 days after the transplantation.
Between 1968 and 1970, Professor Wada was accused three times by other physicians. The charges were: (1) unnecessary but purposeful murder (Wada was charged for taking the heart of the donor who was in a state of apparent death.) and (2) professional negligence leading to death (Wada provided unnecessary transplantation to the recipient leading to the premature death of the recipient due to immunological rejection.). \(^2\) However, the Prosecutor's Office of Sapporo decided to drop the case.

The Sapporo Prosecutor's Office happened to release the draft of a criminal liability report which indicated that the case was filled with doubts and unresolved questions. The Prosecutor's Office pointed out that it was doubtful that the donor was really dead at the time of the organ procurement. When the donor was transported to Sapporo Medical University Hospital, he was treated with a pump-oxygenator despite the presence of spontaneous respiration. Assuming that spontaneous respiration ceased at a certain time while the donor was on the respirator, the prosecutor suggested that death should be declared when the respirator was terminated and no spontaneous respiration was observed. However, the transplantation team provided no evidence that they actually carried out the test and observed a lack of spontaneous respiration before declaring the donor's death. Instead, they terminated the respirator at 2:27 AM and observed that the donor's heart was in a state of fibrillation at 2:30 AM. Concluding that the donor's heart was in nonreversible cardiac arrest, they proceeded to procure the heart. According to the prosecutor's statement of criminal reliability, the donor's inability to maintain spontaneous respiration was never used to declare his death, thus leaving no evidence of when the
donor died. There was a record indicating that the donor's heart showed a
decline of spontaneity around 10:35 PM. Therefore, the heart's spontaneity
ceased between 10:35 PM and 2:30 AM when the heart was procured; however,
the prosecutor could not know exactly when. The prosecutor could not deny
the possibility that the donor's heart was procured while his heart still had
spontaneity; but at the same time, the prosecutor could not confirm this.\(^3\)

In addition, many pointed out that the transplantation was unnecessary
for the recipient.\(^4\) Miyahara, the recipient's previous attending physician, was
one of these. Miyahara stated that the recipient suffered from mitral stenosis,
which he considered not serious enough to require organ transplantation. He
requested the transfer of the recipient to the surgery department in order for
him to receive a replacement of an artificial heart valve.\(^5\) Another doubtful
point was that the valves of the recipient's heart were taken apart and hidden
for about half a year with the donor's heart. The prosecutor then asked the
department of forensic medicine at Tokyo University to evaluate the valves, but
the prosecutor was informed that there was no evidence to affirm or deny that
the valves were replaced by other's. However, many assumed that the valves
were replaced because the team was afraid a judicial autopsy would find out
that the team's justification to provide organ transplantation to the recipient,
organic disfunction in the recipient's heart valves, was not accurate.\(^6\) At the
interview, the prosecutor clearly admitted that they decided to drop the case
simply because there was not enough evidence to prosecute Wada in spite of
the fact that there were many doubtful questions were left.\(^7\)
It is probably true that the Wada heart transplantation should be regarded as the most notorious and the most influential event in the history of organ transplantation in Japan. This transplantation should be remembered not because it was the thirtieth heart transplantation in the world and the first whole brain-death organ transplantation in Japan, but because the case revealed ethical problems in Japanese healthcare. It also had negative consequences for the later organ transplantation movement in Japan.

Three negative consequences of the Wada heart transplantation can be suggested. First, this event helped the Japanese people to develop a negative image of organ transplantation and healthcare in general.8

The second consequence of the Wada transplantation was much more clear and serious in terms of its influence on the development of the organ transplantation movement in Japan. It eventually created a situation in which the prosecutor decided to adhere to traditional signs of death, thus setting a restrictive legal standard for determining death in Japan. This meant that the prosecutor’s office declared that it would prosecute a physician who procured organs from a person declared dead according to whole brain criteria. This is one of the main reasons why Japanese physicians have been reluctant to perform whole brain-death organ transplantation. In Japan, performing whole brain-death organ transplantation literally meant that one would be prosecuted. This was also part of the reason why many believed whole brain-death organ transplantation had to be legalized in Japan. Without legal warrant, it had been too risky.9
The third consequence of the Wada transplantation has had the most pernicious influence on the organ transplantation movement. The two consequences already mentioned may convince many that the Wada transplantation was mainly responsible for the prohibition of whole brain-death organ transplantation in Japan for nearly 30 years. However, the issue of organ transplantation is only part of the whole picture. It is accurate to state that different issues accumulated and intermingled to hinder whole brain-death transplantation in Japan. However, the Wada transplantation should be remembered in different way. This transplantation was historically significant because the case was not critically reviewed and no fruitful lessons were learned from it, which points to the third consequence. The third and most pernicious consequence of the transplantation, therefore, was that the case did not generate serious discussion of whole brain-death and organ transplantation despite its great publicity.

Lack of serious discussion about whole brain-death and organ transplantation is surely the chief characteristic of the period from 1968 to 1982. The prosecutor made it clear in the Wada transplantation case that he would adhere to the traditional definition of death of a person until physicians offered a new definition that achieved societal consensus. However, none of the Japanese medical associations, including the Japan Physician Association, the Japan Brain-Wave Association, or the Japan Organ Transplantation Association, seriously advocated whole brain death. They even appeared to assume too optimistically that societal consensus would be reached with ease.
In conclusion, the period from 1968 to 1982 was an unproductive period in the history of the whole brain-death and organ transplantation controversy in Japan. Productive discussions did not occur and valuable lessons were not learned from the first controversial whole brain-death transplantation. It eventually ended up undermining the significant need to advocate whole brain-death criteria and to ask Japanese society to re-examine the meaning of a person's death.

From 1982 to 1992: Unproductive Controversy

This period included the beginning of full-scale discussions about whole brain-death and organ transplantation and the rise of an active organ transplantation movement in Japan. Because the movement's ultimate goal was to make organ transplantation possible in Japan, the discussion explored the possibility of societal consensus on whole brain-death. The question was whether whole brain-death should be regarded by society as the death of a person so that organs can be procured from a brain-dead individual for transplantation.

There are four important incidents in this period that deserve examination. First, the introduction of the first official Japanese whole brain-death criteria in 1985, the Takeuchi Criteria, can be regarded as the most fundamental step. Second, the Tukuba-dai pancreas-liver simultaneous transplantation in 1984 was historically important because of its negative effects on the transplantation movement. Third, the Japan Physician Association finally established a Bioethics Council to arrive at a consensus on whole brain-death as
the death of a person in medical circles. Fourth, Noshi-Rincho (Brain-Death Ad
Hoc Committee), considered to be the most important event of this period, was
established by the Japanese Health Administration to build a national consensus
on whole brain-death as the societal death of a person.

The Takeuchi Brain-Death Criteria

In 1983, Koseisyou (the Department of Health and Human Services of the
Japanese government) took the first step initiating an organ transplantation
movement by establishing a special study team to develop the first official
whole brain-death criteria in Japan. The study group was asked to carry out
nation-wide research on clinical brain-death cases, analyze them, and develop
competent brain-death criteria that would subsequently make whole brain-
death organ transplantation possible in Japan. The developed criteria, now
commonly called 'Takeuchi Criteria' after the chief director of the team, adapted
the Harvard whole brain-death criteria. These criteria defined brain death as the
irreversible loss of the whole brain's function. The criteria required six
conditions to be met in order to declare brain death: (1) "deep coma, 300- Japan
coma scale, 3- Glasgow coma scale," (2) "apnea, confirmed by apnea test," (3)
"bilaterally fixed pupils larger than 4 mm in diameter," (4) "absent corneal,
ciliospinal, oculocephalic, vestibular, pharyngeal and cough reflexes," (5)
"isoelectric electroencephalogram," and (6) "duration of observation: 6 hours,
or longer if necessary." In addition, these criteria required at least two or
more physicians with adequate experience with brain-death cases to declare
death based on these standards. The validity of the Takeuchi Criteria is
apparently well established because many agree that the criteria are as strict as any other whole brain-death criteria in the world.\textsuperscript{11} Also, the special team specifically declared that the criteria were established only to define clinical criteria for brain death, but not to create new definition of a person’s death.\textsuperscript{12}

The Tukuba-Dai Pancreas-Liver Simultaneous Transplantation

The Tukuba-Dai transplantation is historically important because of its negative influence upon the organ transplantation movement in Japan. When this incident took place, the special study team was in the process of formulating the Takeuchi Criteria. Therefore, there was no medical or societal consensus in Japan regarding whole brain-death. In addition, the physician who carried out the transplantation was a member of the special study team. Therefore, the physician should have known and understood that whole brain-death was not accepted in Japanese society and that he would be prosecuted if he procured organs from a brain-dead patient.\textsuperscript{13}

The important difference from the Wada heart transplantation case was that there was clear evidence in the Tukuba-Dai case that the physicians procured the organs while the donor’s heart was still beating. Thus the case was guaranteed to be prosecuted. Another controversial point of the case was that the donor had a high degree of mental disability. The consent for the donation was given by the donor’s husband who remembered the donor saying that she wanted to donate her organs while they watched the news of Wada heart transplantation 14 years earlier.\textsuperscript{14} The physicians were accused in 1985 and the Prosecutor’s Office is still investigating the case.\textsuperscript{15} The consequence of this case was to slow down the organ transplantation movement. Some believe that the
special study team took over two years to develop the Takeuchi Brain-Death Criteria because of the controversy caused by the Tukuba-Dai case.

**The Bioethics Committee of the Japan Physician Association**

After the formulation of brain-death criteria in 1985, the Japan Physician Association established a Bioethics Committee in 1988 that aimed at fostering consensus on whole brain-death in Japanese medical circles. The committee made two important points in its position paper. First, the committee argued that the most important aspects of a human being are: the capacity of the brain stem to coordinate biological life, and the mental activity that resides in the cerebral portions of the brain. Having said that, the committee concluded that whole brain-death could be considered the death of a person from medical and biological perspectives because in it a patient has lost what it regarded as the most important aspects of being human. Second, the committee suggested that whole brain-death should be legally defined as the death of a person for two reasons: (a) legalizing it would eliminate the possibility of being prosecuted if one procured organs from a brain-dead person, and (b) legalizing brain-death was the most effective way to achieve societal consensus.16

**The Brain-Death Ad Hoc Committee**

In 1990, the Department of Health and Human Services of the Japanese government established what was called, "Noshi-Rincho" (The Brain-Death Ad Hoc Committee) which sought a settlement of the whole brain-death and organ transplantation controversy.17 The committee consisted of persons in various professions including physicians, social workers, lawyers, writers, and philosophers. Aiming at reaching an agreement on whether brain death is the
death of a person, and under what conditions brain-death organ transplantation should be allowed, the committee held thirty-three regular meetings, three overseas field trips, two opinion polls, and six public hearings. The work of this committee was therefore the most important development in this period because the progress of the organ transplantation movement depended on how well this committee developed societal consensus. However, the committee failed to reach "Manjo-Icchi" (unanimous agreement) which was expected to be mandatory in Japan for such governmental commissions, and ended up delivering two separate position papers: a majority opinion and a minority opinion.

Review of the Majority Opinions. The majority opinion begins by examining the death of a person from medical and biological perspectives. Because of the introduction of respirators during the 1960s, medicine and biology had begun witnessing whole brain-death and had begun to understand a person as a living system or an organic and integrated individual that possesses both consciousness and sensation. The majority opinion, thus, defines the life of person as a state of organic integration as a whole; it is a state in which internal organs maintain mutual dependency, a state in which organs purposefully and sensibly maintain different mental and physical activities and preserve homeostasis. Subsequently the majority opinion defines the death of a person as a state in which a person loses such organic integration as a whole.

Having said that, the majority opinion insists that the whole brain, including the brain stem, possesses functions that maintain this organic integration as a whole. It agrees with the recent trend in medicine and biology
to regard the loss of whole brain function as the death of a person because whole brain-death does mean to lose organic integration as a whole. The majority opinion uses the reports of medical advisors to demonstrate that certain human cells show signs of life for a long period of time after the heart has arrested. It concludes that postponing the declaration of death until all brain cells have died is unreasonable. Therefore, the majority opinion insists that the determination of the irreversible loss of the functioning of the entire brain is medically sufficient to determine whether a patient has lost organic integration as a whole and is dead. The majority opinion also affirms that the Takeuchi Brain Death Criteria, developed eight years earlier, is still valid and effective.

Next, the majority opinion examines the most controversial point, that is, whether Japanese society should accept whole brain-death as the societal death of a person. However, as the minority opinion points out, the majority opinion concludes this without providing sufficient and justifiable evidence. The majority opinion's basic opinions are three folded. First, the majority opinion discusses mind-body dualism. Second, the majority opinion talks about traditional Japanese ethics and religions. And finally, the majority opinion concludes that it is appropriate to carry out whole brain-death organ transplantation in Japan.

The minority opinion insists that mind-body dualism, which helped Westerners implement organ donation, does not fit with the traditional Japanese view of life and death. In response, the majority opinion defends its position by merely saying that "it is difficult to imagine that there is direct
relationship between mind-body dualism and the definition of death of a person as the condition where a person loses organic integration as a whole"\textsuperscript{18} without providing any explanation nor supporting evidence.

In addition, in response to the minority opinion's insistence that traditional Japanese ethics and religious perspectives do not accord with a definition of brain-death as the societal death of a person, the majority opinion only states that "from Japanese traditional religious and ethical perspectives, we are not able to find any practical reason why we must reject the new definition of death."\textsuperscript{19} However, the majority opinion fails to provide even one single supporting explanation or line of evidence to justify its statement.

The majority opinion finally appears to provide a justification of organ transplantation from whole brain-dead patients by saying that "the new definition of death is widely accepted by many foreign nations which have different cultural and religious backgrounds, and accords with the understanding of a person's death in the international community."\textsuperscript{20} The majority opinion therefore concludes that whole brain-death is the societal death of person. However, it is easy to agree with the minority opinion's criticism that the majority opinion's argument is invalid and unjustifiable because its conclusion lack supporting evidence and explanations. It is very difficult to understand why the majority opinion spends only a few paragraphs on the most vital part of the whole brain-death and organ transplantation controversy.

Review of the Minority Opinion. The minority opinion consists of two major parts. In the first part, the minority opinion criticizes the majority
opinion. In the second part, the minority opinion presents its basic position statements to support its thesis that whole brain-death cannot be regarded as the societal death of a person in Japan.

First, the minority opinion summarizes the majority opinion's viewpoints on whole brain-death as follows:

Death should be considered as a medical and biological event, but also as a societal and lawful (judicial) event as well as a philosophical and religious event. However, when defining the death of a person, medical and biological understandings of death must take precedence over others. We cannot prevent ourselves from agreeing that whole brain death should be regarded as the death of a person because, according to the most recent understanding of death from medical and biological perspectives, the death of a person must be understood as the loss of brain functions that preserve the integration of biological and organic activities.21

The minority opinion then criticizes the majority opinion's greater reliance on medical and biological understandings of death as compared to philosophical, religious, and cultural understandings of death. In addition, it also criticizes the majority opinion's understanding of a human being as an integrated biological and organic unit. Furthermore, the minority opinion insists that the new definition does not make any sense to the Japanese people because of their natural perception that a brain-dead individual is still a living person. Then the minority opinion suggests that there must be some more basic reason that drives the majority opinion to advocate such inconsistent and inaccurate definitions of death.

