Regular Article

Governing Assisted Reproduction in Japan: Lessons for the Medical Profession from Its Counterpart in Justice

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Abstract

Despite the promulgation of a law for assisted reproduction in Japan in December 2020, the policies in this area of medicine here remain largely determined by the Japan Society of Obstetrics and Gynecology (JSOG). The validity of the assertion that the Society only rules because the legislature is loath to do so put aside, the doctors' "service" as policy-makers does not appear to be held in high regard. Indeed, JSOG's decisions often come under sharp criticism domestically and internationally. This article presents the latest manifestation of this phenomenon. In particular, I focus on the condemnation with which the recent efforts of JSOG have met to expand, beyond the cases where there is a survival risk in childhood, the application of a procedure known as pre-implantation genetic testing for monogenic disorders (PGT-M). With a view towards resolving this stalemate in a way that both enjoys greater acceptance by the public and frees JSOG from the impossible task of devising policies that reflect something as elusive as the public's "common sense", the article advances the idea that the Society lobbies for the instalment of a citizen-dominated regulatory body modeled on the example of the British Human Fertilization and Embryology Authority (HFEA).

Keywords: Pre-implantation genetic testing for monogenic disorders, Japan, Japan Society of Obstetrics and Gynecology, disability, assisted reproduction, Human Fertilization and Embryology Authority

1. Introduction

In 1988, a pioneering assisted reproductive procedure was developed at the In Vitro Fertilization (IVF) Unit of London's Hammersmith Hospital. With the help of geneticists, the team led by scientist-cum-physician Robert Winston had managed to deliver diagnosis of pre-implantation embryos of couples affected with X-linked heritable conditions so that an unaffected such could be selected for transferring to the womb and becoming that couple's child. The procedure, which was thereafter described in a paper in the high-profile journal *Nature* (Handyside *et al*. 1990), was performed on five couples at risk of transmitting recessive X-linked disorders, including X-linked mental retardation, Adrenoleuko Dystrophy, Lesch-Nyhan Sndrome and Duchenne Muscular Dystrophy, with all of the women in question having previously undergone termination of affected fetuses. The rationale behind the procedure was that since girls inherit two X chromosomes, one from their mother and one from their father, whilst boys inherit an X chromosome from their mother and a Y chromosome from their father, if a mother is a carrier of a condition owing to a mutation on one of her X chromosomes, there is a 50% probability for a girl to be born a

carrier (which entails low likelihood of manifested symptoms) and a boy to be born affected. In other words, by selecting for a female embryo, the team could reduce significantly the possibility that these couples, who wished for an unaffected child, would go through another fetal termination.

With time, the technology became more sophisticated and instead of seeking to control for a condition through sex-selection, it became possible to test directly for the parental genetic mutation in embryos. Indeed, within five years, a report emerged from the same group in another major medical science platform — the *New England Journal of Medicine* — that healthy babies were born after three couples where both members were carriers of the ΔF508 deletion for Cystic Fibrosis were targeted for pre-implantation diagnosis (Handyside *et al*. 1992). As the range of genetic characteristics for which testing could be performed from a technological viewpoint grew substantially, bioethical debates began to emerge as to whether employing such technology is wise and where the line should be drawn with regards to controlling its implementation. On the one hand, there were those who were of the opinion that the technology should be employed without limitations, with philosopher Julian Savulescu, most prominently for example, employing the principle of procreative beneficence — as in the moral obligation of a couple thinking of procreating, with all other things being equal, to attempt to have the child with the best chance of the best life possible — to explain his stance (Savulescu 2001; Savulescu & Kahane 2009). Founded on this principle, Savulescu and colleagues have even argued that there is a moral case to be made for the state funding such IVF cycles for their citizens (Kemper, Gyngell & Savulescu 2019). On the other hand, there were those who held that this principle is problematic on many levels, most notably in that it places lower moral value on the disabled and the lives they lead (to cite just a few examples: Sandel 2004, 2009; Bennett 2008; Holland 2016), with the implication often mentioned that, once this principle is adopted and procreative liberty through unlimited genetic testing is adopted, it would lead to a slippery slope where children would be selected for all kinds of reasons beyond the consideration of wellbeing.

