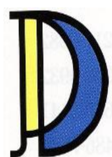
Excerpts from



Japan Society for Dying with Dignity Newsletter

No. 181, April 1, 2020

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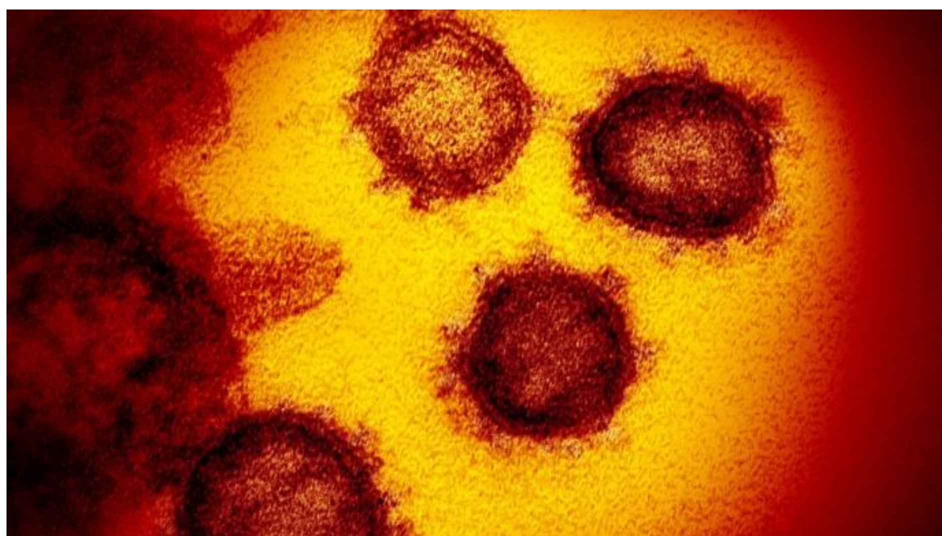
- 2020 Surviving Family Survey Results
- Telephonic and Email Medical Consultations (#7)

The 9th session of Japan Living Will Study Workshop (Virtual Conference)

The Pandemic and Dying with Dignity: how to coexist with the Coronavirus



The 9th session of Japan Living Will Study Workshop was held as a virtual conference on November 28, 2020 as the third wave of the pandemic swept Japan. Naturally, the topic of the conference was "The Pandemic and Dying with Dignity." How do we preserve dignity in dying as the new strain of the Coronavirus spreads globally? How do we coexist with this virus? We were able to hear from our board directors who are very engaged in the real medical setting.

Opening Speech by Dr. Soichiro Iwao, JSDD President

Is our mission facing a crisis?

Our annual gathering to share activities and research was conducted virtually due to the pandemic this time. This new strain of the Coronavirus spread worldwide at a rapid rate. No effective treatment has been found at this time, and the whole international medical community is still fighting against this unknown virus.

This viral pandemic has challenged our healthcare system in so many ways. The rapid increase of patients infected with the disease, elderly death rate, and administrative inefficiency of treating infected patients have caused chaotic situations everywhere. This situation has brought out discrimination and prejudice not only toward patients, but even toward medical professionals taking care of patients.

Our activities revolve around JSDD's basic principle "Live pleasantly and die peacefully." However, in the current situation in which no rescue is available in some cases, how can we ensure that people can end their lives peacefully with dignity? Is our mission facing a crisis?

We would like to hear from all of you who are not only directors of JSDD, but also deeply engaged in our healthcare setting, especially any updated information and assessments in your own fields. Perhaps, our discussion may lead to some answers as to how we can coexist with the Coronavirus and continue to honor dying with dignity.

What to do if there is not enough time to prepare an Advance Care Planning?

Dr. Satoru Mitsuoka, JSDD Director and President of Mitsuoka Internal Medicine Clinic

First of all, I would like to explain a little bit about our topic and agenda. This new strain of the Coronavirus originated in Wuhan, China was officially declared a pandemic by the World Health Organization (WHO) on March 11, 2020. By the end of November, the number of infected patients globally was over 60,000,000, and the number of deaths due to the virus was 1,420,000.

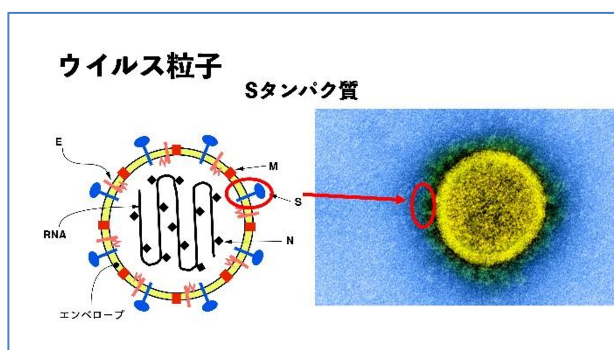
Our current healthcare system was not adequate to confront such a rapidly contagious infection, especially in Europe. Some cities in Italy, Spain, as well as in New York, experienced some serious shortages of medical supplies and equipment such as respirators and Extracorporeal Membrane Oxygenation (ECMO) machines, and unavailability of medical facilities. This situation led to healthcare providers having to prioritize lifesaving based on patients' conditions. Until now, it was a natural principle to be able to provide medical care and treatment without any restrictions; the pandemic has caused a paradigm shift to our healthcare system.