The controversial gap between the majority and the minority opinions is confirmed by the interpretation of opinion polls about brain death. The two polls conducted by the committee demonstrated that almost half of the Japanese
people regard whole brain-death as death of a person. The majority opinion interprets this result as a clear sign that Japanese society is ready to accept whole brain-death as death of a person. On the contrary, the minority opinion interprets the same result as a sign that Japanese society still resists the idea of whole brain-death. It therefore criticizes the majority opinion for inappropriately using the poll results and drawing too optimistic and unrealistic conclusions.

Charging that the majority opinion's ideological positions are governed by scientism, rationalism, human-mechanism, and Westernism, the minority opinion identifies its fundamental ideological positions as follows:

We choose not to depend upon these ideological positions that the majority opinion takes, but we emphasize that a person's body is a host of the spirit as well as biological life. We respect the human being not only for rational thinking, understanding that a human being's life shares its significance with the lives of other species on this earth. We resist scientism's excessive strides, honor the cultural tradition of mankind, and critically adopt modern Western civilization and culture.22

Although the minority opinion realizes how difficult it is to determine which opinion is more truthful, it holds that its position should receive at least as much attention and respect as the majority opinion.

Understanding that whole brain-death is very close to the death of a person, the minority opinion admits that it is very hard to find reasons to denounce a donor's sincere and voluntary will to donate organs to others. In addition, it also recognizes that a voluntary choice to donate organs does not offend the spirit of Christian love or the Buddhist understanding of life and death. Therefore, it is willing to open a path that would make organ procurement possible as a legally justifiable medical action.
The minority opinion proposes four conditions to carry out whole brain-death organ transplantation in Japan without defining and legalizing that whole brain-death is the societal death of a person: (1) an official written document that clearly shows the donor's will to donate organs, (2) maintenance of equal opportunity in recipient selection, (3) valid informed consent to receive transplantation, and (4) development of certain systems that ensure the patient's rights and autonomy.

Several observations are in order. First, the committee could not reach agreement on the matter that was its ultimate goal: whether whole-brain death ought to be regarded as the societal death of a person in Japan. Part of the reason for this disagreement is that the majority opinion did not support its position at all and did not respond to the minority opinion's questions. Of course, there were essentially different opinions on the matter among the committee members which were in large part responsible for the disagreement; however, it is never possible to resolve disagreements without intense discussion and the dynamic exchange of critical opinions. At the end of its position paper, the committee concludes: "While paying close attention to the fact that there are various opinions in regards to the death of a person, the committee hopes to see that brain-death organ transplantation guided by good sense is carried forward to benefit as many patients as possible."23 This final statement, which well represents the committee's conclusion, is at most vague and indecisive. This leads to the conclusion that the Ad Hoc Committee failed to settle the whole brain-death and organ transplantation controversy in Japan. In short, this period, from 1982 to 1992, can be considered as the beginning of the organ
transplantation era in vain. Discussions were provoked and opinions were presented, but no productive exchanges took place that achieved consensus.

From 1992-2000: Legislation and Implementation

This period was marked by the introduction of organ transplantation legislation and the first organ transplantation from a whole brain-dead patient since 1964. After the Brain Death Ad Hoc Committee submitted its final report to the "Koseisyou" (Department of Health and Human Services), the members of the National Diet voluntarily formed a bioethics study group to prepare for proposing an organ transplantation bill in 1993. In December of the same year, several political parties established a special discussion council about whole brain-death and organ transplantation. In the following year it proposed the first draft of an organ transplantation law that defined whole brain-death as the death of a person. "Nichibenren" (The Japan Federation of Bar Associations) immediately released a statement objecting to the council’s proposal. On January of 1994, the Department of Health and Human Services proposed guidelines for procuring organs which allowed family members to donate organs without a donor’s consent. In April of the same year, the bill was finally submitted to the Lower House, but political turmoil over other issues prevented its discussion. Two years later, on June of 1996, the bill was modified to limit organ procurement to cases in which the donor’s choice to donate organs was assured in a written consent forms. The bill was then returned to the Lower House, but three month later the bill was once more abandoned due to the dissolution of the Lower
House. On December of the same year, the new bill, called the Nakayama proposal, was re-submit ted to the Lower House, but deliberation of the bill was again delayed. On March of 1997, the Japan Organ Transplantation Association finally developed its own guidelines to allow brain death transplantation in Japan without relying upon the law. At the same time, the Kanada proposal, which does not define whole brain-death as a person's death, was submitted to the Lower House. Again the main argument in the House was whether whole brain-death ought to be defined as the death of a person.24

The Organ Transplantation Law

In April of 1997, the Nakayama proposal was carried and the Kaneda proposal was withdrawn by the Lower House. The bill was then submitted to the Upper House, but by the next month another proposal similar to the Kaneda proposal was also submitted. In order to resolve this conflict, "whether the law should define whole brain-death as person's death," the Upper House finally settled for a modified Nakayama proposal which was considered to be an appropriate compromise. According to this compromise, whole brain-death was defined to be death of a person only when organ donation had been voluntarily offered and organ procurement was to follow. The modified bill was re-submitted and carried by the Upper House as well as the Lower House on April 17, 1997.

This organ transplantation law, the modified Nakayama proposal, has three noteworthy points. First, whole brain-death is considered to be the death of a person only in cases of organ transplantation under two conditions: (1) presentation of the donor's written consent to donate his or her organs and (2)
the presence of no objections from the donor’s relatives. Therefore, this
definition of death should be regarded as a new definition of death specifically
for organ transplantation. Second, the law acknowledges the right of the
donor’s family to override the donor’s choice to donate his or her organs. In
another words, the family members of the donor, not the donor himself or
herself, retains ultimate control. Third, the law prohibits organ procurement
from those under 14 years of age. Organ donation is only allowed by the law
when the donor has autonomously and voluntary chosen to donate his or her
organs. Because in Japan fifteen is earliest age one is allowed to write a living
will, the law holds that those under fourteen can not make an autonomous and
voluntary decision to donate organs.  

Brain Death Organ Transplantation in Japanese Law

On October of 1997, half a year after the law was passed, the
transplantation law was finally implemented. Many people expected whole
brain-death organ transplantation to take place shortly. However, one year and
four months passed before the first organ transplantation from a brain dead
person actually took place. It is possible that the very strict requirements of
the law caused the delay. A donor must obtain a donor card, follows its
directions precisely, and provide his or her own and other family member’s
signatures. Without a donor card, none of the any other written or oral forms of
consent is valid. Physical presentation of this donor card is required to procure
organs from the donor and proceed with organ transplantation.

There have been at least eight whole brain-death transplantations
performed in Japan since the law was implemented. Some of these eight
transplantations included minor mistakes and pose certain questions. The most controversial question is how to balance the obligation to disclose information to the public and also to protect the privacy of the donors' and recipients' families. The Department of Health and Human Services makes clear that only information that is permitted by the donor's and recipient's relatives will be disclosed. It even suggests that none of the information will be disclosed if family member desire this. This, too, has generated much controversy.

A Summary

In this chapter, the history of the whole brain-death and organ transplantation controversy in Japan has been reviewed in three periods. The first period, from 1968 to 1982, was the most primitive and most futile part of the history. This era witnessed the controversial Wada heart transplantation in Japan, but it failed to review the case critically. This resulted in the total prohibition of whole brain-death organ transplantation in Japan for over thirty years. The second period, from 1982 to 1992, finally gave rise to various organ-transplantation movements, but failed to lead society in achieving consensus about whole-brain-death due to the fact that none of the committees or study teams provided fundamental solutions to the conflict stemming from different views on whole brain-death. Without deciding whether whole brain-death should be regarded as the death of a person, the next period, from 1992 to 2000, witnessed relevant legislation and at least five brain-death organ transplantations between 1998 to 2000. The organ transplantation law in Japan is unique in the
world because it regards whole brain death as the death of a person only when the donor has chosen to donate organs and organ procurement follows.

From this historical review of the whole brain-death and organ transplantation controversy in Japan, we are able to arrive at one important conclusion: the whole brain-death debate has not yet been settled in Japanese society. The review tells us that the center of the debate has always been whether whole brain-death should be regarded as the death of a person. Organ transplantation has attracted much attention by the public in Japan not because transplanting someone's organs is controversial but because the majority of donors are brain dead. The various committees could not reach an agreement on the single most important point, whether whole brain-death ought to be accepted by society as the death of a person. Furthermore, organ transplantation legislation was vigorously debated at one point: whether whole brain-death should be defined as the death of a person by the law. As a result, the law does not recognize whole brain-death as person's death in general, only with regard to organ transplantation. If the whole brain-death debate has not yet resolved, what is the reason? What prevents Japanese from accepting whole brain-death? Does this also prevent Japanese from donating their relative's organs? The next chapter will explore various anti whole brain-death arguments and try to answer these questions.
The historical review in the last chapter revealed that the leading problematic and yet-to-be-resolved issue in the whole brain-death and organ transplantation controversy in contemporary Japan is whether whole brain-death is the death of a person. The purpose of this chapter is to explore this crucial issue further from various Japanese perspectives. These include the Japanese views of life and death, traditional religions, and ethics. It is evident that this study cannot cover all of the vast and diverse arguments of the controversy. It therefore reviews the most prominent arguments carefully and summarizes them in the following four points: (1) brain-death criteria are nothing but neurological criteria, but the death of a person is an important social event which should be determined by the whole of Japanese society, not medicine alone; (2) a consensus to define brain-death as a person's death has not been reached by Japanese society; (3) the concept of brain-death does not fit with traditional Japanese views of death; and (4) the Japanese have a distinctive ethical orientation that emphasizes relationships in a way that makes it difficult for them to adopt the concept of brain death, particularly when it is advocated in order to make organ procurement and transplantation possible.

Medicine and Society

The first common objection against whole-brain death in Japan is that it
provides merely medical and biological criteria that cannot be equated with the definition of a person’s death. In 1992, the minority opinion of the Japanese Brain Death Ad Hoc Committee summarized the majority opinion as follows: “medical and biological perspectives should have priority over other social, legal, philosophical perspectives for the sake of defining a person’s death.”\(^{28}\) The minority opinion of the committee criticized this suggestion. It insisted that medicine does not have the authority to define the death of a person because the Japanese people view death as a societal event.

Some believe that medical criteria for death can become the definition of societal death only through certain procedures. When the first Japanese whole brain-death criteria were introduced in 1983, Takeuchi, who was the chairman of the brain-death committee, noted that the report simply proposed criteria or standards of whole brain-death, but it never intended to introduce new a definition.\(^{29}\)

Uozumi suggests that only Japanese society as a whole should decide whether to accept whole brain-death criteria as a new definition of a person’s death. “A criterion of medical death could become the criterion of societal death through an appropriate process” he says. “Once the medical criteria receive societal recognition as a person’s death, physicians will finally be granted the right to use them to declare a person’s death.”\(^{30}\) Hara believes that the lawyer’s role is to actualize society’s consensus about whole brain-death issues and to help establish a balance of benefits for donors, recipients, and families only after consensus is reached by the whole Japanese community. This belief leads him to
deny that medicine has the authority to define whole brain-death as the person’s death.\textsuperscript{31}

Given the viewpoints presented, it is clear that the Japanese differentiate societal death from medical or biological death. Many insist that the definition of societal death can be equated with the whole brain-death criteria only when the Japanese society approves it in a formal process called “social consensus.”

The Absence of Consensus

The second general argument against whole brain-death in Japan is that Japanese society has not yet arrived at this consensus in favor of it. There appear to be several reasons for this. One of them is that there is no effective and useful tool with which to measure the degree of consensus on this issue. Polls and surveys are not effective tools because in Japan they are frequently used with varying results. The Brain Death Ad Hoc Committee, nationwide newspapers, and “Sorifu” (Office of the Prime Minister) have all repeatedly carried out polls to see whether Japanese society is ready to accept whole brain-death without success. It is helpful to look at some of results to see how these polls and surveys are not reliable.

The Office of the Prime Minister conducted a poll on the people’s attitude toward whole brain-death and organ transplantation in 1985. Forty-six percent of the people thought that whole brain-death organ transplantation should not be done while only thirty percent thought it should and twenty-four percent were uncertain.\textsuperscript{32} Surprisingly, totally opposite results were found in a poll administered by \textit{Asahi Shinbun}, one of the Japan’s major national newspapers, in
the same year. This poll revealed that fifty-two percent of the people answered ‘yes’ to the question “organ transplantation from [whole] brain-death cannot be prevented from taking place” while twenty-nine percent believed that it should not occur. Margaret Lock, a philosopher who has published several articles regarding the whole brain-death and organ-transplantation issues in Japan, remarks that the survey results she has encountered are all paradoxical to her:

“All the surveys reveals a paradox, however, in that many people approve of organ transplants from brain-dead patients, although they themselves do not accept brain death as the end of life. It seems that Japanese people are willing to allow transplants to take place, even though they personally would not be comfortable with participating in such a procedure”

As Lock indicates, the various poll and survey results appear to reveal inconsistent attitudes among Japanese people toward the issues. These inconsistent results make one feel that the Japanese continuously oscillate or that maybe there is no social consensus. At this point, there appear to be three ways to interpret this situation. First, it can be assumed that there is a “real” and consistent Japanese attitude toward whole brain-death somewhere and that we must continue to search for it. Second, it can be assumed that the Japanese people really do change their attitudes; perhaps their attitudes are so ambivalent and so inconsistent that it is extremely difficult to summarize them one way or other. Third, it can be assumed that there is some other factor that makes it appear that Japanese attitudes toward whole brain-death and organ transplantation are inconsistent and uncertain, as if their attitude oscillate from one position to the other.

The third alternative is the most consistent with the findings of this study. There is a distinctive Japanese ethics that prompts the Japanese people to act in
particular ways in particular situations so that their attitudes appear inconsistent and paradoxical to others. It is necessary carefully to study the poll and survey results in order to discover what is really going on.

Despite all these drawbacks, the results of the polls taken from 1998 to 1999 appear to be more reliable because they provide similar results. *Asahi-Shinbun* conducted two polls in 1998 and 1999, before and after the first whole brain-death organ transplantation since 1968. The results were very similar: the number of people who accepted whole brain-death was fifty-three percent in 1998 and fifty-one percent in 1999. This suggests that finally the Japanese started to form consistent attitudes toward whole brain-death; however it also suggests that the first organ-transplantation under the new law led to no attitude change.

Another recent poll shows that accepting whole brain-death is a totally different issue for the Japanese from donating organs for transplantation. This national poll was conducted by the Office of the Prime Minister in 1998. It showed that thirty-two percent of the Japanese people are willing to donate organs if they become brain dead, but thirty-eight percent are not willing to do so.

The three polls interestingly share one identical result: about sixty percent of the Japanese people would like to honor and fulfill a family member’s choice to donate his or her organs. This reveals an interesting contrast; the number of people who want to donate organs (thirty-two percent) is actually lower than the number of people who believe that whole brain-death is the death of a person (about fifty-two percent). The number of people who would agree to
donate a family members' organ (sixty-one percent) is also higher than the number who believe in brain death (about fifty-two percent).

From this interesting contrast, it is tempting to speculate that whether the Japanese decide to donate organs does not depend ultimately on whether they accept the concept of whole brain-death. Once the Japanese are asked to honor and fulfill a family member's choice instead of their own decision to donate organs, the number suddenly jumps up to about sixty percent. This is ten percent higher than the number of people who believe in the concept of whole brain-death, about twenty percent higher than the number who want to donate their own organs, and about thirty percent higher than those who do not want to donate organs.