Based on such debates, the framework for implementing this diagnostic procedure was set globally, albeit with some countries being exceptions, to be limited to cases where there are medical indications. As Donrop and de Wert, for example, have aptly summarized, in Europe in particular pre-implantation genetic testing has become reserved for cases where there is a high risk of a serious medical condition, with advocacy also being made lately for consideration of other cases in contextualized proportionality (de Wert 2005; de Wert *et al*. 2014; Dondorp & de Wert 2018). To be more specific with regards to the latter point, the inclusion for pre-implantation genetic testing for monogenic disorders (hereafter PGT-M) is urged of cases where there could be a transgenerational health benefit, as in the child of the planned child being given a chance to be free of the said condition without the intermediate generation having to undergo burdensome medical procedures (de Wert 2005), or where the saving of an already existing sibling is at stake (de Wert *et al*. 2014), or, lastly, where "last chance" affected embryos are transferred provided that there is some likelihood with them that they would not lead a seriously diminished quality of life (Dondorp & de Wert 2018).

Against this background of wide global acceptance of PGT-M, it is conspicuous that the application of this procedure in Japan — the country reports the highest number of oocyte aspiration cycles internationally (Mouzon *et al*. 2020; Croydon forthcoming) — is on an extremely low scale. Not only did Japan come onto the PGT-M implementation scene belatedly — or more precisely, a decade and a half after the pioneering first such procedure was performed at London's Hammersmith Hospital in 1988 (Munné & Cohen 2004), but even after it had done so, it applied this kind of screening only in an extremely limited number of cases. As revealed in a 2017 report by the body left to regulate this sector in Japan—the Japan Society of Obstetrics and Gynecology (JSOG), until March 2015, there had only been 125 instances in which this procedure had been implemented (JSOG 2017). Although there is no ready data that permits a comprehensive international comparison, to give an idea of how low the reliance in Japan has been on this procedure, it can be highlighted that in just one facility in the United Kingdom (UK) there had been as many as 3,828 PGT-M cycles for the period of 1997-2019[1].

On the issue of PGT-M in Japan, a formal debate was recently conducted as to whether its application could be expanded beyond the cases where a risk exists for daily life to be markedly affected, or for death to occur, in childhood. Indeed, on the initiative of JSOG, from January 2020 to February 2021 a group of 14 medical experts and 13 specialists in the area of the humanities and social sciences convened on three widely publicized occasions to consider the appropriateness of dropping the phrase of "prior to reaching adulthood (*seijin made ni*)" from the line in the Society's Guidelines that describes the timing of symptom-manifestation in the conditions that qualify for PGT-M[2].

Given the consequential nature of this question, the present article puts a spotlight on these deliberations. To foreshadow what follows, I zoom in on the JSOG-organized deliberations, demonstrating the intense disagreement that exists on the issue and the sense of doubt that the Society is managing this debate well. Taking stock of this material, I then move on to explore a possible path forward on this, as well as other, thorny reproductive issues. In particular, I examine the possibility of a body similar to the citizen-dominated Human Fertilization and Embryology Authority in the UK managing to reach a more broadly supported decision. The reason for choosing to draw attention to the British system in particular is because, as Alghrani has noted, Britain has been a pioneer not only in terms of technological developments in assisted reproduction, but also in terms of devising a regulatory framework for governing and monitoring these, with its system being copied widely throughout the world (Alghrani 2019). How has the country arguably at the avant-garde in this area settled this debate then? How is indeed an issue such as that of

[1] Guy's and St Thomas' National Healthcare System (NHS) Foundation Trust website, www.guysandstthomas.nhs.uk/our-services/pgd/about-us/success-rates.aspx. Accessed 23 October 2021.

[2] JSOG. 2021. "*Jūtoku na idensei shikkan ni tai suru chakushō-zen shindan ni kan suru rinri shingikai (dai san-bu) de no hatsugen aruiwa shōroku teishutsu no onegai* [Request for Submission of Abstracts for Statements Regarding the Third Part of the Ethical Deliberations for Pre -implantation Genetic Testing for Serious Heritable Conditions]," http://www.jsog.or.jp/modules/news_m/index.php?content_id=906. Accessed 21 June 2021.

PGT-M resolved there? Finally, having introduced the HFEA type of governance, I consider what barriers there might be for the British model of assisted reproductive governance to be adopted in Japan. Specifically, I appraise the way in which the possible resistance from JSOG to the idea of surrendering their position as the sole interpreter of reproductive rights in Japan could be countered. To make the idea of lobbying for the installment of such a body more palatable for the Society, I draw on the statements expressing a sense of relief by members of the Japanese judiciary following the implementation in 2009 of the lay-judge system (*saiban'in seido*). Ultimately, I argue that by letting members of the public decide on the controversial ethical aspects of assisted reproduction, the Society could free itself from the onus of having to capture in their judgements the evasive "way of thinking" of the Japanese people.

