Excerpts from

Japan Society for Dying with Dignity Newsletter
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  What is a good death, and how can one achieve a good death?
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the 13th Japan Living Will Study Group

What is a good death,
and how can one achieve a good death?

The 13th Japan Living Will Study Group was held on December 14th last year, using both an in-person venue at the University of Tokyo and an online format.
The theme of this session was "What is a good death?" What kind of death can be considered a "good death," and how can one achieve it?
With Satoshi Mitsuoka, Director of Japan Society for Dying with Dignity (and a physician), as the coordinator, various aspects of "a good death" were explored, including cutting-edge research, survey studies, and case examples from medical practice. The session delved into the concept of "a good death" and what constitutes a "desirable death" from multiple perspectives.
This document summarizes the main points (a video of the session is available on the website).

(Compiled by: Takeshi Gunji, Editorial Staff of the Newsletter)

Coordinator: Satoshi Mitsuoka (Director of Mitsuoka Internal Medical Clinic, Director of Japan Society for Dying with Dignity)

Speakers (in order of speaking):

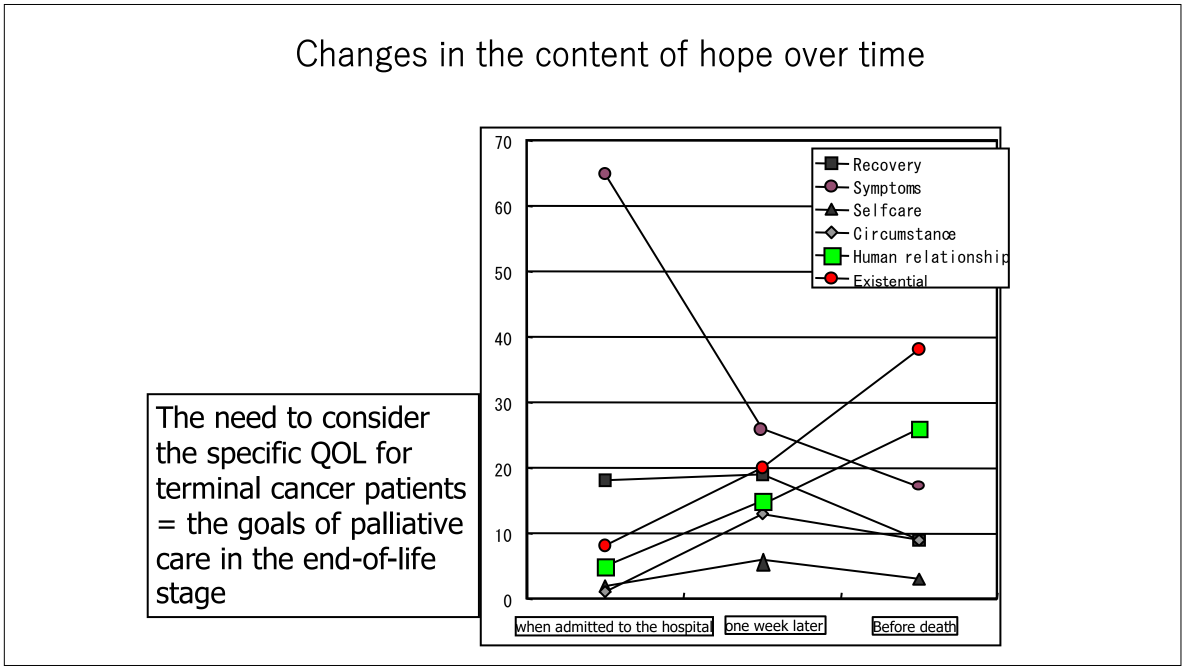
- Mitsunori Miyashita (Professor of Palliative Care Nursing at Tohoku University Graduate School)
- Masanori Mori (Director of the Palliative Care Support Department at Seirei Mikatahara Hospital)
- Satoshi Mitsuoka (Director of Mitsuoka Internal Medical Clinic, Director of Japan Society for Dying with Dignity)

【Desirable Death for Japanese People】

The achievement of a "desirable death" was highest for those receiving care at home.