As stated previously, the prevalent assumption is that whole brain-death criteria prevent Japanese people from donating organs. However, these results reveal that honoring a family member's choice to donate his or her organs receives the most approval, even higher than the percent of those who believe that whole brain-death is a person's death. This suggests that there might be another more powerful factor than whole brain-death criteria that influences Japanese's attitudes toward organ donation and transplantation.

Despite the fact that recent polls finally come up with similar and thus more reliable results, it is still difficult to say that they finally depict a Japanese consensus. In fact, it appears that survey results cannot be used to indicate consensus because the same numbers can be interpreted differently by various individuals and groups. In the 1990s, when the various polls indicated that between sixty five to forty five percent of the Japanese people believed in whole
brain-death criteria and about thirty to forty percent were willing to donate organs, the majority opinion of the Brain-Death Ad Hoc Committee used these survey results to conclude that consensus had been reached. On the other hand, the minority opinion referred to other survey results which showed that forty-seven percent of people believed in whole brain-death criteria, and pointed out that this number “did not even reached fifty percent.” It concluded that consensus had not been reached on this matter. From this example, it is apparent that the problem stems from how the numbers are interpreted. For instance, if one survey showed that eighty percent of the Japanese are willing to donate organs, it is still possible to say that the percent is not high enough to conclude that consensus has been reached or vice versa. Because there is no shared understanding of what social consensus is all about, each can freely define what it is and interpret the statistics accordingly. The danger is that persons and groups are tempted to use self-defined and interpreted understandings of consensus to justify their own positions.

Social consensus is actually an ambiguous concept. Hara effectively describes what it means in Japanese society:

I always ask one question to those who insist that brain death is a person’s death and social consensus has been reached on this matter. The question is ‘Are you going to bring a gift or *koten* (monetary offering to a departed spirit) when your close friend becomes brain dead?’ Almost no person could answer the question. One person said, ‘If I bring *koten*, they will knock me down.’ No matter what medicine or the law says, we should not bring *koten* to the family if we do not want to hurt their feelings. When we no longer feel hesitant to bring *koten*, and the family does not feel awkward receiving it, we will be able to say that consensus has been reached in our society.
Hara’s approach suggests that consensus is not something that can be defined, discussed, and decided. Rather consensus ought to be regarded as a gradual process which takes much time to develop.

There is an additional reason why it is difficult to attain consensus on whole brain-death in Japanese society. When facing important medical decisions, the Japanese people tend to change their minds easily depending on surrounding situations. To be more specific, it depends on who will receive care in the family. Fetters, having conducted many collaborative research projects with Japanese health professionals, provides a good example of the phenomena called the “cancer disclosure paradox”: “If affected by cancer themselves, they would prefer to be told the truth, but that if a family member were afflicted with cancer, they would not want the family member to be told.” Fetters writes that what causes such paradoxical change in attitudes is unknown. In the same paradoxical way, it is very possible that the Japanese may agree to donate their organs but decline to donate those of relatives, or vice versa.

In general, the Japanese people have a tendency not to make important decisions by themselves. Becker points out that the Japanese people find normative guidelines for their decision-making in interpersonal relationships. They carefully consider how one’s action will influence others, and then they cautiously choose an action that aims at least not to harm others, but to enhance interpersonal relationships. Becker also suggests that Japanese society regards individual decision-making as something negative. He concludes that it is very difficult to see Japanese society arriving at consensus on this controversial whole brain-death and organ transplantation issue. Nakajima insists that there is no
way such consensus can be reached in Japan because the debate is too comprehensive and academic and because whole brain-death and organ transplantation are too unfamiliar and unrealistic for most Japanese. Many tend not to take the debate seriously until they are actually put into a situation where a beloved one becomes brain dead.

In light of the unlikelihood of attaining consensus on whole brain-death and organ transplantation in Japan, Uozumi makes a notable suggestion. It is that Japanese society ought to recognize and accept free and independent family-based choices on the definition of a person’s death. He regards this as a first step toward achieving eventually social consensus. Because it is difficult to attain consensus at this moment, allowing a family, the smallest unit of society, to choose either whole brain-death or cardiovascular death would at least safeguard against the abuse of human rights. This view was reflected in the Brain-Death Organ Transplantation Law legislated in 1997 which virtually guarantees the right of family members to choose whole brain-death or traditional cardiovascular death.

It is not certain, however, that this transplantation law will help to establish consensus. In addition, it is easy to agree with Lock’s view that “one is left with the feeling, voiced by many members of the Japanese public, that the whole exercise of repeatedly surveying the nation is essentially a farce, and that the idea of trying to achieve a simple consensus on such an inflammatory subject is without meaning.” The reason for this is evident: the concept of consensus is too vague to be used for settling a public policy controversy. Consensus should
Japanese Views of Death

A third major objection to whole brain-death and organ transplantation in Japan is that it is incompatible with traditional Japanese views of life and death. This argument consists of three major claims: (1) death is a vague and uncertain process; (2) the Japanese people have a distinctive view of a dead human body; and (3) they also possess a naturalistic perception of life and death.

Death as a Vague and Uncertain process

Japanese people traditionally view death as a process which has no clear beginning and ending. It is regarded as a vague and uncertain process that takes time. According to Feldman, the Japanese believe that the soul of the deceased is contaminated by death for forty-nine days. During this period, appropriate ceremonies are carried out by the family members to help the deceased make a smooth transition from the living-side to the ancestor-side. After forty-nine days, the deceased is finally regarded dead, but various ceremonies and offerings follow for many years. Because the concept of whole brain-death employs a number of medical criteria that draw sharp distinctions between life and death, Feldman rightly states that “it is not surprising, therefore, that it has encountered strong resistance from both the medical profession and the lay public in Japan.”

Nudeshima points out that the Japanese people regard both the beginning and the ending of life as a process. He quotes Yonemoto’s description of the
Japanese view of the birth of a person, ("the image where one, who was in a vague and unfocused state, but had been gradually focused, and finally becomes a solid figure surfacing in group consciousness") and points out that death is also a process. It has two major parts: the extinction of personhood in this world, and the transformation and fixation of new personhood in the afterworld. Established social practices, such as funeral ceremonies and burial rituals, are employed by the family to make the whole process as smooth as possible. Because of this emphasis on death as a process, Nudeshima concludes that the Japanese are not comfortable with arguments that try to pinpoint the exact moment of death. They are especially hesitant to draw a sharp line between life and death by using the criteria of whole brain-death.45

Becker warns that adopting whole brain-death as a person's death could change the Japanese perception of this process and have serious side-effects. The most devastating outcome, he suggests, could be the psychological damage that might stem from the lack of opportunity to spend time with the dying person and to express sorrow and other feelings because of the hasty and demanding transplantation procedures. A concept of whole brain-death that presupposes organ transplantation could abnegate long-held Japanese views of death as a process, and may impose serious psychological harms upon those who survive.46

Japanese Views Regarding the Dead Body

One of the most common arguments in Japan against whole brain-death and organ-transplantation is that the Japanese put special meaning and value on the dead body of a beloved one. It is therefore helpful to explore what kind of
meaning and value the Japanese do put on the beloved one’s dead body and how this distinctive view can influence their decisions about organ donation. This exploration can examine two bodies of evidence: Buddhist thought and the results of anthropological field research.

Dogmatic Buddhism. In general, Buddhism can be categorized into Dogmatic Buddhism (Kyojyo Bukyo) and Applied Buddhism (Seikatu Bukyo) according to Fujii.47 Dogmatic Buddhism consists of communities, dogmas, and rituals influencing each other; dogmas are represented and enacted in rituals which enhance a sense of togetherness in community.

Fujii summarizes Buddhism as “the world-wide religion which aims at liberation from life and death.” He declares that there is no idea in Buddhism that requires adherence to the human body itself. He also suggests that there is a dogmatic teaching, “shasyin” (an act of abandoning oneself), which encourages people to forsake the egoistic self and to serve the Buddha and other people. “Shashin” is said to be modeled after the story of Yakuou-Bosatu who burnt himself to console the soul of the Buddha. This act of self-abandonment for the sake of others repeatedly appears in various Japanese folk stories and historical writings. For example, Fujii introduces one story from “Konjyaku-Monogatari,” the largest collection of ancient legends in Japan:

Once upon a time, there were a rabbit, a monkey, an otter, and a fox happily living together. One day a poor old man came to them, asking for something to eat. The monkey brought nuts, the otter brought fish, and the fox brought meat which he stole from a butcher shop. Because the rabbit only ate vegetables, he had nothing to bring to the man. The rabbit then asked the man to gather a woodpile, jumped into the flames, and offered himself to the man. The flames went out as the old man lifted his hand. Then he announced that the dead rabbit was going to become the Buddha in the next world. The old man, as he extended his arms,
turned into "Teishyakuten" (a god who protects dogmas of Buddhism) and put force onto Himaraya, the end of this world. Then, blue liquid drooped down, and "Taisyakuten" used it to paint the rabbit on moon. This rabbit that we see on the moon is, in fact, the Buddha's former incarnation. (Note: Many Japanese perceive the shadow on the moon as a rabbit pounding rice cake.)

Fujii concludes that "shashin" is regarded as the highest charity that a saint can possibly achieve. He suggests that the donation of organs can be regarded as one of the ultimate forms of "shashin." However he strongly emphasizes that concept of "shashin" never justifies a recipient's self-centered desire for organs to extend his or her life. Fujii argues that dogmatic Buddhism may justify organ donation, but does not necessarily justify organ reception.

Given Dogmatic Buddhism's concept of self-abandonment, it is obvious that it puts little value in the body, whether living or dead. Fujii points out that Dogmatic Buddhism defines the body as a temporary place to host five kinds of knowledge: "Iro" (color) that stands for material, "Jyu" (receiving) that stands for the perception process, "Sou" (image) that stands for the expression process, "Gyou" (deed) that stands for the will process, and "Shiki" (recognition) that stands for the recognition process. He regards the death of a person as the decomposition of these five forms of knowledge, leaving the temporal body empty.

These views do not mean that one's body can be neglected. Instead, they require selfless integration of one's life and death with something bigger than the person. Dougen, a famous priest of historical Japanese Buddhism, regarded his life and death as of the Buddha, concluding that negligence of one's life and death directly meant negligence of Buddha's life and death. Thus, Buddhism holds that a person's life and death do not belong to the person's body or soul,
but to an existence bigger than human beings, such as the Buddha or Nature. From this perspective, death can be viewed as an ultimate reunion of the self with Nature or the Buddha.

Buddhism believes there is no essential difference between life and death or a living body and a dead body. They are all same and equal because they are all part of the Buddha and Nature. Thus a body, whether it is living or dead is always important in terms of its relationship with the bigger existence. From these perspectives, Fujii insists that Buddhism can not accept whole brain-death because it sharply distinguishes life and death, or a living body and dead body, at some particular point.

Dogmatic Buddhism aims at ultimate reunion with the Buddha and Nature through self-abandonment and charity toward others. It regards a brain-dead body as an object of charity which requires ascetic self-renunciation from those who survive, such as the recipient, the recipient’s family, and the donor’s family. Fujii’s point is that whole brain-death and organ transplantation can be valid and ethical only when a donor donates his or her organ with a selfless motive to help others and a recipient receives the organ without a self-centered desire to survive. If a recipient desires organs for his or her own survival and wishes someone’s death to achieve this, transplantation is deviated from the original concept of charity and becomes corrupted despite the donor’s sincere desire to help others.

**Applied Buddhism.** Dogmatic Buddhism influences people’s lives through rituals and doctrines, but Applied Buddhism influences their everyday thoughts and behaviors. Fujii outlines the features of applied Buddhism as follows: (1) It is
different from the Buddhism found in India, China, and Korea; (2) Although Applied Buddhism has been directly influenced by Chinese and Korean Buddhism, it fused with native folk religion in Japan; and (3) Buddhism in Japan was incorporated into folk religion, losing some of its original teachings, but at the same time it also incorporating some elements of the native religions. The primary difference between Dogmatic and Applied Buddhism is that the first provides religious rituals and doctrines whereas the second receives and integrates them into people's lives.

Fujii suggests that Applied Buddhism's perspective toward the body can be seen in the linguistic equivocality of the word "Kokoro" (mind). In the Japanese language, conditions of "Kokoro" (mind) are expressed by different parts of the body. For example, the Japanese use "Hara" (abdomen) to express various conditions of the mind such as anger, tolerance, honesty, evil mindedness, and so on. When they finally decide something difficult, the Japanese say "Hara wo kimeru" (literally, "decide on abdomen"), meaning one finally decided one's own way. In the same way, the Japanese also use different parts of the body to express conditions of one's mind such as the chest and the heart. These examples shows that from the Japanese perspective the mind resides not only in the brain or heart but also in all parts of the body. They perceive that mind and body are one united, sacred existence.

This review of Dogmatic Buddhism and Applied Buddhism demonstrates that they influence Japanese's views toward the body in quite different ways. Dogmatic Buddhism, at the conscious level, provides ethical guidelines about how a body should be used. A body should be used to accomplish one's self-
abandonment, charity toward others, ultimate freedom from this world, and finally the reunion with the Buddha and Nature. In contrast, at the level of everyday life and unconscious actions, Applied Buddhism provides mind-body monism; this, Fuji suggests, leads the Japanese to believe that a dead body is a sacred existence which possesses mind, will, and emotion.

The Body and Interpersonal Relationship. On August 12, 1985, a Japan Air Line jumbo jet crashed into a mountain in Nagano prefecture on the way from Tokyo to Osaka, killing 520 people. The crash was so destructive that it was very difficult to recover the dead bodies from the site. However, many surviving family members desired to get to the site and tried to recover even small body parts of their beloved ones despite the difficulty of climbing up the mountain. At the temporary mortuary which was filled with the awful odors of dead bodies, the families intensely attempted to find their beloved one's bodies.

Namihira, an eminent Japanese cultural anthropologist, examined the comments of the relatives of those who died in the crash and summarized the Japanese views toward life, death, and the dead body in nine points.49 (1) The Japanese believe that the dead person's soul is still existing in a different realm that is called as 'the next world,' 'the other side,' and 'heaven.' (2) The Japanese perceive that the dead person's soul exists in an actuality that resembles our lives. They think that the soul has a physical body, eats, drinks, laughs and gets angry. Moreover, the soul also has the ability to perceive heat, coldness, and comfort the same way a living person does. (3) The Japanese believe that surviving family members, relatives, and close friends have obligations to get rid of situations that cause discomfort, scarcity, and unsatisfaciton to the dead
person's soul. They should alleviate any bitterness, chagrin, and anger the soul may feel, and help the soul to arrive at utopia. (4) After the surviving family confirms the dead body, the death of the person finally become definite. For the surviving family, the death of the beloved one does not happen until the dead body is found and confirmed. When the dead body is found, the surviving family feels glad, despite the fact that it confirms their beloved one's death, because the beloved one has been considered missing. (5) The Japanese believe that the dead person wants his or her family members to locate the unfound body. (6) The Japanese also believe that the dead person wants them to visit where he or she died and that such visiting is the only way to console the soul of the dead. (7) The Japanese believe that the dead person wants to return to his or her own house and that fulfilling this wish is an important obligation for the family. (8) Even when they bring the dead body back to their houses and perform funeral ceremonies, the Japanese believe that part of the soul remains at the death-site. (9) The Japanese believe that the dead body must be physically perfect. If not, it is better to have more rather than less parts of the body because the dead person may become handicapped in the afterworld or the dead person may feel sorrowful about missing parts of his or her body and condemn the person who caused it.