Given limited medical resources, we are forced to triage patients in case of emergency rescue care. This is the method of assigning priority of treatment for patients depending on their conditions.

In this regard, the Japan Association for Bioethics announced its proposal for the distribution of artificial respirators. A legislature member of the Upper House who is also an ALS patient made an official statement on how this situation has brought serious concerns for ALS patients. Furthermore, the Japan Medical Association quickly established guidelines regarding Physician Orders for Life Sustaining Treatment (POLST) such as "Do Not Resuscitate" (DNR) when cases arose in which patients' conditions were aggravated so quickly that there was no time to have sufficient discussions on treatment options. Other countries' societies for dying with dignity and euthanasia have published Advance Directive guidelines during the Coronavirus Pandemic. Since this is a viral infectious disease, patients are not allowed to have their last farewell meeting with their loved ones. Some argue that this is an infringement of rights for the dying person. In such situations in which there is not enough time to prepare an ACP, how do we view dignity in dying? How do we deal with it? That is today's main topic.

How infectious is the new strain of Coronavirus?
We can't abandon patients if they can be saved

Dr. Yoshihiro Kitamura, JSDD Director and Professor of Nippon Medical School



I would like to talk about the updated information on the new strain of the Coronavirus, data comparison between Japan and other nations and our future perspective (see illustration). The genome of this virus is covered by a fat membrane and spikes of protein that looks like a Corona, which is why it was named the Coronavirus. There are three methods of infection: through physical contact, microdroplets and airborne. Microdroplet infection can be transmitted from 2- 3 meters, and these particles can linger in the air for hours if enclosed a five meter space. Tuberculosis is a well-known airborne infection for example. The new strain of the Coronavirus is abbreviated as COVID-19 (Corona Virus Disease-2019).

The characteristic difference of COVID-19 from other seasonal influenza is that a flu virus is only transmitted after symptoms appear such as fever, but COVID-19 is transmitted prior to any symptom.

About two days prior to any symptoms appear, the virus starts to transmit to other people for about a week. As you can see, it's a troublesome virus. Another annoying characteristic is that most young people will have no symptoms or a slight one if any, and older people with underlying health conditions will have severe symptoms and a high risk of sudden aggravation. Initial symptom is usually a high fever (80%) followed by coughing and muscle ache. Distinctive characteristic is olfactory and taste disorders, varying from 20-30% or 60% depending on the collected data.

As to the question of death rate from COVID-19, our current data shows 8.1% of patients over the age of 70 years, which is 25% lower than data taken during the initial wave of the infection. This indicates that we are fairly successful in medical defense against the disease; however, 8% is still a high figure compared to other viruses categorized as infectious diseases.

Now, I would like to talk about the current situation. Simply stated, we are currently in the middle of a situation in which anyone can be infected by the virus anywhere, anytime. Here are some comparison data taken at the end of July 2020 and the beginning of November 2020. Back in July, 70% of infected patients were young, between teens to those in their 30s. In November, the young generation infected was down to 50%, but the middle aged generation was 30%, and the elderly generation was 20%. This shows that people of all ages are indiscriminately infected.

As far as patterns, we can see an increase of infection both in the work place and home. Let's say someone was infected by either a coworker or a father based on with whom one had contact, but we still don't know how. We can say that contact tracing is undetermined in 80% of the cases. When the second wave hit Japan, it was publicly announced that the major trouble spot was Tokyo, in particular, night clubs in Shinjuku. The situation now is totally different. There are no hot spots; it is spread nation-wide.

The number of infected people is an issue, but what's more important is the number of critical patients. According to Tokyo's data, 50% of all COVID-19 patients were over 60 years of age at the time the second wave hit. When the third wave hit, it was 80%. Almost all critical patients administered with artificial respirators and ECMO were over 60 years old. Here is another illustrated data shown by Osaka Municipal Office: 6,873 infected patients and divided them into four groups based on their symptoms from no symptoms to severe symptoms. What we have to pay attention to is that 45 patients who were categorized as having light and medium symptoms suddenly died. Only 6 out of 52 patients who were categorized as having severe symptoms were placed in the ICU and died. The question is why did 45 patients who were in the light and medium symptoms categories died suddenly, while only six of the severe symptom patients died? What we found was that they were the ones refused to be placed in the ICU. If the patients are not placed in the ICU, they are not counted as severe or critical. We have to pay attention to this point when interpreting data.