Mitsunori Miyashita

My palliative care journey began with my experience in neurosurgery. This was about 30 years ago. At that time, in neurosurgery, even if it was clear that a patient could not be saved, we would perform CPR until the family arrived or would just continue "life-prolonging treatment." For instance, we would administer vasopressors and intravenous fluids in such large quantities that the patient’s face would become grotesquely swollen. I began to question whether there was any dignity left for those patients, which led me to pursue palliative care.



Changes in the content of hope over time

The need to consider the specific QOL for terminal cancer patients = the goals of palliative care in the end-of-life stage

The diagram presented is a chart from 100 cases at Yodogawa Christian Hospital Hospice, showing "Changes in the content of hope over time." Initially, patients' primary hope was overwhelmingly related to symptom relief, such as pain relief. After about a week, when symptoms were alleviated, hope shifted towards "existential" concerns, such as the meaning of life or personal relationships. The term "existential" also includes aspects of spirituality, such as the value or meaning of life. "Human relationships" refers to hopes related to family and friends. Here, the concept of "Quality of Life" (QOL) emerges. While healthy individuals focus on walking, running, or having no pain, in end-of-life care, QOL also needs to consider aspects like existential concerns and relationships.

Next, I will talk about "Good Death Studies" that began around 2000. The research aimed to clarify what is important to patients as they approach death, and what goals palliative care services should focus on. A famous study by American researcher Steinhauser, published in a journal, quantitatively explored what patients, families, and medical professionals value in end-of-life care. The study concluded that patients value pain and symptom relief, preparation for death, completing their life, involvement in decisions about treatment preferences, and being respected as a person.

This study led me to start researching what constitutes a desirable death for Japanese people. Initially, I conducted qualitative research with 63 end-of-life patients, their families, and healthcare providers, and extracted 57 items. I then conducted a nationwide survey, targeting 5,000 people aged 40–79 from four prefectures (Miyagi, Tokyo, Shizuoka, Hiroshima), and 800 palliative care bereaved individuals from 12 palliative care wards. The results were grouped into categories, and an exploratory factor analysis was conducted. For Japanese people, the 57 items were grouped into 18 categories.

The 10 most common concepts of a "desirable death" were as follows, ranked from the highest:

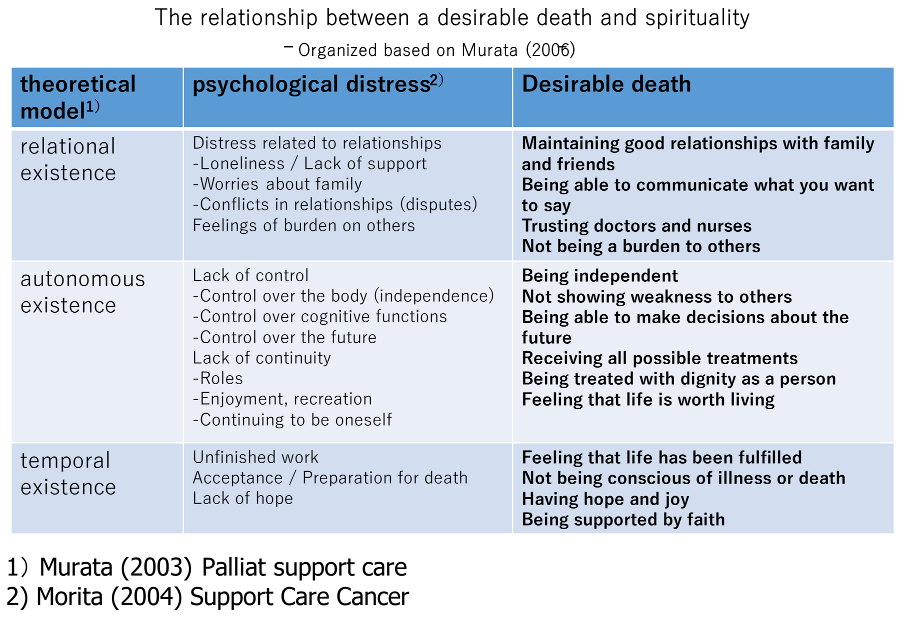
1. No physical or psychological pain.
2. Spending time in a preferred location.
3. Good relationships with healthcare staff.
4. Living with hope.
5. Not being a burden to others, including concerns such as "no worries about money."

