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DEATH WITH DIGNITY: CARDIOPULMONARY  
RESUSCITATION IN THE UNITED STATES AND JAPAN

I. INTRODUCTION

Bioethicists continue to debate whether there are fundamental universal moral precepts that apply to all cultures or whether morality is relative and defined by cultural norms. Tom Beauchamp, for example, argues for universal moral precepts (Beauchamp, 1997), while others such as H. Tristram Engelhardt and Kevin Wildes point out the inevitability of post-modern pluralism (Engelhardt, 1996; Engelhardt and Wildes, 1994). As the longstanding leader of the Japan Association of Bioethics and advocate of bioethics in Japan, Kazumasa Hoshino has cast considerable doubt on universal moral precepts in his explication of the inadequacy of Western bioethical precepts for Japanese bioethics (Hoshino, 1997a). In the context of this current debate, we examine the use of cardiopulmonary resuscitation (CPR) in the United States (US) and Japan and how it reflects differing cultural beliefs about death with dignity. We begin with a brief description of the development and dissemination of CPR. We present data grounded in the reports of US and Japanese physicians about their own experiences and approaches to CPR. We describe how decisions are made to provide CPR, and the goals and preferred outcomes when CPR is provided in the US and Japan.

Not long ago medicine had little more to offer than sympathy and compassion for the dying and their families. However, the development and rapid dissemination of a variety of technological interventions in the last several decades have given medicine the capacity to postpone death for individuals afflicted with illnesses that only a short time ago invariably caused imminent death (Rothman, 1997). These successes have given medicine a great deal of credibility and enhanced the rapid dissemination of and desire for technological treatments. One of the most noticeable applications of life-sustaining technology is the use of resuscitation techniques after cardiopulmonary arrest. CPR includes basic life support in the form of assistance with breathing and chest compressions, and advanced cardiac life support techniques, which involve additional administration of electrical shock (defibrillation) and

medication treatments. These procedures were developed based on a scientific understanding of physiology and pharmacology (American Heart Association, 1997-99).

With the adoption of the technique of external cardiac compression, it became possible to prolong patients' lives, and initially, both in the US and Japan, it became a virtue to do so. For example, the phrase, "*Ichibyou demo nagaku*" (even if just for a minute), is a phrase that captures this symbolic change that occurred in Japan and reflects the physician's duty to save the patient's life. Fueled by the technological imperative (Koenig, 1988; Rothman, 1997), ventilator support and the general techniques of CPR rapidly spread throughout the US and Japan. This intervention offered the hope of rescue to the patient who had fallen victim to sudden cardiopulmonary arrest. As the technological equipment necessary to conduct advanced cardiac life support interventions became available in the US and Japan, attempted resuscitation quickly became the standard of care for hospitalized patients who experienced a cardiac arrest, regardless of the illness. Automatic use of CPR in the event of cardiopulmonary arrest became the default approach.

CPR can save the life of a patient who has suffered acute cardiac or pulmonary arrest, though the patient's chance of making a full recovery drops precipitously if effective circulation and ventilation is not established within minutes. US physicians often discontinue resuscitation after 15 to 30 minutes because the likelihood of survival diminishes and the probability of neurological damage increases with the duration of resuscitation. In reality, the vast majority of resuscitation attempts fail. The overall survival from CPR is around 10-15% (Schultz et al., 1996).

As information about the use of life-sustaining treatment gained publicity in the US through such nationally renowned court cases as Karen Ann Quinlan and Nancy Cruzan, a public reaction calling for limitation of treatment ensued. The Patient Self-Determination Act was passed to promote the use of advance directives, in the context of public opinion that was skeptical of aggressive, end-of-life treatments that were infrequently effective, or might leave the patient in a persistent vegetative state, or other debilitated, technology-dependent state (Omnibus Budget Reconciliation Act of 1990). Public pressure mounted to require patient involvement in decisions about whether to use resuscitation, and is exemplified in a President's Commission report entitled, "Deciding to forgo life-sustaining treatment" (President's Commission for the Study of

Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983).

No sooner had resuscitation become an almost universal intervention used on dying, hospitalized patients in the US, than it was restricted by public interest in quality of life and death with dignity. The tangible development and use of advance directives (Omnibus Budget Reconciliation Act of 1990; Emanuel et al., 1991; Emanuel and Emanuel, 1989; Orentlicher, 1990), and professional efforts from ethicists and many physicians, pressured clinicians to limit resuscitation efforts to cases where the patient desired the intervention or there was a reasonable chance of effectiveness (Blackhall, 1987; Tomlinson and Brody, 1988).<sup>1</sup> Recognition that resuscitation should not be employed in every case led to the development and common use of Do-Not-Resuscitate (DNR) orders in the US (Blackhall, 1987; Tomlinson and Brody, 1988). US physicians became less aggressive about providing resuscitation and DNR orders became common. In a recent study of 42 US hospitals, 60% of deaths in intensive care units were preceded by DNR order (Jayes et al., 1993; Jayes et al., 1996).

In Japan, there is no legislation like the PSDA and there is no legal status of living wills or other advance directives (Masuda et al., 2001). However, citizen groups have begun to form, to draw attention to patient rights to participate in medical decision making (Shibazaki, 1991). Moreover, there is growing interest in advance directives. For example, a group called the Japan Society for Dying with Dignity has formed to pressure lawmakers to legalize living wills. Though these efforts have not been successful to date, the group has developed a substantial membership (Japan Society for Dying with Dignity, 1998). Court cases to date have not demarcated clear lines of support for patient rights, and preserve family and physician influence (Kimura, 1998). Despite these many changes, the family takes a central role in end-of-life decisions (Hattori et al., 1991; Hoshino, 1997a; Kimura, 1998; Fetters, 1998; Long, 1999).

In the following, we draw upon data collected during our investigation designed to understand patients' and physicians' preferences for decision making about end-of-life issues (Danis et al., 1996; Fetters and Danis, 2000; Hanson et al., 1996). Interviews for the US arm of this research began in October 1990 and continued until July 1993 at a teaching hospital in North Carolina. During this time, 158 physicians were enrolled. Japanese data collection was initially conducted from June to

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