These views toward the dead body suggests that the Japanese believe that the deceased individual continues to be a person who still has his or her personality, uniqueness, and dignity. More importantly, they also suggest that the Japanese hold that interpersonal relationships still exist between the deceased and surviving family members. These establish moral obligations similar to
those people usually have to living persons. Namihira points out that “the interpersonal relationship that the person had with other family members still exists in connection with the dead body even after the person has died.” In this sense, the dead body symbolizes the deceased as if he or she continued to possesses personhood. It mediates between the deceased and the surviving family with an authentic sense of an on-going, mutual interpersonal relationship: “The family members of the dead do not cherish the dead’s memory in an unilateral way, but the dead individual, in the form of the dead body, imposes certain demands on his or her surviving family members” says Namihira.

Yanagida, a famous Japanese non-fiction writer, lost his second son to whole brain-death. In his book “Gisei” (“sacrifice”) Yanagida writes that he authentically perceived his son’s brain-dead body talking back to him:

When I and Kenichiro talked to Yojiro, though he was brain-dead, his body talked back to us. This was truly a mysterious experience. Probably this was a sense that can be understood only by members of a family who have shared happiness and sorrows with each other. Despite scientific explanations that a brain-dead person was literally a dead person who had no consciousness or senses, I became quite sure that the beloved one’s brain-dead body meant a lot to the family members who had shared a spiritual life with each other.

This mysterious sense that the brain-dead body talks to the family may seem strange from a scientific standpoint. However, it appears to be an undeniable reality for some surviving relatives in Japan. For them, the brain dead body serves as the medium of continuing interpersonal relationship between the dead and the living; the brain-dead body still has a certain social role even after it loses consciousness.
This view suggests that the Japanese people have a distinctive concept of personhood that is different from the concept common in the West. The Japanese concept of personhood appears not to be limited to the presence of consciousness, but is extended and shared by significant others within the realm of interpersonal relationships. It appears that personhood from a Japanese’s perspective can be defined as a sense of relatedness that is perceived and shared between at least two individuals. This differs from the view common in the West that defines personhood as individual consciousness. Thus, as long as a brain-dead individual is perceived to possess relatedness with significant others, he or she is thought of as a person with full moral status. What matters most is not the degree of individual self-consciousness but the degree of relatedness experienced by those who surround and care for the deceased individual.

**Death Via Subjective Perceptions.** Japanese use subjective perception as a way of understanding death. They hold that death must be perceivable through visual, auditory, tactual, and olfactory sensation. Yanagida writes about how the surviving family members are affected by their encounter with a brain-dead body:

Finally, Kenichiro asked one question that surprised everyone in the room. “I wipe tears from my brother’s eyes a lot, but he does not shed tears does he?” Dr. Tomioka was apparently puzzled by the question. “Well, this is a physiological phenomenon that does not mean he sheds tears. But we do not know why this happens” answered Dr. Tomioka. Even though it is only a physiological phenomenon, family members cannot help perceiving that he sheds tears because he is sad. I was touched by the question because it showed the elder brother’s genuine caring for his younger brother.53

From a medical perspective, such shedding of tears is nothing but a simple physiological phenomena; however, Yanagida’s experience shows that tears can
mean more than that. They can mean sorrow and pain for those who see tears coming down from their beloved one's eyes. When we see a person shedding tears, we perceive that this person feels sorrow and pain. In the same way, Yanagida's elder son sees the tears in his younger brother's eyes and perceives that his brother is weeping as if he were still a living person. This example demonstrates that Japanese people use subjective sense perception to understand the existence of a person. It does not matter for the Japanese whether weeping is a physiological or psychological phenomena. As long as they see tears and perceive that a brain-dead person cries, the deceased individual continues to be a person in the web of relationships.

Nakajima, a well known medical journalist and a writer, closely observed brain-dead patients and coined the term "Mienai-Shi" ("invisible death"). This suggests that brain-death is too hidden for Japanese family members to perceive. In the introductory chapter of her book, she tells the following story:

During a five-month period of observing brain-dead patients in an Intensive Care Unit, there was one thing that caused me to feel very awkward: nobody in the family took the brain-dead person's hands or shed tears when told that the husband, wife, or beloved child was deceased. At first, I tried to convince myself that I happened to have people who were cold-minded, and very rational. But I came to understand that nobody, in fact, could perceive the reality of the beloved one's brain-death. Wearing white or blue antibacterial caps and masks, the family members stand bedside accompanied by life-sustaining machines and a respirator. A physician tries to explain brain death as simply as possible, but the family members only follow the machines and nod. They are almost absent-minded. Under these tense circumstances, they are not allowed to touch or to rub their beloved one's body, not to call his or her name while the physician is talking. The brain-dead person does not appear to be dead, but the physician shows that this is so. The family members can only try to understand with utmost effort that the person is really dead. With half-hearted minds, they do nothing but observe the beloved one until time runs out. However, without exception, these people
start crying intensely or shed tears calmly when the brain-dead person's heart stops beating and the respirator is taken off. At this moment, they finally realize the death of their beloved one.54

Traditional death is easy for the Japanese to understand. Because it is “cold,” “hard” and therefore “visible,” it makes them realize that dead the person will never come back. To the contrary, Nakajima suggests that whole brain-death is too invisible to perceive for the ordinary Japanese people. This “invisible” brain-death is, Nakajima insists, “death in conception” that can be perceived only by those who get used to observing it, persons such as physicians and other healthcare professionals. Nakajima’s story demonstrates the fact that the Japanese recognize death by the exterior appearance of the body rather than by internal medical conditions. For ordinary Japanese people, the perception of sensory information is a more reliable basis for recognizing death than medical information.

The Japanese Ethics of Relationships

A fourth major objection to whole brain-death and organ transplantation in Japan is that it is incompatible with the traditional Japanese ethics of relationships. It is therefore appropriate (1) to review the Japanese ethics of relationships, and (2) to explore how it influences the feelings of Japanese people toward whole brain-death criteria and organ transplantation.

Shinto, Buddhism, and Confucianism

Shinto, Buddhism, and Confucianism each contributes to the Japanese ethics of relationships. Shinto is the indigenous “naturally-occurring” religion of Japan. It has no historical originator, and it has continued to alter itself in order
to co-exist with foreign religions such as Buddhism and Confucianism. Shinto originated in mythology and festivities that developed among the Japanese in ancient times. Under the influence of “rice culture,” people think that mythical gods have power to cause natural disasters. They therefore experience a sense of reverent awe toward nature. As a result, Shinto is a religion which “fosters a sense of immersion in nature” and puts low-emphasis on the individual.

As discussed earlier in this chapter, Buddhism emphasizes idea of separation from this world, life, and death. It denies the egotistic self and emphasizes relatedness with an existence bigger than human beings.

Confucianism has much influence not only in China but also in Korea, Vietnam, and Japan. One of the essential moral teachings of Confucianism is “jinrin.” The Japanese dictionary defines the word as follows: (1) “an order of relationship between persons,” and (2) “the path of righteousness which a person should follow for the sake of being a person.” Moushi, a Confucian philosopher of ancient China, is said to be the originator of “jinrin.” He proposed that there are five essential moral standards or duties: “Shin “Gi,” “Betu,” “Jyo,” and “Shin.” Each of them occurs in particular relationships, such as the relationships between father and son, ruler and allegiant, husband and wife, older and younger brother, and friends. For instance, “Gi” implies a moral standard to encourage a static order between ruler and allegiant. Confucianism, thus, defines a person as a unique entity born within “jinrin” or relationships. This indicates that Confucianism regards the person’s moral existence primarily as a social entity in a web of relationships.
The primary religions of Japan (Shinto, Buddhism, and Confucianism) emphasize relationships in different ways. Shinto's emphasis on nature and Buddhism's suppression of the egoistic self result in a low emphasis on the individual. In addition, Confucianism identifies moral duties based on relationships. It emphasizes that a person exists as a collective rather than as an individual entity and that therefore it is important to foster peaceful and proper relationships with others.

Ethics as the "Study of Relationships"

In the Japanese language, there are many words that signify relationships. However, "ningen" is the best example to show that in Japanese society a person's existence is viewed as essentially relational. Although there are two Japanese words, "hito" and "ningen," that can be translated as "person" in English, they define a person in different ways. A Japanese dictionary defines "hito" as follows: (1) a living creature whose existence is differentiated from other living creatures because it has a developed brain, and has the capacity to use language, fire, and tools and (2) a person who constitutes a society, or an individual.59

On the contrary, "ningen" used to be defined as "a place where persons live". The word, "ningen" is made of two Chinese characters ("人間") while the word "hito" is made of one ("人"). As is evident, the character "人" is incorporated in "ningen" with another Chinese character "間" which literally means "betweenness." Therefore the word "ningen" can be literally translated as "between persons" or more simply "relationships." Therefore, it can be assumed that "a place where persons live" is relational and that "ningen" is originally
meant the relationships in which persons live. Then the word “ningen” gradually came to acquire a new meaning. Now it is defined as “a person who has certain relationships with others to form a society and who are expected to make contributions to a society.” Taking these meanings of “ningen” into account, it can be inferred that the Japanese regard relationships as the most essential aspects of person’s existence.

Watuji is the first philosopher in Japan formally to explore the ethics that emphasizes relationships. Correctly observing that the word “ningen” indicates relationships, he was the first person who called “jinrin” what is called “ethics” in English.61

He proposes that a person consists of two aspects: an individual and the whole. An individual and the whole form double negative relationships. An individual can exist only when it denies the whole, but then the individual must deny itself to come back to the whole. Watuji concludes that each individual should be integrated into a nation, the ultimate moral whole, which he believes completes and actualizes the individual’s personhood.

Watuji regards ethics as a study of relationships. He understands that central features of the Japanese moral life lie in relationships where special moral standards motivate the Japanese people to behave ways that preserve peaceful and orderly interactions.62

Benedict, a prominent American anthropologist, suggested that the Japanese have an ethics that is different from the ethics in the West.63 She points out that the Japanese do not have canonical moral rules or principles, like the categorical imperative or the golden rule in the Western ethics. What makes an
action moral or immoral depends, according to Benedict, on a “circle.” Based upon intensive interviews of Japanese immigrants, she reports that there are several moral codes, such as *chu*, *ko*, *giri*, and *jin*, connecting one person to another to form a “circle” image of web-like interpersonal relationships among Japanese people. One is expected to understand that “each move has its consequences” so that one should estimate “all the factors involved in the situation and do nothing that” disturbs the circle of relationships. One is required to have “watchfulness of all the cues one observes in other people’s acts, and a strong sense that other people are sitting in judgment.” Failing to do so results in a strong sense of shame, which she defines as “a reaction to other people’s criticism.” She defines Japanese culture as a “shame culture” and contrast it with a “guilt culture” which have “absolute standards of morality and relies on men’s developing a conscience.”

Becker, correctly realizing that Japanese morality is firmly embedded in web of relationships, points out that “what to eat, what to wear, where to work, and how to speak can be determined by one’s relationship with the surrounding people in Japan while they can be freely determined by one’s own preference in Western society.” The desirable consequence of the ethics of relationships is to achieve peaceful, proper, and orderly equilibrium in a web of interpersonal relationships.

The ethics of relationships does not have absolute moral standards. Instead, it should be regarded as situational and consequential. For different relationships, different moral standards are employed in a consequentialist approach. This requires the Japanese people to engage in a moral pause that
enables them to foresee how their actions will impact others. They are to weigh the different options and choices that one can take and to make a moral decision that will not disturb peaceful and orderly equilibrium in a web of interpersonal relationships. In this process, different moral principles, rules, and standards are employed to justify one's action with great flexibility. This is why the Japanese people sometimes think and act in difficult and even inconsistent ways from the viewpoint of those in the West.

Fetters reports that the Japanese people respect what is called "family autonomy" more than individual autonomy in the medical decision-making process. His study of the history of the family in Japan suggests that the current family system in Japan has its roots in the Edo period (1600–1868 AC). It holds that the head of the household possesses absolute authority. Each member of the family is expected to live each day without doing something that endangers its continued well being. Thus, obeying the head of the family becomes the highest moral duty. The family rather than the individual is the most important social and political unit in Japan.

Given this historical evidence, Fetters proposes family autonomy as a predominant principle for the Japanese medical decision-making process. "The essence of this principle," he says, "is that a common, socially sanctioned pattern of decision making is for the family to make decisions for other members of the family, regardless of the individual family member's competency."

From the perspective of the ethics of relationships, "the cancer disclosure paradox" can be interpreted as follows. If one perceives that disclosing the truth will imposes a serious psychological burden onto the family member, despite the
fact one may want to be told the truth if one gets cancer, one should not tell the family member the truth. Concealment of this important medical information is morally justified. The family members automatically foresee the consequences of the disclosure of cancer to the patient and use them to judge whether the disclosure is the morally right thing to do. The innate moral nature of truth disclosure or truth concealment is not the most important consideration for the Japanese. What matters most is the probable consequences and their probable impact on interpersonal relationships.

The Ethics of Relationships and Brain-Death

Given the distinctive characteristics of the ethics of relationships, the imperative question must be stated as follows: how does this approach make it difficult for the Japanese people to accept whole brain-death and organ transplantation? The works of two Japanese philosophers' are helpful in answering this question.

Shared Whole Brain-Death. Morioka points out that the Japanese use the word “shinda-hito” which means “a dead person” in English. However, according to many definitions of personhood in the West, “shinda-hito” is a contradictory term: a dead individual cannot be a “person” because a “person” must be living and have what makes a “person” unique, consciousness, the capacity to decide and so on. Morioka points out that the Japanese often use this term in their daily lives without any sense of contradiction. This indicates that a dead body is still regarded as a living person for many Japanese people. For the Japanese family, a brain-dead body is more than a body without brain functions. It is a beloved person with whom the family shares life and history.
Morioka proposes that the essence of the whole brain-death debate lies in the encounter between a brain-dead person and others. He defines whole brain-death as an occasion in which a brain-dead person and others encounter, influence, and interact with each other. He calls this "a place of brain-death," which indicates that brain-death should be understood as a circumstance that includes both the brain-dead person and the others who observe and care for him or her. In this setting, a brain-dead person and others continue to have intimate interpersonal relationship which require etiquette and courtesy. Morioka emphasizes that the lack of such shared etiquette and courtesy in "a place of brain-death" causes confusion and chaos. He asserts that the final resolution of the controversy will require helping Japanese society establish shared moral roles and etiquette in circumstances of whole brain-death.67

Two implications of Morioka's work are worthy of emphasis. First, he correctly points out that there is a continuing relationship between a brain-dead person and others accompanied with a unique ethics which he calls "etiquette and courtesy." Another contribution of his work is his unique concept of brain-death. He proposes that the definition of brain-death should not be limited to a patient's clinical condition. Instead, he extends the scope of the meaning of brain-death by conceptualizing it as an event shared by the patient, family, healthcare professionals and others.

Resonant Death. Komatu points out that in Japan the most problematic idea of accepting whole brain-death as the death of a person is the idea that death only belongs to the dying individual. However, Komatu asserts, this view
completely misses the fact that death has been an event shared by others throughout the entire history of the world.  