6. Good relationships with family.
7. Maintaining independence.
8. Spending time in a calm environment.
9. Being respected as a person, which includes not being treated like a child or as an object.
10. Feeling that one has lived life to the fullest.

The remaining eight items are more "individualized" concepts. These are things that some people desire while others do not. The most individualized items, ranked from highest to lowest, include:

1. Dying in a natural way, including "not undergoing life-prolonging treatment."
2. Being able to thank others and be mentally prepared.
3. Fulfilling one’s role.
4. Not being conscious of death, which includes "dying without knowing it."
5. Fighting cancer until one is satisfied.
6. Maintaining self-esteem.
7. Knowing how much time is left and preparing for it, which includes "having the ability to choose the timing of death, such as through euthanasia."
8. Having faith.

This means that the healthcare system and society must be organized to ensure that everyone can achieve the 10 essential elements valued by Japanese people at the end of life. At the same time, consideration for individual preferences is important, and society should be structured so that people can achieve their desired outcomes if they wish. These 18 items represent what "palliative care" aims to provide.



The relationship between a desirable death and spirituality

– Organized based on Murata (2006)

theoretical model[1]	psychological distress[2]	Desirable death
relational existence	Distress related to relationships -Loneliness / Lack of support -Worries about family -Conflicts in relationships (disputes) Feelings of burden on others	**Maintaining good relationships with family and friends** **Being able to communicate what you want to say** **Trusting doctors and nurses** **Not being a burden to others**
autonomous existence	Lack of control -Control over the body (independence) -Control over cognitive functions -Control over the future Lack of continuity -Roles -Enjoyment, recreation -Continuing to be oneself	**Being independent** **Not showing weakness to others** **Being able to make decisions about the future** **Receiving all possible treatments** **Being treated with dignity as a person** **Feeling that life is worth living**
temporal existence	Unfinished work Acceptance / Preparation for death Lack of hope	**Feeling that life has been fulfilled** **Not being conscious of illness or death** **Having hope and joy** **Being supported by faith**

1）Murata (2003) Palliat support care
2) Morita (2004) Support Care Cancer

The diagram is based on the theory of Professor Hisayuki Murata (Professor Emeritus at Kyoto Notre Dame University), who categorized human existence into three types: relational existence, autonomous existence, and temporal existence. Relational existence refers to relationships with others—family, friends, colleagues, and healthcare providers. If these relationships are disrupted, such as through "loneliness," it can lead to suffering and distress. Autonomous existence refers to the ability to control oneself. As people approach the end of life, they may lose the ability to control their own body, so the ideal scenario is being independent and able to make decisions for oneself. Temporal existence refers to the assumption that life will continue in the future. When this assumption is broken, it can lead to suffering. A desirable death, in terms of temporal existence, is feeling that one has lived life to the fullest and maintaining hope and joy.

To evaluate a "desirable death," a scale was created to assess the 18 items. This scale consisted of three dimensions (questionnaire items) for each item, which people could check off. Using this scale, the actual achievement of a desirable death was evaluated.

The findings showed that, among the 10 common important items, nearly 90% of people across general hospitals, palliative care wards, and home care facilities agreed that "being treated with dignity" was essential. When looking at other items, home care was found to have the highest achievement in nine out of ten aspects, excluding "no physical pain." The next highest was palliative care units (PCUs), where "no physical pain" was the highest achievement. This is because palliative care units can respond quickly to symptom relief.