The next question is why they refused to be placed in the ICU. According to Dr. Shigematsu, the President of Osaka Medical Association, the patients and their family members responded this way when they were told that unless they are administered artificial respirators, they will not survive, but once it is administered, it may never be removed. Many of them decided that rather than living for the rest of their lives with a respirator, they would rather not accept it. In a way, were they refusing to save lives that could have been saved? These patients were not diagnosed with terminal stages of cancer or a chronical disease. In acute cases like this, you would think that receiving proper medical treatment would be anyone's top priority. The Japanese Society of Intensive Care Medicine presented a proposal regarding withholding or terminating medical treatments during the COVID-19 pandemic from the perspective of distribution priority of limited medical resources. It proposes that the decision of withholding or terminating medical

treatments including palliative care should not fall solely on the individual, but upon thorough discussions among the medical and healthcare professional team. This completes my update on the COVID-19 current situation.

Update on the worldwide situation and the future plan
Criteria of triage is not based on age, but fairness

By Dr. Masahiro Nomoto, Vice President of JSDD and Visiting Professor of Ehime University

I would like to first talk about the worldwide situation. Here is a report on patients receiving palliative care for COVID-19 at Colombia University Hospital in New York. A total of 110 patients were observed over two weeks, most of whom over the age of 80 years with other health issues: high blood pressure (76 %); heart disease (66%); diabetes (51%); chronic renal failure (33%); and obesity (22%). Their situations prior to being admitted for the virus were as follows:

- Location prior to hospitalization: home (66%); nursing home (32%)
- Advance directive or doctor's instructions of continued treatment required: Yes (6%); No (88%)

Only 6% had either an advance care directive or some other instructions of their wishes, and 88% had none.

Most importantly, 80% did not have the mental capacity to make their own medical decisions at the time of emergency rescue. As to a health care agent, 14% had appointed their spouses while 64% were their children naturally since most of the patients were in their 80's. The following results were regarding palliative care, which we refer to as ACP (Advance Care Planning) in Japan:

29% - wish to have palliative care after having an ACP
43% - wish to have medical treatments continued, but not if it is not available

The next topic is VitalTalk (communication advice from the U.S.). VitalTalk is a U.S. training organization to help clinicians to communicate more effectively with seriously ill patients and their families. When the situation forces you to make some difficult decisions due to restrictions or limited medical resources, how do you communicate and listen to your patients and their families?

For example, when asked a question such as "Why is my 90 year old grandmother not able to receive ICU care?" you should answer in this manner; "I am so sorry to have to say this, but we are currently in an emergency situation, and we must follow strict rules for the allocation of limited medical resources in a fair priority order. We totally have the same sentiments with you for wishing that we had more beds and healthcare professionals." Many other examples can be searched on the internet to give you a good reference.

With respect to the triage, I can show you a good example by referring you to an article written in the Swiss Medical Association magazine. Priority criteria is based on how quickly a life can be saved. The patient's age is not one of the criteria, as it would be unconstitutional. It also states that ECMO is difficult to administer to older patients as it requires enough physical strength to endure it. The American Respiratory Society suggests having good communication with regards to triage, and making the best use of available beds in the community. It also places its emphasis on fairness rather than age.

Here are the key points of the worldwide situation that I discussed here: 1) Not many patients have an advance directive; 2) Patients are unable to communicate their wishes in many cases; 3) VitalTalk has been established and is available; 4) Triage for the ICU is not based on age, but on short term prognosis. Unfortunately, elderly patients typically have poor physical conditions and other health issues to have a positive prognosis.

A proposal and a warning from the Japan Geriatrics Society
A message against prejudice and discrimination

By Dr. Sumito Ogawa, JSDD Director and Assistant Professor of Tokyo University Graduate School

In 2012, the Japan Medical Association presented a position statement that all human beings have the right to receive the best medical care and treatment available which respectfully honors the individual's values, ideology, faith and beliefs upon facing death or the ending phase of life.

The purpose of the Japan Geriatrics Society to present a position statement regarding end of life medical treatment and care for elderly patients was to support and promote this human right. The statement consists of 11 supporting views emphasizing the opposition against age discrimination

and the current one-fits-all measure of self-satisfaction. In addition, the society later presented "Guidelines for the care and self-determination process of advanced age patients" and "Diagram for the self-determination process portraying artificial hydration and nutrition," both of which are posted on their website. In June 2019, they also presented a proposal on the promotion of ACP, which corresponds with the "Guidelines for the care and self-determination process of advanced age patients" and the 2012 position statement.