2. The PGT-M expansion deliberations: Stalemate and condemnation

In simple terms, the proposal that JSOG put forward for consideration in January 2020 was to make PGT-M applicable for all conditions that can impact a person's everyday life in a notable way, regardless of whether they have an early-life onset or a late-life onset. As for the format of the deliberative sessions, lasting half a day each, time was secured for stakeholder statements — i.e. patients' organizations, disability groups, academic and medical associations — as well as members of the ordinary public. Although with respect to the latter, there was a requirement that they send to JSOG an abstract in advance conveying their arguments, their comments were made in real time through the web-meeting system.

These efforts of JSOG to secure social consensus and achieve a revision of what constitutes a "severe heritable condition (*jūtoku na iden-sei shikkan*)" notwithstanding, the debate about expanding PGT-M application ended on a standoff between, on the one hand, representatives of feminist and disability groups, as well as other stakeholder professional medical societies, and, on the other hand, patients of reproductive age with non-life-limiting/threatening or late-life onset conditions. The former objected to the proposed change on grounds such as that too many conditions would qualify in one fell swoop for PGT-M, or, more fundamentally, that this procedure constitutes discrimination towards people with disabilities and is a way of pressuring women to give birth only to children of a particular kind. As for the latter, they complained about not being permitted to avail themselves of the existing technology and having to entrust instead the future of their offspring to something as uncertain as the development of therapeutic treatments.

Not only was the outcome of these deliberations, the extent of which is evident from the nearly 900 pages in terms of minutes[3], a stagnation, but JSOG also became the subject of a severe reprimand by the opponents of PGT-M for this initiative towards expansion. In particular, the JSOG minutes show one civic group representative[4] commenting that, by seeking to loosen the rules, JSOG is becoming majorly complicit in the

[3] *Ibid.*

[4] Note that the names of everyone but the panelists in these sessions were withheld by JSOG in their minutes for anonymity purposes.

"grading of life and the selection of humans (*inochi no joretsuka ya ningen no sembetsu*)"[5]. Even until this point, this person states, JSOG's "incompetence (*fugai nasa*)" induced cerebral palsy in many babies, with there being a mountain of evidence attesting to this. Referring to the Eugenics Protection Act (*Yūsei Hogo Hō*), which was abolished only in 1996 and which permitted the involuntary sterilization of people with intellectual, mental and physical disabilities, this citizen argued that JSOG had lent its hand to eugenics and was now "trying to eliminate disabled people from the bud (*shōgaisha wo moto kara tatō to iu koto darō ka*)". "Are you not a bit arrogant? (*Sukoshi gōman sugiru no de wa nai desō ka*)", they asked rhetorically, suggesting also that if embryo screening becomes rampant, so many disabled people would become discriminated against as "existences that were not meant to be (*umarete kuru beki de wa nakatta sonzai*)". Objection was also taken by a number of other attendees to the referring as "concerned individuals (*tōjisha*)" in the discussions of only those who come to the medical facilities seeking PGT-M. This was one-sided, the argument was made. People with disabilities are as much concerned, they said whilst referring to articles of the United Nations Convention on the Rights of Persons with Disabilities, and it was unfair to exclude them from the decisions about this procedure. Lastly, the protest was expressed that the conclusion about what the PGT-M regulations should be had already been drawn by JSOG before the start of the deliberations. The way the opinions were ordered, one critic argued, of first objections being voiced followed by expressions of support, with only a member of the Society being allowed to then summarize the discussions, was prejudiced, and left people "feeling powerless and as if their time and effort had been wasted (*tōro ni owari, muryokukan ni mitasare, jyūjitsukan no nai hakanasa dake ga kokoro ni nokotte imasu*)".

Based on the impasse reached, and in the face of such denunciations, the Director of JSOG, Tadashi Kimura, closed the last deliberative session in February 2021 with the remark that further discussions would need to take place before the Society could decide if to implement PGT-M expansion or not, thereby leaving ambiguity about what precisely could be expected to follow. Since then, however, JSOG has released on their website a concrete proposal for expansion along the lines of their original suggestion, inviting the public to give feedback on it[6]. Whilst this is in line with Kimura's comment above that further consultation will take place before a verdict is given either way, the reportage that followed in the media is that the Society has already decided upon expansion for illnesses that can commence in adulthood and that the implementation of this decision will take place from 2022[7]. To recap, it appears that

[5] *Supra* note 2.