Based upon Aries’ study of death in medieval times, Komatu coins the term “resonant death.” There are three characteristics of resonant death. First, it is a process that is marked by the flow of various events from the premonition of one’s coming death to burial. Second, the most important features of resonant death are not its medical and biological criteria but the social experience that is initiated, shared and sustained by others with death-rituals such as farewell ceremonies before and after one leaves this world. Third, resonant death penetrates observers such that the death of someone else becomes the observer’s own death. Resonant death does not belong to only one individual; it overtakes the dying individual and it engulfs and penetrates others. Komatu compares resonant death to several sounding bodies with the same frequency which start to resonate in sequence to produce harmonies.

This idea of resonant death leads to a distinction between its two aspects. In general, death can be defined as a condition of someone’s absolute non-existence in this world. However, since resonant death implies that someone’s death can be shared and experienced by others, it is possible that death can also be defined subjectively from the observer’s viewpoint in relationships.

An analogy may help some to understand Komatu’s resonant death more fully. Let us imagine that you are born alone on an island. There are no other human beings or any other form of living creatures on this island. In this hypothetical situation, you happen to have a small stone and you are asked one question: “how can you be sure that this small stone that you have really
happens and exists in this world?” The question appears to be silly because you can see, touch, and feel it and thus be able to conclude that it really does exist. Now let us change the question little bit. How can you make sure that your death really happens in this world? Now suddenly the question becomes more difficult to answer for two reasons. First, it would be very difficult for you to know what death is all about. Why? Because you have never had a chance to observe it. We, human beings, must observe the death of others in order to formulate and define it. Death is only defined through our observations. Second, it would also be very difficult for you to know whether your own death really happened. If you are not yet dead, you have not yet experienced your death and therefore you are not able to confirm it that really took place. On the other hand, when you are really dead, you are gone, which means that you also cannot confirm that you have died. You need someone to watch your death in order for that person to confirm that your death really happens. Death is essentially and primarily a social event that must be observed and shared by others.

“Keshi-No-Mino-Iryo”

Yamaguchi, a Japanese physician, proposes “Keshi-No-Mino-Iryo” (“care of poppy seeds”) that emphasizes relationships. He uses one case of brain-death to depict how this approach can be applied in healthcare settings. Yuki, a nine year old girl, was involved in an accident when she rode in a car her mother drove. Despite much effort to save her, she became dead according to whole brain-death criteria. As the attending physician, Yamaguchi came to Yuki’s father, who
was a Buddhist monk, to discuss treatment plans. Yuki’s father asked Yamaguchi to do “Keshi-No-Mino-Iryo:”

Mr. Sadamichi looked down and listened to me, then he faced up and said this. “Doctor, we really appreciate that you understand and respect our feelings. During this period of nine days, we have seen the changes in our daughter and we are starting to understand that she may not make it. You have won our confidence during this time. So, please do whatever you think is best for Yuki. We will follow your guidance. However, I think that care is not only to be given to the patient. From this standpoint, care is very similar to what Buddhists preach that we should deliver. In the case of Yuki, there is a mother who truly regrets that she harmed her daughter. I want you to provide care for her. Do you know the story of Keshi-No-Mi (poppy seeds)? A mother comes to the Buddha and asks ‘Please bring back my beloved child’s life.’ The Buddha says to the mother. ‘You need poppy seeds. They must come from a home where none of family members die.’ In vain, the mother tries to find such poppy seeds, and comes back to the Buddha. However, by that time, she realizes the reality of her child’s death. What I would like you to do is this ‘Keshi-No-Mi-No-Iryo’ (‘care of poppy seeds’). I understand that my daughter is not going to make it. But we just cannot give up our hope till the last moment. Please understand this feeling and provide the best care for my daughter. I truly believe that this will be a precious lesson for your philosophy as a clinician.” I was surprised by the father’s remarks because, at the bottom of my mind I expected him to say, “Please terminate care because it is doing nothing but hurting my daughter.” But I decided to respect Mr. Sadamichi’s suggestion and left the room.

During the next twenty-nine days, under the “care of poppy seeds,” Doctor Yamaguchi observed that the facial expressions of Yuki’s mother softened. Sometimes she smiled and talked proudly about her daughter. He began to believe in the care of poppy seeds, the care for family members.

When Yuki’s heart stop beating, her parents peacefully accepted their daughter’s death. When the mother was cleaning her daughter’s body, she sometimes smiled and talked with the nurses. At the end of the cleaning service, Yamaguchi heard her express her last farewell to her daughter: “I am very sorry
Yuki, but you tried very hard to live. Thank you.” Yamaguchi expressed his sentiment as follows: “I felt that I could not save Yuki’s little life, but I could save other life.” Yamaguchi provided care of poppy seeds and saved the mother’s life by giving her plenty of time to sort out her painful feelings and to receive the consolation and peace necessary for accepting her daughter’s death.

Five years after Yuki died, Yamaguchi met Yuki’s father who had the following recollection:

After Yuki died, we began contemplating more about issues of death. From our religious perspectives, death does not occur at the point when a heart stops beating. Even more, death does not occur at brain-death. Rather, death is finalized and completed after it is shared and remembered by others when they spend a night with the body. After the burial, there are several rituals such as “Oshichinichi,” “shijyu-kunichi” and “Isyu-ki” which help the survivors to console the hard feelings of those who still can not give up the dead person. These religious rituals, I think, might be a natural and traditional scenery which wisely reflects the mental action (psychology) of human beings. If someone’s death is not accepted by others in the natural way, misfortune will happen again. After we lost our daughter, one of our neighbors also lost their beloved son. The father killed himself after several months. When we heard it, we talked with each other that “we were saved because of the 39 days. Yuki, our daughter, gave us the period in order for us to sort out our feelings.”

Sadamichi, Yuki’s father, beautifully defines religious rituals as ultimate wisdom needed to help people accept and complete the death of beloved one. This also implies that for Japanese death is a process rather than an instant event and that is shared and co-experienced by others. The case also suggests how important it is for Japanese people to be with the dead. The family members may not need medical prescriptions, but the care of poppy seeds insists that they also need ample attention and consolation from healthcare professionals.
Yamaguchi says why he was motivated to write the book: "I have seen that many ethics committees start to advocate whole brain-death without paying attention to those who oppose to it. The family members of the brain-dead patient, the healthcare professionals who care for the brain-dead patient, and the brain-dead patient are totally ignored in the movement of whole brain-death organ transplantation." The care of poppy seeds that Yamaguchi proposes can not afford to ignore the patient’s family members because it embraces the ethics of relationships which tries to fulfill the needs of family members to have ongoing, intimate relationship with the deceased patient.

The ethics of relationships, which is deeply integrated in Japanese life, makes it difficult for the Japanese to give up their sense of hope and obligation toward the brain-dead. They often believe that whole brain-death criteria hastens their beloved one’s death against their will.

Negative effects can result from deaths that feel hastened to others. Once the family members agree to donate organs, the entire procedure can start to shift towards transplantation. Suddenly the room is filled with medical professionals, and family members are not allowed to approach the deceased which makes the relatives feel neglected and abandoned. Some feel guilt, confusion, and anger.

In addition, hastened death can cause family members to think that their beloved one’s human rights were seriously neglected. Some believe that the brain-dead deserve society’s protection because they are weak figures in society who still have human rights but do not have any means to advocate it.
Summary

This chapter has examined four main reasons why it is said that whole brain-death criteria are incompatible with Japanese society. The first is that they cannot establish a person's death because the Japanese define it not according to medical facts but according to social relationships. The second point is that it is impossible to determine societal consensus in Japan on this issue. The third point is that traditional Japanese views toward life and death are incompatible with whole brain-death criteria. The fourth point is that whole brain-death criteria for the purpose of organ-transplantation is incompatible with the Japanese ethics that emphasizes relationships. The more ongoing and more intimate the relationships are between family members and the deceased, the more probable it is that family members will perceive him or her a living person and the less likely it is that they will accept whole brain-death criteria with respect to their beloved one. This ethics of relationship will receive further consideration in the next chapter.
The last chapter examined the most frequent arguments in Japan against accepting whole brain-death as a person's death. The common speculation is that, because of a view of death which is thought to be incompatible with whole brain-death criteria, Japanese people tend to think of those who satisfy these standards as still living. This makes it virtually impossible in Japan to procure organs from a brain-dead person for organ transplantation. The previous chapter then suggested that actually the ethics of relationships is the fundamental factor that encourages these attitudes among Japanese people. The claim is that, not whole brain-death criteria as such, but the ethics of relationships ultimately prevents Japanese people from donating organs. This chapter, using the ethics of relationships as a guidepost, explores in even more detail why adopting organ transplantation in Japanese society is very difficult.

A Missing Element in the Japanese Controversy

In 1968, the same year that the first Japanese heart transplantation took place, Yoko Terao was born with severe congenital heart disease. Despite many medical difficulties, her mother helped Terao go to school and to enjoy her education. However, in 1986, her condition became worse and she was forced to withdraw from her high school. In 1988, she suffered from several attacks which
made her condition even worse, leaving heart-lung simultaneous transplantation the only way to save her life. When she was told this grim prognosis, she suddenly remembered the Wada heart transplantation which ironically had taken place the same year she was born. She agonized about the fate that required her to seek for the same organ transplantation to save her life. Ever since she was little, she had experienced ambivalent feelings toward organ transplantation. Sometimes she was anxious; nevertheless, she was still hopeful that she eventually would receive an organ transplantation in the United States and get better. However, when she was informed of her poor prognosis, and of her more immediate need of transplantation, she began to think about the meaning of existence and came to believe that there ought to be a purpose for her difficult life. Hoping that she could contribute to the medical development of organ transplantation in her nation, she chose to wait for an organ transplantation in Japan instead of going aboard. When she turned twenty, however, she desired to become an independent and healthy woman so that she could take care of her mother and have a full and fruitful life. Therefore, she changed her mind about receiving an organ transplantation abroad and started fund-raising by writing and publishing essays. But then she felt that people regarded her change of mind as “selfish and self-centered.” Seeking for the right thing to do, she began to read books about whole brain-death and organ transplantation. After a long struggle, she finally decided not to pursue organ-transplantation at all. She explains how she reached this conclusion as follows:

One day, my mother, while reading a newspaper, said with eager expression that “if I become brain-dead, I would like to donate my organs.” At that time I finally realized that I had ignored the most important thing: I was about to collect somebody’s well-
intentioned fund-raising, go abroad and receive organ transplantation that was based on somebody’s death. If my mother becomes brain-dead, as long as I can feel my mother’s heartbeat, her body warmth, she is still my ‘living mother’ and I want to stay with my mother who looks like she is sleeping. Although she becomes cold, I want to stay forever with my mother whom I trust most. Among organ transplantation advocates, some say that ‘organ-donation is love.’ I, too, think that it is ‘great love’ in one sense, but as long as I continue to feel that I could not agree to donate my mother’s organs if she became brain-dead, my desire to seek for organ-transplantation is nothing but an egoistic, self-centered desire of which I truly feel very ashamed. I decided to end this trembling feeling and realized that I needed courage to decline [organ transplantation].”

What triggered Terao’s drastic change in attitude toward whole brain-death and organ transplantation? She writes that she tried to imagine that her mother became brain-dead and she asked herself whether she would be willing to donate her mother’s organs. Terao concludes that she would not agree to donate her mother’s organs because she could not perceive her mother as dead even if her condition satisfied whole brain-death criteria.

Terao experienced a shift in her standpoints from the recipient’s to the donor’s side. After she consciously imagined what she would do if her mother were brain-dead, she was able to put herself into the donor’s standpoint and see whole brain-death and organ transplantation from a new and different angle. The result was a complete turn-around in her attitudes. Even though she needed life-saving organ transplantation, she decided not to pursue it because she now realized that whole brain-death cannot be the death of a person.

Terao’s experience suggests several things. Clearly, whether one accepts the concept of whole brain-death may not depend solely on one’s philosophical, religious, and cultural beliefs. The important factors that caused Terao’s change in attitude toward whole brain-death and organ transplantation included
intimate feelings and love for her mother which were firmly embedded in their intimate relationship.

It is extremely difficult to maintain both viewpoints of what it would be like to become a donor and a donor's family or a recipient and a recipient's family like Terao did. It appears very difficult for the Japanese to realize the pain and agonies experienced by both those on the donor side and those on the recipient side. In the Japanese arguments for and against whole brain-death and organ-transplantation, this is what is consistently lacking. Assuming the viewpoints of both the donor side and the recipient side and striving to attain mutual understanding between the two is rare. It is as if there were a huge "wall" standing between the donor side and the recipient side preventing people from understanding and helping each other. This "wall" between the donor side and the recipient side is the ultimate factor that prevents the Japanese people from donating organs and hampers organ transplantation from taking root in Japanese society.

The Ethics of Relationships: Conceptual Analysis

The most fundamental belief of the ethics of relationships is that the essence of a person's existence is constituted by relationships. There are three types of relationships that define a person: first-person relationships, second-person relationships, and third-person relationships. Each of the three types of relationships is as important as the other two in constituting a person.

Three Types of Relationships

The ethics of relationships defines first-person relationship as
"relationships with oneself." First-person relationships are those we hypothetically conceive in our minds. One can think of oneself as an independent entity that exists in one's mind and have a hypothetical relationship with it. A good example of a first-person relationship is the concept of self-image in psychology. There is common agreement that we human beings have various self-images in our minds. Although these self-images are created by ourselves, they are considerably influenced by outer factors, such as other people's judgments. The ethics of relationships views such self-images as one form of having relationships. Another example, which can be taken from ethics, is the sense of integrity. In ethics, integrity is considered to be one of the ethical virtues which means, according to Beauchamp and Childress, "soundness, reliability, wholeness, and integration" of one's moral character. The ethics of relationships proposes that the moral sense of integrity can be also viewed as a conscious monitoring of one's moral self, as if one is having a relationship with the objectively monitored self and is constantly judging one's fidelity toward moral rules and principles.

Second-person relationships are defined as "relationships between you and me." This is very close to what we usually experience in our real lives. These relationships typically develop between husbands and wives, parents and children, brothers and sisters, and close friends. In addition, relationships between strangers can be also transformed to second-person relationship as people spend more time together. Such relationships tend to occur between teacher and student, or physician and patient.
Third-person relationships can be defined as "relationships between strangers" through laws, social rules, and moral norms in society. For example, we usually form a line to buy a ticket at a movie theater because there are certain social rules for such things which are shared by us and others. We unconsciously or consciously perceive the existence of strangers and feel motivated not to cause trouble but to live more peacefully with them by obeying laws, social rules, and moral norms. This demonstrates that we often have undetected but still mutually interpersonal relationships with strangers.

The ethics of relationships reveals that the existence of a person can be defined from three different directions. First-person relationships allow us to define a person as a single, individual, and independent entity that is perceived in self-consciousness. Second-person relationships allow us to capture a person as a dependent and interrelated existence. Third-person-relationships allow us to regard a person as a public and social being that constitutes group, community, and nation.

**Ethical Theories and Principles in Relationships**

Based upon the three different relationships that constitute a person, the ethics of relationships proposes that different ethical theories and principles can be categorized. Three broad categories of ethical principles and theories can be identified: first-person ethics, second-person ethics, and third-person ethics. Ethics of the first-person can be defined as a group of ethical theories and principles that are frequently employed in first-person relationships. Moral agents in first-person relationships focus upon self-consciousness and self-image. The moral standards tend to depend on what one believes the moral right or
wrong thing to do is. The principle of autonomy can be regarded an ethics of the first-person because it encourages the individual self to be a self-governing being who chooses his or her own moral position and accepts responsibility for his or her own choices and actions. Kant's deontology can be also categorized as a moral theory of first-person relationships because Kant's moral duty emerges from an individual's pure reason: "I ought never act except in such a way that I can also will that my maxim should become a universal law." Some types of virtue ethics are examples of ethics of first-person relationships because it strives to attain the individual's virtuous character.