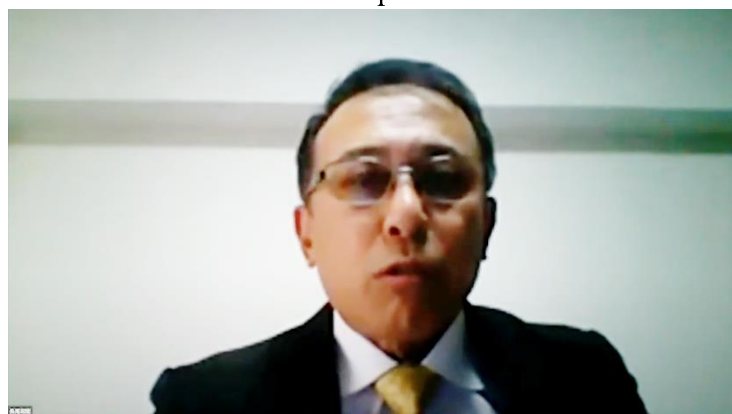
Reflecting on these concepts, "Medical handbook for health and longevity" was revised with five end-of-life care guidance points for clinicians. In particular, #4 describes the importance of team approach and supporting the patient's self-determination as part of palliative care, especially for non-cancer patients who are at an advanced age. Point #5 summarizes palliative care as being end-of-life care with so many different circumstances.

During the peak of the COVID-19 pandemic, Japan Geriatrics Society made another proposal entitled "The best time to conduct your ACP," which is closely related to the theme of today's conference.

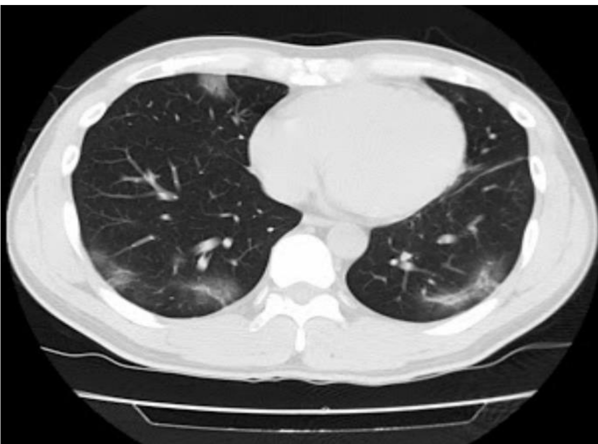
The proposal has four points. For example, #2 is about the concrete practice of ACP during the peak of COVID-19. The proposal also contains guidelines for the proper administration and removal of artificial respirators, and the need to comply with the wishes of the patients and their families in deciding the place of medical treatment and care. Finally, point #4 sends a strong message to end prejudice and discrimination against COVID-19 patients and healthcare providers involved in the treatment, care and preventive care of COVID-19. This concludes my explanation of the position statement and proposals presented by the Japan geriatrics Society.

What is happening in the clinical setting?
Stress placed on in-home terminal medical care

By Dr. Kazuhiro Nagao, Vice President of JSDD and President of Nagao Clinic, Yuwakai Medical Corporation



I would like to start my speech with these three key items: ACP, yielding card and terminal care. I currently operate out of four tents to take care of my outpatients. One is the main clinic; the second one is for inquiry diagnosis by asking various medical questions such as history and symptoms. The third tent is for PCR testing, and the fourth one is for accounting. In the photo, the top one is the inquiry diagnosis. Patients with high temperatures will be diagnosed in the tent and if necessary, we conduct CT scans of the lungs in the clinic tent. It takes 5 minutes to find out if the lungs are infected with COVID-19. If they are, we contact a health center (see the CT scan picture). For a salivary PCR, results take about 3 to 4 days. We also conduct drive-thru anti-body testing.



We receive phone calls every day from senior care facilities. They are mostly regarding aspiration pneumonia, not COVID-19. If we suspect a patient to be infected with COVID, we escort the patient from the back door for a CT scan. The PCR testing is known to be about 70% accurate, 30% false negative. This means that there are many people who show negative in the PCR testing, but are actually infected.

Next, I would like to talk about hospitalization and artificial respirators. We have some cases in which no artificial respirators were administered in order to respect the patients' wishes. What I've been hearing more from the patients is that even they are infected, they would definitely refuse an artificial respirator. This is like a verbal living will. If you're infected and have symptoms such as a slight fever, fatigue and coughing at home, these symptoms can gradually be aggravated. In other cases, habitual daily life during the pandemic may lead to insomnia, heavier drinking, depression and finally suicide. By staying home, a lot more people may die. In my opinion, the public is scared of the Coronavirus more than it should be. I think Coronavirus should be ranked down to Class #2 like seasonal influenza. We can then do better at treating people.

In any case, the current situation is triggering depression, fragility and dementia in many people, as well as hypochondria. There has been a lot of cases of behavioral health issues in which one can't adapt or adjust their lifestyles to the new environment due to COVID-19. They become

hypersensitive to new information or suddenly display aggressive behaviors. In these cases, it is important that they only seek information that they need and not changing their lifestyles forcefully.