[6] JSOG website. "*Rinri iinkai teian: Jūtoku na iden-sei shikkan wo taishō to shita chakushō-zen idengakuteki kensa ni kan suru kenkai/saisoku (Kaitei-an he no paburikku comento boshū)* [Ethical committee proposal: Guidelines regarding genetic testing for serious heritable conditions (An invitation for public comments on the revision proposal)], https://www.jsog.or.jp/modules/committee/index.php?content_id=191. Accessed 13 November 2021.

[7] For example, see: Mainichi Shimbun. 19 November 2021. "*'Handan kijun wa?", 'Kakudai no hadome wa?': Chakushō-zen shindan kakudai ga motarasu mono*" ['What will the criteria be?', 'What safeguards will be put in lace?': The questions raised by the expansion of PGT- M], https://mainichi.jp/articles/20210827/k00/00m/040/096000c. Accessed 6 November 2021.

the Society's continuous efforts towards diversification of PGT-M implementation leave it vulnerable to the censure that the deliberative public consultations it orchestrated were merely for show and that its true goal with them was to simply legitimize, or create an alibi for, the conclusion that it had already reached in favor of expansion. JSOG's critics are accusing it of acting unilaterally and *in spite* of wide-spread public reservations. Observers are levelling the charge at the doctors that it does not count as consultation, at least not an inclusive one, when they hear that there are objections and then still proceed anyway with what they themselves see fit.

3. Within whose remit is PGT-M policy anyway? Not the doctors'!

In 2009, in an article exploring the differences around the globe in assisted reproductive technology (ART) governance, Belgian bioethicist Guido Pennings made an argument that pertains deeply to the situation with regards to PGT-M management in Japan. Whilst acknowledging that in many places around the world a lack of legal framework means that doctors are left by default as regulators and arbitrators on difficult moral issues in this area, he suggested that a state of affairs is inappropriate. To cite him, "the most controversial issues [in assisted reproduction] are not medical issues and, consequently, the physicians have no special expertise to decide these matters. Therefore, why should society leave it to the doctor to determine the moral status of the embryo or the acceptable risk for the child?" (Pennings 2009: S17). In other words, in Pennings' view, the ethical elements of ART treatments do not fall within the purview of the medical professionals.

In line with Pennings' suggestion, the question that has now been at the center of ART controversy in Japan for over two decades of "*For which couples, and for which genetic disorders, is it permissible to grant access to PGT-M?*" is an ethical one. Indeed, it is not one about best clinical practice, as in efficacy and safety. Thus, the situation in Japan of the obstetricians and gynecologists being the ones who ultimately call the shots with regards to access to PGT-M, amongst other assisted reproductive treatments, appears arbitrary. As has been argued elsewhere (Croydon 2021), the doctors are trained to answer questions about which medical treatment is best in a particular situation, and whether these are safe; they have no more expertise than the next person to adjudicate on whether it is morally justifiable to make someone eligible for such a treatment. This is indeed a question that society at large ought to answer. The JSOG might well be an institution that operates in the public interest. However, at the end of the day, its composition is exclusively of medical practitioners and there is no reason why the resolution to questions such as that about the accessibility to PGT-M should be left to them; the moral view of the doctors cannot be guaranteed to converge with that of society as a whole. The *de facto* monopoly that doctors here hold over implementation of such procedures needs to be ended. Their occupying the position of the administrator of such treatments on the site does not in itself represent a qualification for making decisions on everyone's behalf.

So what other modes of governance could be adopted to make the decisions on the ethical aspects of ART more pluralistic and thereby democratic? How are other countries managing the clashes between interested parties in assisted reproduction? The next section examines this issue, zooming in on the specific model of

governance adopted in Britain — a country that has pioneered not only numerous ART treatments but also relevant regulatory instruments.

4. Towards a resolution of the stalemate: Borrowing from Britain?

In the same article by Pennings as cited above, an outline was presented of the advantages and disadvantages of the various ways in which a nation can choose to regulate its ART sector (Pennings 2009). Although the main impetus of Pennings was to defend the existing international legal mosaicism in the governance of assisted reproduction against pressures to "harmonize" the existing regimes, a somewhat favorable view was expressed of the British example. "The best example [of an intermediary regulatory authority for ART] is the [British] HFEA," he stated (*Ibid.*: S17). Although those called to make the decisions on ART treatments within the HFEA are not elected in the way politicians are by a public vote, their decisions, he explained, are defensible in front of citizens and help avoid emotional gut reactions. "[T]he composition of such authority may differ depending on its task, but the idea of bringing experts together with lay people has an advantage when the recommendations have to be defended publicly", Pennings wrote (*Ibid*.). In other words, while the HFEA has the drawback of not necessarily representing the values and mores of the majority in British society, its rulings could be said to carry a certain level of legitimacy. This is because the majority of those who made these rulings are ordinary citizens.