In second-person ethics, moral theories and principles emerge from second-person relationships. The principle of beneficence, feminism, and the ethics of care can be categorized and generalized as ethics of the second-person because of their emphasis upon sympathy, compassion, fidelity, love, friendship, and sensitivity toward the needs of others.

As indicated earlier, traditional Japanese ethics, jinrin, is a moral theory of second-person ethics. As discussed before, jinrin identifies five close and intimate relationships as the most fundamental contexts of moral experience. Keeping peace and order among those relationships is jinrin's interpretation of what it means to be moral. The five special relationships are parent-child, king-feudatory, husband-wife, brother-sister, and friend-friend. All are second-person relationships.

Also, the Japanese principle of "family autonomy" is also a moral principle of second-person ethics because it allows patients and family members to form dependent relationships with each other and share autonomous medical
decision-making. The ethics of relationships can explain why the "cancer-disclosure-paradox" occurs. As Fetters points out, it is unclear why the Japanese people say more than one thing regarding the disclosure of a diagnosis of cancer: each wants to be told that he or she has the disease, but none wants to tell other family members. However, from the perspective of the ethics of relationships, it is evident that the two different attitudes stem from different moral principles. When one wants to be told that he or she has cancer, one engages the principle of autonomy derived from ethics of the first-person. However, when one does not want a family member to be told the truth, one now uses different ethical principles, especially the principle of "family autonomy" derived from second-person ethics. This paradox is a good example of how the Japanese people employ different moral theories and principles depending on their relationships. It also highlights the essential difference between the principle of autonomy of the West and that in Japan. The principle of autonomy of the West is an expression of first-person ethics. That of Japan emerges from the ethics of the second-person. They both emphasize autonomy. However, the West emphasizes the autonomy of the individual while Japanese society emphasizes the autonomy of the family.

In third-person ethics, ethical theories and principles emerge from third-person relationships. The principles of justice, equality, and utility are expressions of third-person ethics. When we face strangers, we find it more difficult to feel compassion and obligation toward them. Because of this lack of intimacy, we tend to become more selfish and unethical. Third-person ethics is especially important because it reminds us that, although we do not have
intimate relationships with strangers, we still have certain moral responsibilities toward them. Third-person ethics instructs us how to deal and live with strangers peacefully. For instance, the principle of justice suggests that strangers must share “fair, equitable, and appropriate treatment in light of what is due or owed to persons.” Utilitarianism also tells us that we sometimes need to be selfless, impartial, and more group-oriented to seek the maximum benefit for the community to which we belong.

**Relationships and Perceptions of Brain Death**

The ethics of relationships further proposes that whole brain-death can be perceived differently depending on which type of relationship one emphasizes. Yanagida is one of those who propose that there are three types of death: first-person death, second-person death, and third-person death.

According to Yanagida, first-person death can be defined as “my own death.” Advanced medical directives, for instance, indicate how one wants to be treated near the end of one’s own life. One needs to imagine what is expected to happen in the future and to decide whether being declared dead according to whole brain criteria is acceptable to oneself. Therefore, from this perspective, whole brain-death is regarded as a matter to be accepted or rejected in light of one’s own autonomous values and beliefs.

Second-person death is that of a spouse, parent, child, brother, sister, boyfriend, or girlfriend. Because of the unreplaceable memories and intimate relationships, second-person death often evokes nonrational, subjective, and impractical feelings and emotions among Japanese people. This is often
experienced as a very emotional and difficult event, one that is not conducive to discussions of whole brain-death and organ transplantation.

Yanagida points out that third-person death is an objective event that can be calmly observed from a stranger’s standpoint. “Even if five young people die in a traffic accident or a million people die in Africa, we can still sleep well at night and our lives today and tomorrow do not change at all,” wrote Yanagida. The clinical criteria for whole brain-death are examples of third-person death. The personality and history of the deceased are irrelevant considerations. What matters most of all is the time and cause of brain-death.

The ethics of relationships therefore believes that a person ought to be understood through three important relationships: first-person relationships, second-person relationships and third-person relationships. Persons employ different sets of ethical theories and principles, and they perceive brain-death differently, depending which of these three types of relationships they make primary.

The “Wall” Between Donors and Recipients in Japan

Having reviewed the ethics of relationships in Japan, we are now able to examine organ transplantation in Japanese society. This discussion follows the diagram found in the appendix.

This diagram has two sides, the donor side and the recipient side, with various relationships within and across them both. There are two different kinds of arrows in the diagram: the bold arrows indicate more intimate second-person relationships and the dotted arrows indicate less intimate third-person
relationships. The relationships are more close and intimate on the longitudinal axis because they are second-person-relationships. On the lateral axis, the relationships between the donor and the recipient sides are less intimate and visible because they are third-person relationships. Those on each of the two sides end up concentrating their attention on their own second-person relationships.

For the donor’s family, the death of the donor is a second-person death while the death of the recipient is a third-person death. This makes it difficult for the donor’s family to think about the recipient’s need for organs. In a similar fashion, for the recipient’s family members, the death of the recipient is a second-person death while that of the donor is a third-person death. This makes it difficult for family members of recipients to conceive the pain and agony that the donor’s family members face. Therefore, relationships between those on the donor side and those on the recipient side, which ought to be the central part of organ-transplantation, become weak and distant. Each side become more indifferent and negligent toward the other. The metaphor of the “wall” is an apt to illustration of this special circumstance between those on the donor and the recipient sides.

Barriers Between Donors and Recipients

A wall is an object that prevents one from seeing what is on its other side. This is exactly what this “wall” does for organ transplantation in Japan. It prevents those on the donor side and those on the recipient side from understanding each other. Because his or her relatives love the donor so much, they simply cannot think of the recipient’s needs. They therefore lack
motivation to donate organs. Because the recipient's family and physicians really love and wish to save the recipient's life, they simply cannot imagine the painful reality of the donor's relatives. The "wall" implies unconscious indifference toward the other side's welfare. It illustrates a state of mind which is completely filled with a strong desire to help one's own relative, so strong that one becomes blind to the pain, agony, hope, and needs of those on the opposite side. The general rule appears to be that the more intimate one's relationship is with a donor or a recipient, the more indifferent and blind one becomes toward the welfare of those on the other side of the "wall."

This "wall" becomes even taller and thicker as both sides develop different concepts of whole brain-death and employ different types of ethical theories. For the recipient side, the whole brain-death of the donor is third-person death. As such it evokes no strong emotions and feelings. When these on the recipient side think of the donor, they are able to think of whole brain-death criteria calmly and rationally. They employ third-person ethics, such as respect for the autonomy of strangers (in the case of organ donation) and utilitarianism (in the case of organ transplantation). At the same time, when they think of their beloved recipient, they employ second-person ethics, such as the principle of beneficence and the ethics of care. In this mode, the most important goal is to save the recipient's life. This goal justifies everything, including legalizing whole brain-death as a person's death despite the fact that many Japanese people are still opposed to these criteria.

On the other hand, for those on the donor side, the death of the donor is second-person death which evokes many intense emotions. The donor's family
thinks of whole brain-death without calm and rational minds. They use subjective perceptions to understand their beloved one's death and they are inclined to conclude that whole brain-death can not be death of a person. They want to fulfill their obligation to stay by and share the beloved one's death until the last moment. They tend to regard the recipient's approaching death as simply the death of a stranger which evokes no strong emotions. As a result, they employ aspects of third-person ethics, the principle of justice, for example, to defend the donor's rights.

Therefore, the whole brain-death and organ-transplantation debate in Japan is a manifestation of an even more profound conflict between second-person relationships and third-person relationships. It is ultimately a conflict between the needs and the welfare of one's loved ones and those of strangers. In Japan, it seems that second-person relationships usually win. For the Japanese people, second-person relationships are much more important than third-person relationships. The donor's welfare is much more important than the recipient's welfare for the donor's family and the recipient's welfare is much more important than the donor's welfare for the recipient's family members. The "wall" is tall and difficult to overcome.

Overcoming the "Wall"
Between Donors and Recipients

There are at least two ways to see the other side when we face a "wall": we can break down the wall or climb over it. The two share the same end of seeing the other side. However they differ in their means. Breaking down a wall implies that one destroys the differences between between second-person
relationships and third-person-relationships. This means that one comes to view third-person relationships as intimate and close, suggesting that strangers practically become loved ones. The metaphor of climbing over a "wall" implies that it still exists but one tries to climb over it to see stranger's genuine needs. The second way, that of climbing over the "wall" is often thought to be more realistic. The key to overcoming the "wall" is, therefore, the existence of a special morality, a tool like a ladder that makes us able to scale it and to see the needs of strangers.

The "Gift of Life" in North America

What makes it possible for greater numbers of people in North America to scale the "wall" and to accept whole brain-death and organ-transplantation? This question has attracted many scholars in Japan. Umehara, one of the leading Japanese philosophers who objects to legalizing whole brain-death in Japan, contends that there are two philosophical factors that inform North American attitudes. These are body-mind dualism and pragmatism. Body-mind dualism, rooted in Descartes' thought, makes consciousness the central feature of human life in a way that leads to rationalism. Umehara reasons that it is logical for mind-body dualism to arrive at the conclusion that whole brain-death is a person's death. In addition, Umehara refers to what the Japanese call "ningen-kikai-ron" ("human-machine theory") which represents the human being as a physical machine. This word was originally found in La Mettrie's book, L' Homme Machine and then translated into Japanese so that there is no equivalent term in English. Umehara insists that this theory makes sense of the idea of exchanging bad parts of a body with good parts from other bodies, making
organ transplantation a reasonable and rational medical option. Further, Umehara insists that pragmatism is so deeply embedded in North American belief systems that it has become "common sense": what produces effective consequences is right and what doesn't is wrong. Under the influence of pragmatism, North Americans tend to think that the criteria of whole brain-death ought to be employed over cardio-respiratory criteria because they are more convenient for organ transplantation.

There is no doubt that the body-mind dualism, "ningen-kikai-ron," and pragmatism that Umehara identifies actually do provide philosophical pressures that encourage North Americans to accept whole brain-death and organ-transplantation. However, Nudeshima correctly observes that there must still be other motivating factors. Nudeshima insists that concept of the "Gift of Life" is one of these additional factors. So what is the "Gift of Life?" How does this concept encourage North Americans to believe that organs can be gifts? The answer to these questions seems to be related to the Christian idea of neighbor-love, which is also prevalent in North America.

**Christian Neighbor-Love**

The Bible includes several discussions of Christian neighbor-love. However, one of these is particularly effective. This is the parable of "the Sheep and the Goats" taken from the Gospel according to Matthew.

The parable begins with a scene in which all people are gathered in front of "the Son of man" who separates "his sheep" on his right side from "the goats" on his left. The Son of man says to the people on his right, "Come, ye blessed of my Father, inherit the kingdom prepared for you from the foundation of the
world." The reasons why they can inherit the kingdom follow: "For I was an 
hungred, and ye gave me meat: I was thirsty, and ye gave me drink: I was a 
stranger, and ye took me in: Naked, and ye clothed me: I was sick, and ye visited 
me: I was in prison, ye came unto me." Then the righteous surprisingly ask 
Him: "Lord, when saw we thee an hungred, and fed thee? Or thirsty, and gave 
thee drink? When saw we thee a stranger, and took thee in? Or naked, and 
clothed thee? Or when saw we thee sick, or in prison, and came unto thee?" The 
righteous people appear deeply surprised by the Lord's invitation to inherit the 
kingsdom because they do not remember that they offered Him food, drink, 
clothes, and a place to stay although, as the Lord says, they certainly offered 
these to strangers.

In order to understand this parable from the perspective of the Japanese 
ethics of relationships, we need to know who is in the parable and how they are 
related with each other. There are four general figures in the parable: the Lord, 
the righteous, the unrighteous, and the "least." Without any difficulty, it can be 
understood that the relationship between the Lord and the righteous is a very 
close second-person one. To the contrary, the relationship between the 
righteous and "the least of these" is not as close and intimate as the one with the 
Lord. Therefore, the relationships between the righteous and "the least" are 
third-person relationships.

In response to the inquiry of the righteous, the Lord states the essential 
lesson of this parable: "Verily I say unto you, Inasmuch as ye have done it unto 
one of the least of these my brethren, ye have done it unto me." The central
point of the parable, therefore, is very clear: simple help offered to "the least" is equal to help offered to the Lord.

Although this parable is generally viewed as defining God’s standard of judgment, as Barclay points out, it is also interpreted as helping us realize that assisting strangers is analogous to helping the Lord. This motivates persons not only to refrain from being unethical toward strangers, but also to offer generous, positive help to them. The essence of Christian neighbor-love, therefore, is a special ethical analogy that makes it possible to feel as though strangers are significant people. This analogy uses the Lord as a metaphor to transform less intimate and more distant third-person relationships into more close and more personal second-person ones.

This parable also suggests that there are no third-person relationship for God because every person is significant to Him. In addition, the parable depicts the finite and fallible nature of human beings as a moral agents. We are inclined to view others only as strangers, or as "the least" whose existence is grasped only in third-person relationships. We human beings may act morally in second-person relationships but immorally in third person ones. We tend to be more altruistic, compassionate, and kind with significant others but more selfish and cruel with strangers. The ethics of relationships effectively reminds us of the essential difference between our morality and God’s. In God’s morality there is no difference between first-person ethics, second-person ethics, and third-person ethics. In fact, God’s morality expresses only one type of ethics, God’s unconditional love for all.
Moral imagination

Compared to the heavy emphasis of Western bioethics on principles, moral imagination has received far less attention in North America than it deserves. Johnson proposes that “our moral understanding is essentially imaginative.” Using his experience of the Vietnam War, Johnson emphasizes that ethical theories and principles can only help us increase our moral understanding, but “never tell us what we should do in our real lives.” Ethical theories can help us to understand who we are and what ethical options we have, but they can never tell us which options we should choose. Moral imagination, by contrast, makes us able to place ourselves imaginatively in various circumstances. By imaginatively putting ourselves in certain hypothetical situations, we can acquire a realistic sense of what the consequences of our actions will be. This can evoke our moral sensitivities and eventually motivate us to choose one option. In particular, moral imagination allows us to see things from the perspectives of other people, thus helping us to make less selfish and more impartial decisions.

Christian neighbor-love is one type of moral imagination. The key to understanding this again lies in the interpretation of relationships. Moral imagination of the first-person is the capacity to picture a self-image that will result from one’s own autonomous decision. Ordinarily, when one faces a situation where moral a decision is required, one analyzes the situation, applies ethical principles and theories, compares and contrasts possible options, then draws a moral conclusion.
Moral imagination should be integrated into the process of examining options. Moral imagination of the first-person helps one to imagine the most likely results of one's own autonomous choices upon one's subsequent self-image, thereby helping one to draw a moral conclusion. Moral imagination of the third-person is the capacity to picture the group-image that will result from the group's decisions. Based upon relationships between oneself and strangers, it helps one to put oneself in the place of larger group, such as the enterprise, community, or state, and motivates one to imagine how one's actions, or the group's action, will affect it as a whole. Moral imagination of third-person, thus, can be characterized by attenuation of the self in favor of the group's gain.