During the pandemic, Dr. Fuminobu Ishikura of Osaka University developed a card easily filled by anyone, especially older people, to present to their medical staff in case they are placed in an ICU. The card states, "I will yield my treatment option involving rare and technological equipment to younger patients who need it." I know this has become a controversial topic, but I think of this card as an emergency conditional living will. We are in the middle of a pandemic, and there is no sufficient time or space to have these discussions and conduct an ACP. As mentioned earlier about VitalTalk, which I consider to be an American version of our ACP, communication is the foundation.

Next, I would like to discuss the challenges of conducting an ACP during the pandemic. Sudden worsening of conditions is one of the characteristics of the Coronavirus, therefore, urgency is crucial. Many people would be participating in the discussions, and social distancing becomes an issue. If the living will is available and ready, it may be the solution. The next thing is to not hesitate to call for an ambulance. The patient may refuse it in a state of confusion, so someone else can call for an ambulance. We should stop and think about the meaning of dialing 119 once again in this midst of pandemic.

In the past several months, we have seen an increase of patients returned home from hospitals or senior care facilities. I see the same increase level with my in-home terminal care patients. However, I have not had any Coronavirus infection cases. Every year in Japan, the number of patients dying from seasonal influenza is around 10,000. The number of death from the Coronavirus has been very low. There has been a lot of emphasis on this virus, and some facts seem to be distorted to paint a very different picture than the reality.

However, we definitely have a shortage of visiting nurses and caregivers for in-home terminal care of COVID infected patients. While patients wait for their PCR test results, typically three to four days, they may suffer from a respiratory failure, and not have access to an urgent rescue. If the patient dies at home, a legal question may arise as to who was responsible: the primary care doctor or the health center? I have somehow managed to continue my patient care despite all these issues; however, now with the third wave of infections and some health services being shut down, the in-home terminal care system has taken a big hit, not only the ICUs.

It is more important now, more than ever, to promote the living will and encouraging the public to still conduct ACP even if it's done virtually.

2020 Surviving Family Survey Results

95% of Living Wills were respectfully honored
Living Will is also a declaration of how to live

"My mother started having a fear of death when she was diagnosed with cancer. It apparently did not occur to her to tell the doctor that she is a member of JSDD. She had a hard time following through with her strong conviction that was reflected on her membership card when the time came."
Surviving families are sending us messages of the reality they faced, and how profound and complicated the situations can be to die with dignity.

When I presented my father's (98) JSDD card, his doctor nodded three times and started devoting himself to remove my father's pain and suffering.
-Miyagi prefecture

The sense of security and peace of mind that comes with being a JSDD member is indescribable.
-Kanagawa prefecture

- By declaring her Living Will, my mother (81) was able to live her life to the fullest. She was able to spend quality time with her family up until her last moment. I believe she had the best departure. I realized that the living will was not a declaration of how to die, but a declaration of how to live.
  -Tokyo

- There was a COVID infected patient in the hospital where my mother (85) was, so that I was not allowed to visit her when she died. Although she died with dignity as she wished, but it was not how it should have been. I wanted to see her, hold her hand, and to be near her. She must have had those same wishes as I did, but I was unable to make them happen. I regret it, and it still hurts me a lot.
  -Miyazaki Prefecture

- My husband and I joined JSDD which gave me so much relief because I knew I would not be so upset when the time came and not having to explain the whole story to convince his wishes to the healthcare providers. Actually my husband (67) passed away just the way he had wished.
  -Tokyo

- Although the doctor recommended an advanced treatment, the nurse supported my mother's (93) living will. As a result, she was able to receive heartwarming care at a special nursing home and spend her last days in peace and comfort.
  -Tokyo

- Both of my parents were members of JSDD. After my father died, what supported my mother (87) emotionally was the fact that she knew how to end her life.
  -Kanagawa Prefecture

- My husband (87) who was diagnosed with pneumonia said to his doctor, "I know your mission is to save lives, but I have been a member of JSDD for nearly 30 years. Please do not administer any life prolonging measures on me." For six days after that, the doctor and the nurses devoted their time to support his wish. His last facial expression seemed like a gentle smile.
  -Kanagawa Prefecture

- When my mother (77) was going to the hospital, she wore her membership card around her neck. It was a significantly meaningful card.
  -Tokyo

- My husband (80), while bed ridden, asked me to read his living will. He seemingly wanted to digest the contents of it, making sure it's a proof of agreement among family members and him. I have also written my wish list which I hope will lead to my way of living and firm determination.
  - Kanagawa prefecture

- The progress in medicine has opened up many life prolonging choices that it is difficult not choose one of them. The fact that my husband (76) was determined about his end of life decisions when he was still in good health has meant a great deal to my family. I think it is very important to pass on the message to your family as to what you want them to do, not just verbally, but to keep a document like a card. I think you have to initiate the discussion by bringing up this subject to your loved ones.
  -Tokyo

- My father (98) showed his membership card to the doctor and told him, "I am a member of this organization." The doctor nodded three times and said, "Let's take it one week at a time." He devoted himself to removing all the pain and suffering for my father.
  -Miyagi Prefecture