In conclusion, a desirable death for Japanese people consists of 10 universally important items and 8 items that vary by individual. Data shows that the achievement of a desirable death was highest in home care facilities.

【What a Palliative Care Physician Thinks a Good Death Is】

I believe that a good death is a reflection upon it after it has passed.

Masanori Mori

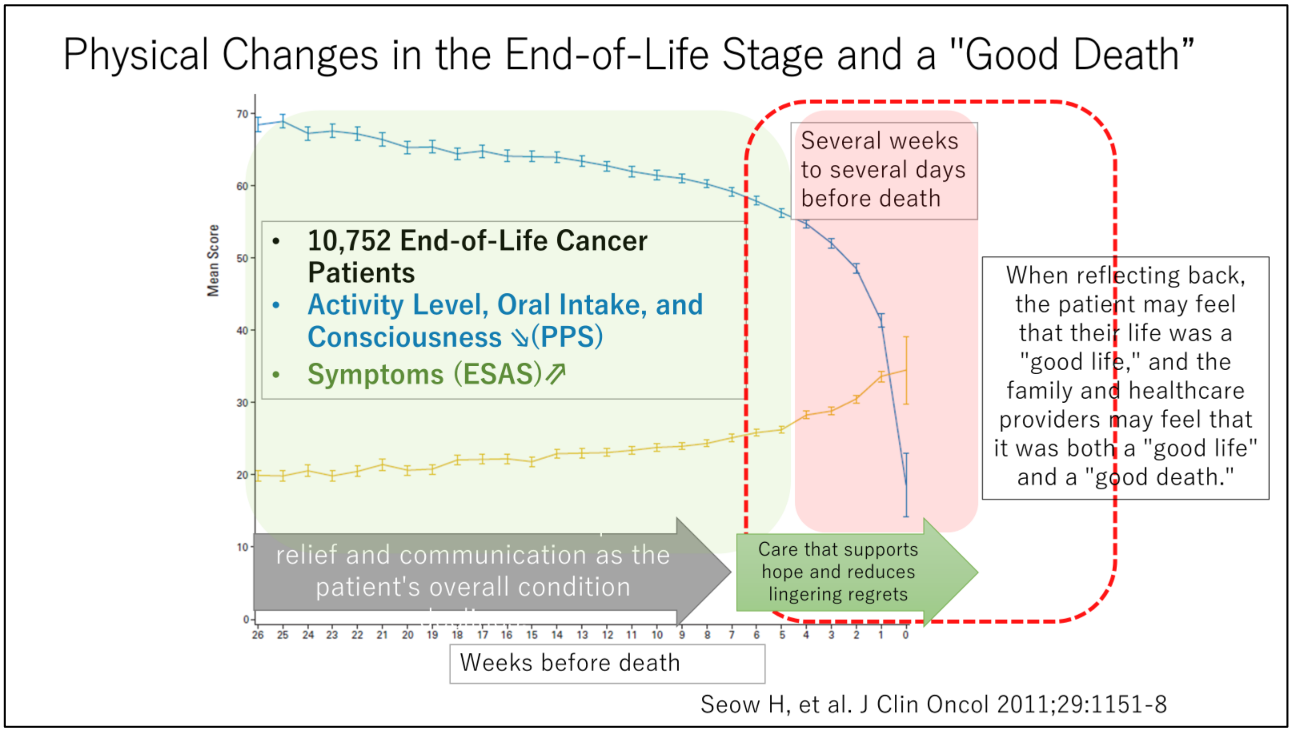
I will talk about the “good death” from the perspective of the hospital. In the current discussion, it was noted that the quality of death in hospitals tends to be the lowest. However, I would like to look at this from the viewpoint of a medical professional, not from the perspective of the bereaved, but from the point of view of those who are currently living and receiving care.