Moral imagination of the second-person indicates the capacity to picture anticipated relationship between oneself and significant others. Johnson appropriately calls this moral imagination "empathetic imagination" and depicts it as follows:

It is the capacity for one to imagine oneself in another's situations. To be empathetic means to imagine oneself in the place of another, to become more sensitive to others' needs, and to see the world through the eyes of others but not through one's own values and ideals.89

The most important characteristic of moral imagination in second-person relationships is the desire to know the other's values and ideals. When we engage in moral-imagination of the first-person, we have to know only our own values and ideals to imagine and judge whether an action is morally sound. Once we engage in second-person relationships, however, the probable impact of one's choice on others must be imagined and judged not only from one's own perspectives but also from the perspectives of others. Although it is impossible
for one to know for certain how a significant other is going to perceive one's action, it is better for one to know his or her values and ideals. These may provide important indications as to how one's choices may affect him or her. Moral imagination is an effective tool to motivate people to become more sensitive to the needs of others, to evoke moral emotions and feelings, and thus to help others.

Some relatives of organ donors do engage in this moral imagination of the second-person. When they decide to donate their loved one's organs to strangers, they imagine that their own child is waiting for an organ. In addition, some families report that they have to imagine a potential recipient in order to decide to donate organs. This appears to indicate that a vivid imagination of the recipient's needs, pains, and hopes can help a family regard a potential recipient not as a stranger but as a significant person.

All this makes it clear why North Americans can somewhat more easily than the Japanese overcome the "wall" between strangers and accept the concept of "gift of life" somewhat more easily than the Japanese. The rich tradition of Christianity in the West, especially Christian neighbor-love, encourages North Americans to develop a special moral imagination that makes it possible for them to perceive and treat strangers as though they are significant others. This concept of Christian neighbor-love is deeply embedded in the belief systems of North Americans. Therefore, they often find it easier to accept the concept of the "gift of life" as morally praiseworthy. This concept of neighbor-love is not as prevalent in Japan.
The Japanese Concept of "Gift"

Pointing out that the Western religions and intellectual traditions provide a fundamental basis for developing the concepts of whole brain-death and organ transplantation, Ohnuki-Tierney, a cultural anthropologist, suggests that organ donation expresses Judeo-Christian values such as love and altruism. Yet, Ohnuki-Tierney claims that "donated organs - 'the gift of self,' literally - are not and cannot be the gift of self because organ donation lacks the most critical element of gift giving and exchange: social relationship." 91

Ohnuki-Tierney examines the Japanese practice of gift exchange so as to demonstrate how it sustains social relationships. According to her observations, Japanese people exchange gifts "in such a way that one remains indebted to the other, causing the social relationship to continue." 92 One way to do so is never to repay a gift at its full value, thereby giving the recipient an opportunity to return another gift on a subsequent occasion. Quoting Mauss' work, she emphasizes that in Japan exchanging gifts is used to establish and to maintain social relationships by both making and repaying debts. Then she points out that for the Japanese organ donation cannot reflect the meaning of gift exchange because it is unilateral.

It is now apparent why the Japanese are hesitant to donate organs. There are at least two essential reasons. First, an emotional and psychological "wall" prevents them from understanding and sharing the needs, emotional upheavals, and welfare of those on the opposite side of the transaction. More importantly, the second reason is that they lack a special moral tool that would motivate them to climb over the "wall" to see and understand things on the other side, a
concept like Christian neighbor-love. The Japanese do not have the custom of giving gifts to strangers. This makes them, in general, less interested in the welfare of strangers and in donating organs to them.

**Anonymity**

After the Organ Transplantation Law was enforced in October of 1997, there was no organ-transplantation from a whole brain-dead patient until February of 1999. Since then there have been eight cadaveric donors in Japan while there were 5798 cadaveric donors in North America during 1998 alone, according to the United Network for Organ Sharing.93

These numbers make it difficult not to conclude that the Japanese people are still more hesitant to donate organs than North Americans, which makes one wonder how organ-transplantation can be established in Japan. Organ donation is essential for organ transplantation. The simple fact is that there can be no organ transplantation if there is no organ donation. Therefore, the success of organ transplantation in Japan depends on how well the Japanese can be motivated to donate organs.

One way to encourage this would be to use the traditional metaphor of “gift of life,” or the recently adopted metaphor of “relay of life,” in Japan. This may heighten awareness among the Japanese people about the need for organs and secure their agreement to donate. The emphasis should be placed on helping families fulfill their sense of obligation to carry out the deceased person’s sincere desire to donate his or her organs. This should be regarded as a traditional approach because it has been used in North America for a long time.
Another way to encourage organ donation in Japan is more radical. This would be to abolish the usual practice of maintaining anonymity between the donor and the recipient sides. The logic of abolishing anonymity is simple: if the “wall” between the donor’s and the recipient’s sides prevents the Japanese from donating organs, and if there is no special ethics that can help them to climb and overcome the “wall” to see the needs of those on the other side, then the only remaining option is to destroy it, or at least lower it enough to allow those on each side to see each other.

How can this be done? The easiest, and most effective way would be to wholly or partially to transform the more distant third-person relationships into more intimate and close second-person ones by wholly or partially removing the barrier that prevents people on both sides from appreciating each other’s challenges. This more intimate knowledge would not depend upon moral imagination but upon actual contact with actual people facing actual difficulties. It would enable those on each side of the “wall” to know real people on the opposite side in a genuine and not merely in an imaginative way.

Several considerations favor the radical approach. In order to share the pain and agonies of others, we must know them intimately. But for the Japanese, organ-donation can not be an ordinary act of love because they do not know how to perceive and treat strangers as if they are close significant others. This does not mean that Japanese people are barbarous and narrow-minded. It simply means that they do not have the custom of thinking and acting in these ways. In Japan, in order for organs to become gifts, there must be reciprocity. Under the veil of anonymity, this is impossible. Thus, the Japanese must invent
some way to enable those on the donor side and those on the recipient side to know each other. The whole or partial abolishment of anonymity is a promising way to accomplish this.

The traditional and common belief that knowing each other is harmful for those on both the donor and the recipient sides must be re-examined. Since the beginning of organ-transplantation, the principle of anonymity has reigned as an untouchable rule that is rarely reconsidered. However, how can we know the real harm of relaxing this rule without trying it? In fact, it may be that some donors and recipients do want to know more about each other. This may suggest that not knowing each other may actually be harmful for those on both the donor and the recipient sides.

Summary

This chapter began with one Japanese woman's decision not to receive life-saving organ-transplantation in order to identify what is a missing element in the Japanese controversy. In order for Miss Terao to live, she needed fresh organs, but that meant she must wait for others to die. For Miss Terao, this was a very serious and cruel moral conflict. This depicts what is the essential problem in the whole brain-death and organ transplantation controversy in Japan. What is missing in the controversy is a mutual understanding of these issues on the part of those on both the donor and the recipient sides. However the debate did not settle the conflict that Miss Terao faced. It only divided people into two camps, those on the donor side and those on the recipient side, and few now see the problems from both points of view. The essential cause of these problems is
the "wall" between the two sides which implies insensitivity and indifference to the needs of those on the other side. Because the Japanese people do not have a special ethics like Christian neighbor-love, one form of moral imagination which helps North Americans see strangers as if they are loved ones, and because the Japanese do not have the custom of giving gifts without reciprocity, it is unrealistic to expect them to donate organs to strangers.

The most promising solution would be to abolish the ordinary practice of maintaining anonymity between those on the donor and the recipient sides so that each is finally able to become more realistic about the needs of those on the other side. All Japanese people should first attempt to put themselves on both sides of this exchange. Each should try to understand the pains, agonies, hopes, and needs of each. Only by doing this, can the Japanese people truly understand that, as Fujii points out, they can live by helping others to live and by letting others help them to live.94
The first chapter of this study suggests that whole brain-death criteria have been regarded as the central, yet-to-be-resolved issue in the Japanese organ transplantation controversy. The most common hypothesis is that the Japanese hesitation to accept whole brain-death as a person's death prevents organ transplantation from becoming rooted in Japanese society. This study's second chapter surveys the various reasons that are often offered in support of this hypothesis. The third chapter of this study argues that we should try to see what is going on beneath the surface of the reservations of the Japanese people regarding whole brain-death. It concludes that a distinctive Japanese ethical orientation, which puts much emphasis upon second-person relationships, makes it hard for the people of Japan to believe that their significant others who fulfill the requirements of whole brain-death criteria are actually dead.

This ethical orientation makes it difficult for those on both the donor side and the recipient side to see the other's special needs. This phenomena was illustrated as an emotional and psychological "wall" that stands between those on the donor side and those on the recipient side preventing each from seeing the other's pain and needs. Without the presence of the distinctive moral imagination of Christian neighbor-love, it may be that the Japanese will have to look for an alternative way to overcome this "wall." One promising suggestion is to remove the requirement of anonymity that separates the donor side and
the recipient side so that those on both sides can become non-strangers who share each other's pain and understand each other's needs. Hopefully this will lead to a reciprocal "gift of life."

Ethics of Organ Donation and Transplantation in North America

The most practical implication of the Japanese controversy for North American bioethics is that the ethics of organ donation and transplantation in North America deserves to be critically reviewed. Organ donation appears to be successful in North America because the metaphor of the "gift of life" appears to be well accepted. In general, it seems that this is an effective expression by which to motivate people to become organ donors in North America. However some are starting to disagree with this conclusion.

Siminoff and Chillag recently pointed out that the "gift of life" should no longer be considered an effective metaphor in North America. Although it is supposed to convince people that organ donation is virtuous, altruistic, and good, an insufficient number of organ donations is increasingly a problem in North American society. Siminoff and Chillag observe that "families' unwillingness to do so when asked in actual donation situations" is the the essential cause of insufficient organ donations. They claim that the common assumption that "awareness of need would be enough to persuade people to donate" is simply too optimistic, even in North America.95

Siminoff and Chillag suggest that the "gift of life" metaphor is "fallacious." They are convinced by gift exchange theory that, without social relationships and social reciprocity, it is contradictory. There can be no
reciprocity between the donor and the recipient because the donor cannot be a "gift giver." The donor is a "gift object" rather than a "gift giver" because he or she is already dead when organs are procured and donated. Likewise, the recipient cannot be a "gift receiver" who is supposed to repay the debt. "The debt cannot be repaid to the deceased ..... nor can a gift of such magnitude -- of life itself -- be adequately repaid to a proxy" they claim.

Siminoff and Chillag use their recent research regarding the donation and transplantation experience to report several other interesting findings. Their studies show that in North America eighty percent of healthcare providers disagree with donating organs of their relatives, whereas only three percent believe in cardiovascular death as a person's true death. This suggests that whether or not one believes in whole brain-death criteria does not necessarily correlate with one's willingness to donate organs. Their research also shows that in North America there are still many misconceptions and confusions caused by the concept of whole brain-death among surviving family members.

Their research identifies a number of trends that are also seen in Japan. Some family members in North America exhibit certain beliefs about the body and burial that discourage organ donation, such as that "one should leave the world as one entered it." By donating a beloved one's organs, some family members find "hope that the patient will somehow live on in others" and show a "desire to help others, especially so that the death of the patient would accrue meaning." These findings about recent trends in North America concur with this study's report that in Japan organ donation is often made by family members for the sake of the donor rather than the recipient. In North America, as in
Japan, many family members tend not to donate organs because they altruistically want to help strangers. Rather they do so mainly because they want to honor and fulfill a loved one's choice or because they want to find some meaning in their loved one's death.

Given these various suggestions, Siminoff and Chillag contend that "altruism is not necessarily the primary motivation when families decide to donate." They state that the "gift of life" metaphor is a fallacious concept that no longer serves its original function of motivating people to give a gift for the sake of recipient. They insist that there is a strong need for an alternative metaphor.

The ethics of organ donation in North America appears to consist of two discrete beliefs. First, someone's autonomous choice to donate organs to save others should be respected. Second, donating organs is a virtuous and honorable deed that coheres with Christian neighbor-love. However, it is becoming apparent that these two convictions do not promote organ donation and transplantation to the needed extent. This makes some wonder why the "gift of life" metaphor has not been more successful even in North America.

A straightforward answer might be that all human-beings are naturally self-centered. Japanese philosopher Iida uses European social contract theory to demonstrate that human nature is basically selfish. Proposed by Hobbes, Locke, and Rousseau, social contract theory successfully guaranteed individual freedom and equality, but it also highlighted the self-centered nature of human-beings which surfaced in the form of pursuing individual rights. Iida points out that for naturally selfish human beings the "gift of life" metaphor, which stands
on the principle of self-sacrifice, is a "god-like or superhuman ethics" that cannot be rooted in ordinary human society.

North America also appears to be facing a new problem. The "gift of life" metaphor does not help the donor's family members or the recipients after organ transplantation. A documentary televised by Nippon Hoso Kyokai (Japan Broadcasting Corporation) in 2000 revealed that North America has now turned its attention to what awaits the donor's family and the recipient after organ donation. The program highlighted the tremendous senses of guilt and repentance experienced by the donor's surviving relatives toward their decision to agree with organ donation. The program also depicted the complex reality of the recipient's life after transplantation: the inward struggle and loss of identity. These findings suggest that the "gift of life" metaphor might be effective enough to motivate some family members to donate their loved one's organs, but not effective enough to assure them that the donation decision was the right thing to do at the time. Also, the metaphor appears not to guarantee that recipients will experience inner peace and comfort after receiving organs as a gift.

The documentary also revealed an interesting phenomena in North America: increasingly family members of donor's and recipients want to know more about each other. The documentary followed a donor's mother who desired to see the recipient so that she could hug her "son" once more. Accompanied by a transplantation coordinator, the mother was invited to the recipient's birthday party where they finally met each other for the first time. They embraced each other, exchanged words, and spent time looking at the donor's pictures and discussing his life.

85
Afterwards, the donor's mother made a very interesting comment. She said that she felt her son's heart beating when she embraced the recipient, but that she finally understood it no longer belonged to her son but to the recipient. She said she finally realized that "the miracle" would never happen. It is inappropriate to generalize too much from this particular experience because of the lack of detailed information and parallel cases. Nevertheless, it does suggest that in North America there are unfilled desires on both the donor and recipient sides that cannot be wholly satisfied by the "gift of life" metaphor.

It therefore appears that bioethics in North America is starting to realize that organ donation is a complex exchange that cannot be sustained only by the "gift of life" metaphor. It has complex psychological consequences for those on both the donor and the recipient sides. The most important implication is that the "gift of life" metaphor is not sufficient even in North America. North American bioethics should pursue an alternative path which will not merely help people to donate organs but also help them prevent or minimize negative psychological consequences for all after the transplantation.

It would appear that Japan and North America have taken different paths in dealing with organ transplantation. Japan, viewing organ transplantation as unnatural from the beginning, must somehow become accustomed to the awkwardness of this new technology. North America, having comparatively less resistance to adopting it, seemingly must discover the unnaturalness and awkwardness of this already accepted therapy. Japan and North America concurrently started their learning processes in the last decade of 20th century. This suggests that there is still plenty of room for exploring how organ
transplantation ought to be ethically carried out in both Japan and North America, especially in terms of its psychological consequences for all who are involved.