Pennings's observation about the legitimacy which the HFEA enjoys appears to be valid. True, many criticisms have been levelled at this Authority — from failing to undertake proper inspections of clinics, to issuing license for a condition multiple times, to allowing clinics to charge inflated prices for IVF treatment and associated genetic tests, to not taking measures where lack of compliance with licensing requirements has been found), leading sometimes to experts, such as Robert Winston mentioned at the outset of the article, to call for it to be scrapped (Morris 2004; BioNews 2004). However, the appropriateness of the idea on which it is based — that public participation in the governance of ART is desirable — is not something that is often questioned. This principle was in fact precisely what Mary Warnock sought to uphold with her recommendations for the Authority's design[8]. She wanted it to be seen as neutral and objective, as opposed to merely reflecting the biases of the medical and scientific community. By recommending that more than half of its members are neither doctors nor scientists engaged in human embryonic research and the provision of fertility services, but lay people, and by decreeing that its Chair and Deputy Chair will be laymen as well, the Warnock Committee made it clear that the concern of the Authority is the advancement and protection of the "public interest".

To link this with the case of PGT-M in Japan, given the accusation leveled at JSOG by members of the disability and feminist community from the very early days after the advent of this technology of trying to impose its own view on the rest of the society, it appears

[8] "Report of the Committee of Inquiry into Human Fertilization and Embryology." *Department of Health & Social Security*, London, 1984.

appropriate to suggest that its leadership considers retracting from the decision-making scene and directing its efforts instead towards the installation of a formal, statutory body, perhaps similar in design to the British HFEA, that would take over the governance of such thorny assisted reproduction issues as this one. After two decades of trying to respond to the needs of patients while also failing to secure support for this from other sections of the public, the Japanese doctors' community could perhaps learn that the role of being the interpreter of reproductive rights is not really theirs to play. As Croydon points out, the adjudication of matters such as who is eligible for ART treatment and when the latter can be applied does not fall strictly within the purview of medical specialists, whose qualification goes only so far as commenting on what constitutes best clinical practice (Croydon 2021). Answering questions of ethical nature is, in the end, the prerogative of the society at large.

With regards to this proposition, the argument could be made that an HFEA-like body in Japan might not yield an outcome different to the one already in place. If it is citizens that clash, why would another format of discussion between them yield a different result? In response to this, it is necessary to highlight that unlike JSOG's drafting of Guidelines, which is voluntary, a statutory body installed for the purpose of regulating assisted reproduction would need to legitimize its existence by delivering decisions. Furthermore, if the example of the HFEA is followed, these decisions would be made on the basis of a simple majority, which is a much lower threshold for producing judgements than the apparent current goal of securing a consensus. Finally, to consider one more possible objection to the idea that an HFEA in Japan might not make a difference, it is true that depending on who is selected as board members and what the tone set by the Chair is, the decisions on PGT-M might end up just the same as they are now. However, to reiterate what was said earlier in this article, the fact that the majority of the HFEA members are not medical or scientific practitioners but simply private citizens makes all the difference for the legitimacy their decisions enjoy with the public. Even if a patient or another concerned party is not satisfied with a policy or a decision that has been made on their case, it is difficult for them to make the argument: "Yes, but the people who decided this are all doctors, and their views are skewed, as they have no way of understanding what it is for ordinary members of the public". As explained earlier, over half of the members of the HFEA at any one time are neither medical professionals nor scientists. This means that the criticism levelled at the JSOG that they have inherent bias cannot be made for the HFEA.

To elaborate further on point made above, suppose a British-style model is adopted. In the UK itself, the board of HFEA is currently composed of:

- a former corporate lawyer active also in a learning disability and children's charity (Chair)
- a former correspondent on national security issues (Deputy Chair)
- a management consultant and former civil servant with experience of unsuccessful IVF
- a Professor of Healthcare Law
- a Medical Director and Person Responsible of a Fertility Unit
- a Professor of Law

- a Consultant Embryologist
- a Medical Director of a hospital's Assisted Conception Unit and a PGT-M program Director
- an ordained minister of the Methodist Church
- a consultant in Clinical Genetics
- a broadcaster with experience of fertility treatment and with a daughter born through gestational surrogacy
- a Professor of Clinical and Molecular Genetics
- a former film maker, magistrate, and member of the HFEA's independent appeals committee
- an infertility counsellor[9].