If I think about it on a daily basis, I realize that I haven’t often approached patients with the idea of helping them achieve a “good death.” More often, I have been thinking about how to help them live a good life, rather than focusing on the death itself. So, how did those who came before us talk about this subject, and what was their approach when death was imminent? Let’s take a look at that.

Shiki Masaoka, in his work *Byōshō Rokushaku* (Meiji 35, 1902), wrote just before his death at the age of 34, “Until now, I had misunderstood what Zen’s so-called enlightenment was. Enlightenment is not about being able to die calmly in any situation, but about being able to live calmly in any situation.” More recently, in his last book *For You Who Are Living* (2017), Dr. Shigeaki Hinohara, at the age of 105, was asked about life-sustaining treatments. He replied, “Life-sustaining treatments are a difficult issue. I don’t know what will happen when I am in such a situation.” He continued, “That is why I believe it’s important to talk about life with your family on a daily basis. If I’m in a state where I can’t express my wishes, I would accept with gratitude whatever decision my family, who understands me, makes, and go peacefully.”

Now, let’s look at what happens in hospitals, at the scene. When I was a young doctor, an elderly woman once said to me, “Let’s go together, all the way to the end.” She had lung cancer, but we hadn’t told her about her diagnosis. She didn’t understand why she was in pain, or why she needed oxygen, and kept calling me to her bedside. Around 3 a.m., she grabbed my hand and said this. A 30-year-old female teacher with colon cancer said, “I want to go home. I want to live a normal life, watching the curtains sway by the window.” A woman in her 50s, who had lost her child at an early age, said, “I don’t need life-sustaining treatment. I just want to see my child again.” A 70-year-old architect said, “Please tell me my prognosis. I want to draw the blueprint for my second son’s house.” He had already built a house for his first son, but he knew he wouldn’t live to see the house for his second son completed. He said, “At least I want to draw the plans for him.”

These final thoughts vary greatly from person to person. So, I think there are three key elements to a “good death”: 1) It depends on one’s views on life and death; 2) Death is an extremely individual and delicate topic; and 3) It’s important to reflect on one’s thoughts. Everyone has their own story, but not everyone wants to share it with you. Therefore, as a healthcare provider, it’s important to approach these situations with a sense of awareness of these thoughts.



Physical Changes in the End-of-Life Stage and a "Good Death"

- **10,752 End-of-Life Cancer Patients**
- **Activity Level, Oral Intake, and Consciousness ↘(PPS)**
- **Symptoms (ESAS)↗**

Several weeks to several days before death

When reflecting back, the patient may feel that their life was a "good life," and the family and healthcare providers may feel that it was both a "good life" and a "good death."

relief and communication as the patient's overall condition

Care that supports hope and reduces lingering regrets

Weeks before death

Seow H, et al. J Clin Oncol 2011;29:1151-8

This is a study of 10,000 cancer patients in their end-of-life stages. As their activity level decreases and symptoms worsen, their condition approaches the end-of-life stage. During the earlier or stable stages, healthcare providers work to build trust and focus on pain relief and communication as the patient’s overall condition declines. As the end nears, particularly in the last few weeks or days, the focus shifts to “supporting hope as much as possible and reducing lingering regrets” along with symptom relief. In considering what constitutes a “good death,” I believe it involves, in hindsight, patients thinking that their life was a good one, and that both their family and healthcare providers feel it was a good life and death.

So, what leads to a “good death”? A study of 1,157 cancer patients in palliative care wards in Japan found that it is important for patients to be in a place where they can pass away without sudden distress, in peace, and be able to talk with their family. What makes the heart “calm,” then? A study of 1,761 patients with advanced cancer in palliative care wards in Japan, Korea, and Taiwan showed that the three key factors for a “calm heart” are: 1) Acceptance of death; 2) Preparedness of both the patient and their family; and 3) Absence of pain.