The Ethics of Relationships and North American Culture

One of the most distinctive features of this study is its proposal that the ethics of relationships is a decisive factor in the Japanese doubts about whole brain-death and organ transplantation. However, because it is not yet a fully developed and justified theory, some may find it difficult to comprehend. It therefore seems appropriate to summarize it, add some theoretical explanations, and suggest some general contributions it can make to North American bioethics.

The basic theme of the ethics of relationships is that a person ought to be represented as functioning in three types of relationships. Each type of relationships highlights a different aspect of human personhood and evokes different ethical principles and theories. First-person relationships evoke an hypothetical association between one's own mind and one's own self-image. Because the only moral subject involved in this relationship is oneself, this becomes the single source of moral standards. What is morally right or wrong tends to be determined by what one thinks is right or wrong. The moral question becomes "what should I, as a sole moral agent, do in this particular situation?" The principle of respecting one's autonomy, the theory of deontology, and theory of virtue and character are categorized as ethics of first-person relationships. These principles and theories all tend to emphasize that the
singular individual is the central moral agent who possesses the moral authority or is the source of the moral standards that determine what is right and wrong.

Second-person relationships represents very close affinities between the self and significant others. In these kinds of relationships, there at least are two moral subjects, the self and the significant others who now share moral authority and together become the source of the moral standards that determine what is morally right or wrong. The moral question now becomes "what should we, I and my loved one, do in this particular situation?" As stated before, the principle of beneficence, the ethics of care, the ethics of feminism, and the traditional Japanese ethics of "jinrin" can be categorized as ethics of second-person relationships. They all emphasize that what makes an action morally right or wrong depends upon how well it results in the best outcomes for significant others as well as for oneself.

Third-person relationships represent comparatively distant connections between the self and strangers who share moral authority and are the source of the moral standards that determine what the self and the whole ought to do. The moral question then becomes "what should we, I and those strangers together, do in this particular situation in order to keep peace, equilibrium, and order within this group, community, or nation?" The theory of utilitarianism and the principles of justice and equality can be regarded as ethics of third-person relationships because in them what is morally right or wrong is determined by what will enhance the interests or protect the rights of those who do not know each other well.
These three alternatives may be depicted in a diagram that demonstrates that the ethics of relationships can achieve different forms of moral equilibrium depending upon how much weight is placed on each of the three types of relationships. The diagram displays the three kinds of relationships on a horizontal line. First-person relationships are on the left, second-person relationships are on the center, and third-person relationships are on the right, all positioned according to the number of moral subjects involved in each of the three relationships.

| First-Person Relationships | Second-Person Relationship | Third-Person Relationships |

Each of these relationships is extremely important; each is equally required to depict a person. This sense of the equal necessity of each of the three types of relationships is a key concept in the ethics of relationships.

How can we balance these three relationships? Second-person relationships play a decisive role in this process because they are located between first- and third-person relationships. This makes second-person relationships especially helpful in achieving balance, equilibrium, and order. This does not mean that they are more important than the other two kinds of relationships. Rather, because they are psychologically positioned between first- and third-person relationships, they are close enough to both to provide a better basis for equally balancing all three.
For example, if one takes a moral position closer to first-person relationships, the diagram below reveals its greater psychological distance from third-person relationships. Such a stance confines one's moral viewpoint within individualistic perspectives, making it more difficult to realize the significance of the other two kinds of relationships. In similar way, if one takes a moral position leaning toward third-person relationships, one limits one's moral viewpoint within group-centered perspectives and tends to neglect the other two kinds of relationships. However, if one takes a moral position centering upon second-person relationships, the diagram shows that one is now equally close to both first- and third-person relationships.

Second-person relationships have a better capacity to provide a moral position that allows us to avoid viewpoints that are confined and unbalanced in opposite ways. Because second-person relationships are located between first and third person relationships, they can effectively make us realize that one's moral approach should not be restricted to one particular type of relationships, but should be extended to cover all of the three in an equally balanced equilibrium.

First-Person-Centered Model

<table>
<thead>
<tr>
<th>First-Person Relationship</th>
<th>Second-Person Relationship</th>
<th>Third-Person Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O---------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moral standards, in the simplest sense, show what is right and wrong. The ethics of relationships proposed in this study holds that the reality of the person ought to be drawn equally from all of the three types of relationships, just as God's reality is equally expressed in Father, Son, and the Holy Spirit. The ethics of relationships sets moral standards as follows: any action that makes us capture the reality of a person in an unbalanced and restricted way, that is to say, with an unbalanced concentration on one particular type of relationships, is
unethical even if the action itself is justified by the ethical resources usually associated with that one alternative.

A good example with which to illustrate this moral standard is the justification of active, voluntary euthanasia based solely on the principle of autonomy. If one takes a moral position that concentrates only on first-person relationships, one tends to use principles such as autonomy to justify this kind of euthanasia. The ethics of relationships suggests that such justification is unethical, despite the fact that when taken by itself, the principle of autonomy may well ethically justify a decision to have one's life terminated. It is ethically wrong because it dismisses the other two important relational perspectives. If one wants to justify active, voluntary euthanasia, the ethics of relationships insists that one must do so from all three of the relational perspectives. This choice must be ethically justified and defended not only by the ethics of first-person relationships but also by the ethics of second- and third-person relationships. Some general rules of the ethics of relationships can be summarized as follows:

(1) The ethics of relationships proposes that moral blindness, that is to say, an unbalanced understanding of a person based upon only one instead of all three types of relationships, is morally wrong. Moral justification drawn from either (a) only one type of relationships or (b) from only one type of ethical theories cannot be valid.

2) The perspective of second-person relationships possesses a capacity to help us avoid moral blindness because of its positional advantage over first- and third-person relationships.

3) A moral justification is adequate if and only if it is equally supported by first-, second- and third-person relationships and their ethical resources.
The ethics of relationships can provide a helpful interpretation of moral diversity. From this perspective, moral diversity depends upon which type of relationships a person, group, or culture emphasizes. Every person, group, or culture potentially shares and incorporates the very same basic moral theories and principles, but they may differ as to which type of relationships they emphasize. This diversity may lead them to employ different sets of moral principles and theories that correspond to the relationships they particularly emphasize. Geographical conditions, history, political and social systems, religion, and gender are some of the considerations that may influence a person, group, or culture to emphasize different relationships to different degrees. For example, as Carol Gilligan and some other scholars emphasize, women generally tend to emphasize second-person relationships. This influences them to employ the ethics of second-person relationships with priority upon beneficence, the ethics of care and so on. Another example would be communist nations which put a strong emphasis on third-person relationships. As a result, these nations tend to apply principles such as justice, equality, and utility to the society as a whole. This approach, which does not lend support to normative ethical relativism, provides important opportunities for further cross-cultural research and reflections.

Whole Brain-Death in North America

Although this is no longer as true as it once was, north American bioethics has a long tradition of putting much emphasis on the consciousness of the
individual. This, together with the American tradition of pragmatism, convinces people in that part of the world that death must be rationally and objectively understood rather than emotionally perceived. However, this consciousness-centered approach appears to have one weak point. This is its inability to explain why people, even in North America, often feel hesitant to recognize both whole brain-dead patients and permanently vegetative patients as dead even though they fully understand that the both have forever lost consciousness.

The consciousness-centered approach is very good at showing what differentiates higher brain-death from whole brain-death. What confuses people is not the objective and scientific difference between higher and whole brain-death, but the appearance of patients in both states. Our rational minds tell us that whole and higher brain-death are rationally and objectively equivalent to the death of a person, but our emotional and subjective states often tell us the opposite. An even more problematic point is that the consciousness-centered approach convinces us that subjective perception in such matters is irrational, illogical, naive, and thus irrelevant.

The ethics of relationships disagrees with such views and insists that our subjective perceptions of death ought to be respected. The Japanese ethics of second-person relationships understands the importance of how family members perceive their beloved one's circumstances and condition. A good example is the current transplantation law in Japan which allows the family members to choose the criteria of death they find most helpful. If the family members cannot accept whole brain-death criteria, the Japanese law allows them to choose traditional cardiovascular standards instead.
Lock summarizes what North American bioethics can learn from Japan: "What we learn from Japan is that the person (hito) is not equated with individual consciousness, nor is the person located in the brain. Personhood is diffused throughout the mind and body and, moreover, is a condition that is fundamentally social and not individual in essence." Adding to Lock's comment, we can emphasize that personhood is fundamentally relational as well as individual. Personhood is initiated and possessed by an individual, but at the same time it is developed, shared, and most importantly, completed by significant others. This sense of the unity, togetherness, and relatedness of second-person relationships is a central feature of Japanese morality that North American bioethics tends to dismiss too easily. This does not mean that North Americans lacks an intimate sense of unity within close relationships, but that, because of their strong emphasis upon individual consciousness, they dismiss their subjective emotions toward their loved ones as irrational and thus irrelevant.

The point is very simple. According to the ethics of relationships, the so-called "irrational" and "illogical" perceptions that we FEEL toward a brain-dead individual or permanently vegetative individual are as morally pertinent as our rational and scientific understandings. The death of someone we love is a very intimate and special event that cannot be defined merely by medical facts. Should we, must we, and most importantly, can we really believe, both at the rational and at the nonrational levels, in the whole brain or higher brain-deaths of our significant others? North American bioethics would do well seriously to seek an answer to this question.
Summary

This chapter focused on what the whole brain-death and organ transplantation controversy in Japan can contribute to North American bioethics. It emphasized that the ethics of relationships can provide different perspectives that North American bioethics would do well to consider. The intention of these remarks is not to denounce the moral viewpoints of North American bioethics, but to show that there are moral perspectives that differ. In addition, this controversy ought to be viewed as illustrative of the general difference between Western thought and traditional Japanese ethics, and possibly Eastern ethics more generally.

Of course, North American bioethics can totally dismiss the whole rest of the world as ethically irrelevant. But it is difficult to give up the idea that there is truth that cannot be discovered if we take a one-sided view. Whole brain-death and organ transplantation is such a case. North American bioethics ought to consider seriously the fact that about fifty percent of the Japanese people still feel uncomfortable about whole brain-death criteria.

Japanese philosopher Hiroshi Mizutani uses an interesting analogy to emphasize the importance of both rationality and nonrationality in society.

When we see a close friend off at train station, there are kinds of people who think that it is of no use to stay on the platform after we exchange farewells and we are no longer able to see the friend’s face in the train. And there are also other kinds of people who like to stay at the platform and stand for a while even after the train has left. Aside from which type you like, the truth is that our society is made of these two kinds of people."100 Mizutani points out that those who leave right away can be viewed as rational people and those who stay a while and feel affectionate toward the person who
left can be viewed as nonrational people. His point is not to ask which type is more ethical or which way is more ideal, but to understand that both rational and nonrational people are important because our society is formed of both of types. Given Mizutani's suggestion, it is important to acknowledge that we, North Americans and Japanese, have both rational and nonrational natures. Just as we value rationalism which propels science and medicine, we ought to appreciate our nonrational natures because they are among the things that make us human.

Yanagida states that there are three areas in which Japan is said to be far behind North America and other advanced nations, according to the Japanese physicians who advocate whole brain-death and organ transplantation: (1) Japan is behind because its surgeons do not practice the high organ transplantation skills they possess; (2) Japan is behind because many Japanese people do not accept whole brain-death criteria; and (3) Japan is behind because the voluntary spirit of the "gift of life" has not yet been rooted firmly in Japanese society. Yet, we should not deny the possibility that what appears to be "behind" might sometimes actually be "ahead."

It is difficult to draw a line between what we are morally allowed to do and what we are not. However, perhaps this line does not always have to be drawn from rational, logical, and pragmatic viewpoints. We may sometimes find it helpful to draw this line based upon our nonrational, illogical, and non-pragmatic emotions and feelings. We might do well to have the courage to admit that sometimes we experience a "must-not-cross" line without attempting to provide logical and pragmatic justification. We human beings are nonrational
beings as well as logical ones. Thus, both Western rationalism and Japanese nonrationalism are vital components of the whole global community. We should try not to rely too much on one or the other.

A sense of balance is vital in such approaches. In order to balance things, we need wisdom and careful observation. Wisdom is needed to help us compare and contrast different cultures and their unique traditions so as learn from all of them how best to deal with difficult ethical problems. Wisdom is needed to balance Western rationalism and Eastern nonrationalism. This is what the goal of globalized bioethics in the twenty-first century should be.
References


3. Ibid., 148-150.


5. Ibid., 58-61.

6. Ibid., 61-66.


9. Machino and Akiba, 229.


12. Machino and Akiba, 205.


16. Ibid., 217-234.
17. Ibid., 244-281.
18. Ibid., 251.
19. Ibid.
20. Ibid.
21. Ibid., 268.
22. Ibid., 275.
23. Ibid., 280.
24. This summary is based on reports published on the relevant dates in Asahi Shinbun.
25. Ibid.
27. Ibid., 13 August 1999.
28. Machino and Akiba, 268.
29. Machino and Akiba, 205.
33. Ibid., 78.

36. Ibid., 28 February 1999.

37. Machino and Akiba, 252, 272.

38. Hideo Hara, 141.


41. Michi Nakajima, "'Mienai Shi' no Rippoka wa Dekinai (Can't Allow the Legalization of 'invisible death')" in Umehara, ed., *Noshi to Zoki Isyoku*, 268.

42. Uozumi, 93-94.


45. Nudeshima, 15-17.

46. Becker, 244-245.


48. Ibid., 290.


50. Ibid., 49.

51. Ibid., 51.

53. Ibid., 50-51.


56. Fetters, 133.


64. Becker, 255.


67. Ibid., 29-30.


69. Ibid., 172-183.

70. Kenichiro Yamaguchi and Yasuko Sekitou, Yuki Chan Arigatou: Noshi wo Mituzuuketa Haha to Ishi no Kiroku (Thank you Yuki: A Record of Brain Death by a Mother and a Physician) (Tokyo: Shakai Hyoronsya, 1997), pp. 41-42.
71. Ibid., 69.

72. Ibid., 122-123.

73. Ibid., 10.


75. Morioka, 75; Nakajima, *Mienai Shi*, 166-167.

76. Yanagida, 135-137.


81. Beauchamp and Childress, 327.

82. Yanagida, 203-204. See also: Fujii, 301-302.; Morioka, 139-145.

83. Takeshi Umehara, "Noshi - Socrates no To wa Hantai suru (Brain Death - A Disciple of Socrates Objects to It)" in Umehara, ed., *Noshi to Zoki Isyoku*, 222-224.


85. Nudesshima, 46.

86. Mt. 25.31-46 KJV (King James Version)


89. Ibid., 199.


92. Ibid., 241.


94. Fujii, 302-304.


100. Hiroshi Mizutani, Noshi-Ron: Ikirukoto to Shinukoto no Imi (A Theory of Brain-Death: Meanings of Living and Dying) (Tokyo: Soshisha, 1986), p. 120.

Selected Bibliography


Appendix: The diagram of Organ Transplantation in Japan

The Donor Side

- Donor
- Death of Second Person

The Recipient Side

- Recipient
- Death of Second Person

The "Wall"

Death of Third Person

Family Members Of the Donor

Family Members Of the Recipient

Bold arrow indicates:
1) relationship of second person
2) death of second person
3) relationship is more intimate
4) relationship is thus more visible
5) Ethics of secondary relationships at work
   Ex: Beneficience, Ethics of Care

Dotted arrow indicates:
1) relationship of third person
2) death of third person
3) relationship is less intimate
4) relationship is thus more invisible
5) Ethics of third relationships at work
   Ex: Justice and respecting autonomy