- Because of the living will, I was able to calmly accept my husband's (88) condition and everything else that came his way. It is so important to understand the living will accurately. I've had mine for 24 years. It has been and it will always be my priceless tranquilizer.
  -Hyogo Prefecture

- Our family members well understood my husband's (85) wish of dying with dignity, but his brothers rushed to from distant places and said that they wished for him to live as long as he could, causing confusion and embarrassment. We are still wondering what my husband thought of this fiasco since his mind was clear till the end.
  - Fukushima Prefecture

- I spent a lot of time between emotions, a wish to send him off quietly and another wish to be with him as long as possible. But I knew what he wished in the living will, so it became my guide when I had to make decisions on various matters. I feel good about those decisions because he had the living will.
  -Chiba prefecture

- My mother (84) became a member of JSDD 15 years ago. She was in good health, so she wanted to die with dignity, refusing any life prolonging measures. However, when she was diagnosed with cancer, she wanted to get better through invasive treatments. When she realized they were not helping her condition, she started to fear death, and was unable to tell her doctor that she was a member of JSDD. When her condition got worse, she was hospitalized and eventually was not able to eat anything on her own. We couldn't bring ourselves to refuse tube feeding. She was suddenly unable to communicate. With every change in her condition, we were asking the doctor for more treatments to make her better. We became confused, and our feelings were complex. Tube feeding may have prolonged her life a little bit, but it caused her body to swell and made her suffer for a period of time. When my mother became a member of JSDD, she had agreed to the principles of JSDD and passed it on to the family members. However, when the time came, it seemed like she was unable to carry it out.
  -Chiba Prefecture

I've had my living will for 24 years. It has been and it will always be my priceless tranquilizer.
-Hyogo Prefecture

I hope JSDD will always be a single light in the midst of dark and mystifying ocean
-Saitama Prefecture

Most responded that the patients' wishes were fulfilled

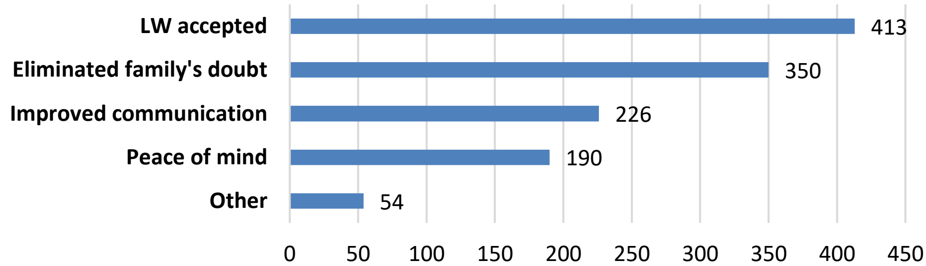
The year of 2020 was swept by the Corona pandemic throughout the world, and Japan was not an exception. We were unable to visit our loved ones before their departure and hold their hands for the last time. It was a painful year; however, even under such cruel circumstance, JSDD members presented their living wills and declared how they wanted to spend their last days, and families supported them in the best way they could.

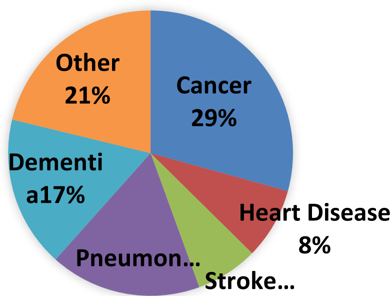
Every year, we conduct a survey to assess the effectiveness of the living will with cooperation from the surviving families. In 2020, we received responses from 675 families, of which 568 respondents (84%) said the patient's living will was submitted to their medical providers; 71%

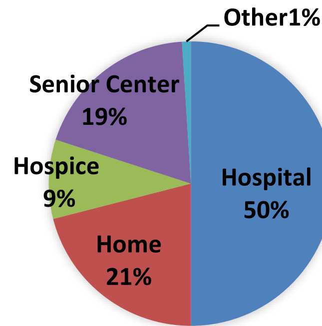
responded that the living will was fully honored; 24% answered that the living will was somewhat honored. Overall, 95% confirmed the effectiveness of the living will.

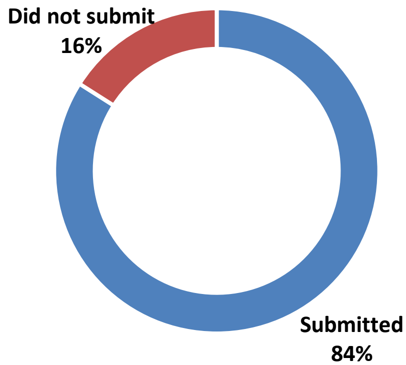
To the question, “What does the living will mean to your family?” (Multiple Answers), the following were the most common responses:
Achieved the patient’s wish: 413
Eliminated family’s doubt or regret: 350
Improved our communication with the doctors: 226
Gave the patient a peace of mind: 190

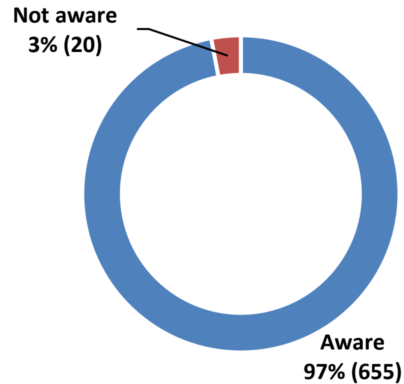
We truly appreciate the kind cooperation of those who participated in this survey.