If the composition of a Japanese HFEA at any point in time resembles the one that the British progenitor has at the moment (and new nominations are made every three years), even if it does not make any radical decision with regards to PGT-M, society can have greater confidence that a broader range of voices have been incorporated into the making of the final decision. To put it simply, in contrast to the current state in Japan whereby people from all walks of life deliberate and the JSOG ultimately delivers a verdict, with an HFEA-like body, a diverse panel of people would deliberate, issuing its own decision at the end. Even if the decision it arrives to is the same as the one that JSOG is currently about to deliver, the former would still be seen as more legitimate than the latter.

In addition to the issue of legitimacy, the question also exists about the consistency of treatments for patients. In this respect, the benefit of adopting a British-like HFEA system is also clear: under such type of governance of assisted reproduction, there would be uniformity in treatment that would stem form the blanket rule that would be adopted. Decisions would be made with regards to each condition, as opposed to each patient. This situation would indeed be significantly different from the current one in Japan whereby JSOG examines on a case-by-case basis each application, with the possibility of bias playing a part.

5. Last words

As far back as 2011, the bioethicist Masayuki Kodama described the PGT-M situation in Japan as follows:

> The reality is that the assisted reproductive medical community in Japan is trapped between a rock and a hard place on the question of whether to expand the indications for PG[T-M] as a therapeutic method: it is caught between patients who want to use this treatment and their supporters, who are trying to respond to these patients‘ wishes, and those who argue for caution out of concern that PG[T-M] could be overused (commercially developed), as well as powerful opposing groups that claim the selection of fertilized eggs based on PG[T-M] results amounts to discrimination against disabled people. (Kodama 2011: 24-5, see also his earlier work in 2006).

Soon after Kodama's account of the stalemate reached, another bioethicist Keiko Toshimitsu produced

[9] HFEA. "Meat our Authority members". http://www.hfea.gov.uk/about-us/our-people/meet-our-authority-members/. Accessed 2 November 2021.

even a more detailed documentation of the history of struggle here towards finding middle ground on the issue of PGT-M (2012, 2014). Breaking with this mode of analysis hitherto of the state of affairs on this issue in Japan, the present article has advanced the idea that rather than attempting continuously to hammer out a consensus between the two opposing sides in this debate, it might be more productive and suitable for JSOG to lobby in parliament for a citizen-dominated regulatory body modeled on the example of the British HFEA. As a way for JSOG members to overcome any aversion they might possibly have of seeing their power erode vis-à-vis that of a third-party body, it might be useful to refer to the unanticipated sense of relief that their professional counterparts in criminal justice — the Japanese judges — reported of having experienced as a result of handing over in 2009 the responsibility of criminal cases adjudication onto lay judges. To explain in greater detail, this transition, which took place after a five-year preparatory period, was triggered by a sequence of high-profile exonerations whereby new evidence had emerged undermining former death penalty convictions (Foote 2014, 2015). From the moment the idea was introduced as a result in Japanese society that the alternative model of criminal justice administration could be adopted of relying on laymen, as the case in the US and the UK, a sense of discontent and displeasure spread within the courts. Several judges quickly condemned this proposed measure, arguing that it represents an unfair criticism of their work. It did not stand right with them that this new lay judge system would be introduced to correct for existing "failures" on their part. Even if there were occasionally miscarriages of justice, judges could hardly be found, they argued, guilty of doing poor work. In their view, the job of sifting for years through piles of often contradictory evidence in search of the elusive "truth" about the criminal case at hand required an immense amount of patience and brainwork, and the accusation that their rulings lacked "common sense" was uncalled for. Nevertheless, once the lay judge system was implemented, many judges communicated experiencing liberation, commenting that they no longer had to worry about facing criticism from the media and the public at large for not handing down watertight judgements—the responsibility for this now mainly rested with members of the public (Inoue 2008; Croydon 2016).

If a lesson could be extrapolated from the judges' case for the benefit of JSOG and in relation to its struggle to pacify its critics, then this lesson would be that it might find it relieving to withdraw from the battle scene. Indeed, instead of insisting on singlehandedly maintaining control of the PGT-M situation and thereby remaining in the crossfire from patients and disability/feminist groups' representatives, JSOG might be well-advised to focus on the merits of letting go of responsibility.

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