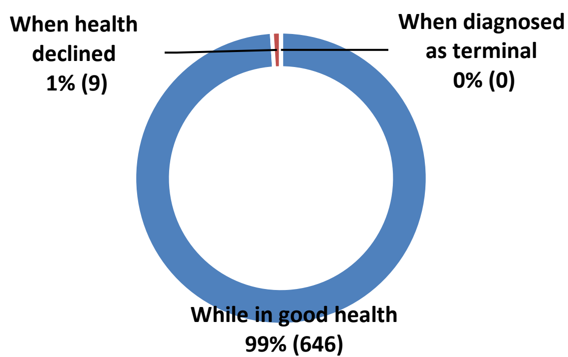


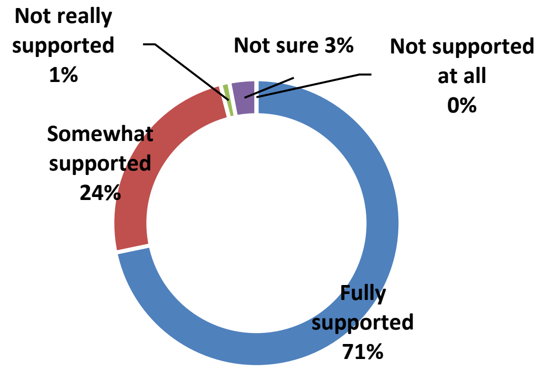


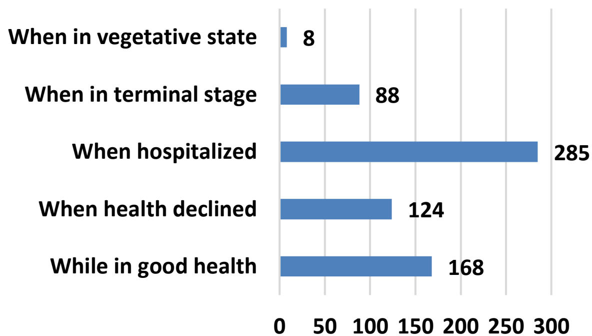


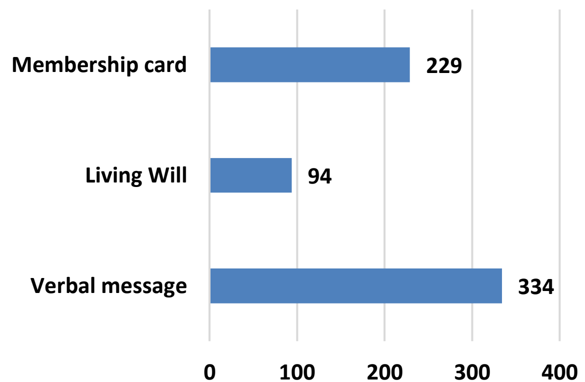

LW SUBMISSION TO THEIR HEALTHCARE FACILITY
Did not submit
16%
Submitted
84%

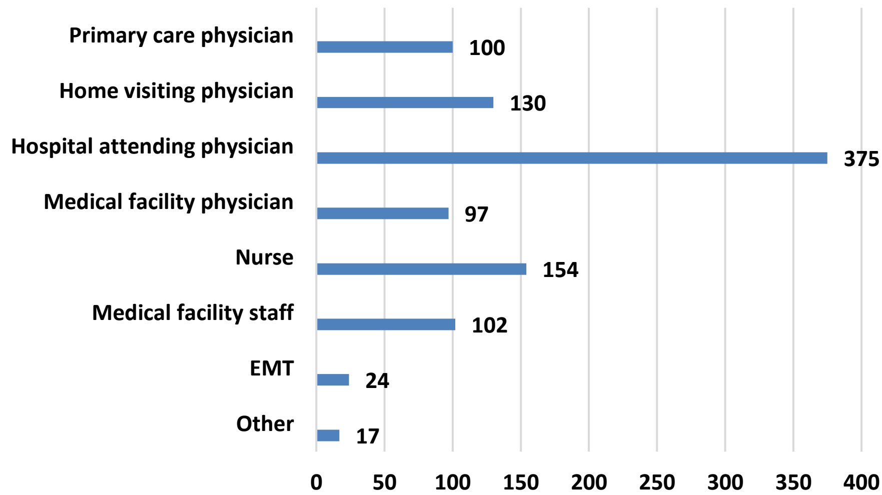

FAMILY AWARENESS OF THE LW
Not aware
3% (20)
Aware
97% (655)


TIMING OF THE LW GIVEN TO FAMILY MEMBERS
When health declined
1% (9)
When diagnosed as terminal
0% (0)
While in good health
99% (646)


PHYSICIANS' RESPONSE TO THE LW
Not really supported
1%
Not sure 3%
Not supported at all
0%
Somewhat supported
24%
Fully supported
71%


TIMING OF THE LW SUBMISSION
When in vegetative state
8
When in terminal stage
88
When hospitalized
285
When health declined
124
While in good health
168
0 50 100 150 200 250 300


SUBMISSION METHOD
Membership card
229
Living Will
94
Verbal message
334
0 100 200 300 400



Telephonic and Email Medical Consultations No. 7

"Let's overcome the pandemic together "

Greetings to all of our JSDD members! Due to this pandemic affecting our lives for a long time, you may be feeling depressed or out of shape. We have received an increasing number of calls with complaints and inquiries about poor physical and mental conditions. We hereby would like to let you know what the other members are saying and our advice.

Questions and concerns from the members:

- In my nursing home, there are so many restrictions. We are not allowed to say anything to each other when we pass people in the hallway, and we all have to sit and face in the same direction during meals, so we feel like we're eating all alone. I wish these restrictions are lifted as soon as possible.

- I live alone and try not to go out except for essential shopping. Since I haven't been going to day service, I noticed that my feet are losing some balance. My meals are very simple, and I spend several days without talking to anybody. My daily life is now becoming quite monotonous and different from what it used to be.
- Inherent cardiac hypertrophy. Sometimes I have to take big breaths to feel comfortable. On one hand, I don't have to take a bath every day, but I really miss not seeing my friends.
- I avoided going to the eye doctor because I was afraid of catching the Coronavirus and just received the prescribed medicine. I heard about the online clinic, but I don't know how to use a smart phone or a personal computer.
- Can I refuse artificial respirators and ECMOs?
- My mother (91) is in a special nursing home, and I am not allowed to visit her because of the Coronavirus situation. I'm concerned that this is not the right way to let her end her life. I'm thinking of switching to an in-home terminal care service, but I don't know where to start.
- I am an elderly, suffering from cardiac hypertrophy, so I am extra careful about avoiding the Coronavirus infection. Today, a package delivery man came. He was wearing a mask, but spoke in a very loud voice. I am now afraid that I may have caught the virus from him.
- My husband (86) is hospitalized, and I am not allowed to visit him. I can communicate with him online, but he doesn't look cheerful, and I'm afraid he's not well.

Through these conversations, we understand that they are living quite a different lifestyle, totally different from the previous days as the day service and other daily commuting services are now closed. They don't have many opportunities anymore to go out and meet with friends and family living far away, as senior care facilities and hospitals are restricting meeting in person. As a result, emotional anxiety and instability are enormously high. We can sense people's firm determination to defend their own dignity by refusing artificial respirators or ECMOs when they are infected.

Advice from our consultants:
Because we are in difficult times, it is even more important to maintain good health both physically and mentally through a healthy lifestyle. The basic preventative measures of infection are to avoid close contacts, wash hands frequently, gargle, and wear a mask when going out to public places.

Lifestyle suggestions:

- If you are over precautionary about going outside and sitting tightly at home, your physical and mental functions will decline. Try some exercises at home like walking in place or standing on your toes while watching TV or just moving your body as much as you can at home. Radio calisthenics are also recommended. When the stores are not crowded, walk extra during shopping.
- Get some sunlight for 20 minutes a day even from indoors to improve the regulation of your nervous system.
- Check your body condition and temperature every day.
- Check your body weight to make sure it's not fluctuating excessively.

- Try to eat balanced meals. If you don't have an appetite, you can have smaller, more frequent meals rather than sticking to the traditional three meals a day.
- If you normally visit your doctor periodically, you can keep going since they should have taken preventive measures for outpatients. If you're not comfortable going in person, you can try their online visits or phone consultations.
- Some senior care facilities and hospitals allow visitations. It doesn't hurt to make a call. If you want to have in-home care service, contact your local general health center or medical consultation office.

Make more time for relaxation:

- Hobbies stimulate your brain. Do your best to continue it. Start with something simple such as drawing or crafting presents to someone.
- Communicate with your family, friends or neighbors who are in a similar situation as you by phone or online as much as you can to avoid isolation. Light conversations are very important.
- If you live alone, you may find yourself not talking to anybody all day. Many places keep their venues open while following the pandemic restrictions and implementing other counter measures for social opportunities. Contact your local town office to find out what is open.

In closing:

We are starting to receive vaccinations. It may take some time before the whole population is inoculated, but normalcy will eventually come back slowly. Until then, please take good care of yourselves.