Let’s also look at “lingering regrets.” Seventy-two percent of patients reported having lingering regrets. These regrets included, “I wish I had spent more time with my family,” “I wanted to resolve any conflicts with family or friends,” “I wanted to do meaningful activities like volunteering,” “I wanted to travel more,” and “I have unfinished business at work.” As for the regrets of families, more than half answered that they had regrets, and 60% said that these regrets caused them pain.

I have faced the final moments of many patients, and as a palliative care physician, I have thought deeply about what constitutes a “good death.” Many patients are focused on simply surviving the end-of-life stage, so I believe that a “good death” is something that can be reflected upon with satisfaction after it’s over. And as we live each day, feeling the limits of life, I hope to help make patients and their families smile, even just a little, and ease their suffering by being a part of the rich life of a patient, even if only in a small way. I believe that even after a person has passed away, they live on in the hearts of those they touched, and as a palliative care physician, I continue to support them.

【What a Home Care Physician Thinks a Good Death Is】

If those involved in the final moments can receive “something warm”…

Satoshi Mitsuoka

I work in both outpatient and home care in Saga Prefecture. Today, I would like to introduce the actual practice of home care in rural areas, which is different from urban settings.

The key to a "good death," as I see it, is “spending time in the place where one wants to be, with the people they want to be with.” In home care, patients can spend their final moments in the place they want to be, with the people they wish to be around. I once had a conversation with a palliative care doctor who said, "I envy home care physicians." He mentioned that while palliative care wards certainly provide palliative care, they can never be like a home; they are not the patient’s true place of comfort. Indeed, a home is a place where one feels at peace. However, for this to be possible, physical and psychological pain must be alleviated.

Let's look at a few examples of home care.

1. A 77-year-old man

He had lung cancer and cancer-related pain. His primary care doctor had said, "He shouldn't be in too much pain since he is taking painkillers." He had not eaten for a week, and the doctor said, "He likely has about a week left." When I saw him in the hospital, I thought the same. However, after moving to home care, we noticed signs of pain. Once we started continuous subcutaneous injections, a few hours later, he was able to drink a lactic drink and, the next day, eat watermelon and melon. After a week, he could stand and even make a peace sign.

2. An 80-year-old man

He had bile duct cancer recurrence after surgery, diabetes, liver metastasis, and old myocardial infarction. He had a long list of health issues. It took 9 months from his first outpatient visit to his first home visit. His strong wish was to be treated at home, where he could continue doing what he loved, such as traveling, visiting art museums, painting, and mountain climbing. For him, a "good death" involved feeling that he had lived a full life. His goal was to create a calendar with paintings of mountains he had climbed and to submit a painting to a local exhibition one more time. He achieved both of these goals just before his passing.

3. A 76-year-old man

He had advanced rectal cancer, cancer-related peritonitis, bladder and ureter infiltration, and end-stage kidney failure. He was given a prognosis of "only a few days left" and lived in a house deep in the mountains. His wish was to "return home." When I asked what he wanted to do at home, he said, "I want to smoke." A few days later, I visited him, and the photo taken then shows him looking much more relaxed and at peace.

While he had been very angry in the hospital, even lashing out at nurses, after he moved to home care, the family saw a different side of him. After showing the photo to the nurses, one of them commented, "I didn’t know he could smile like that." This was the difference that home care brought to his experience.

On the First Home Visit

4. A dementia patient (89-year-old woman)

She was bedridden and could no longer turn over. It was unclear whether she recognized her family members. She had stopped eating, but her family decided against using central venous nutrition or a feeding tube, opting for a natural approach. I gave her small amounts of sweet probiotic drink. She spent several months at home and passed away peacefully.

After her death, I helped her family with "angel care" (washing and preparing the body). I told her family, "She was able to spend her final moments at home with her loved ones, as she wished," and they all showed expressions of satisfaction, feeling that they had done everything they could.

Now, I will summarize the meaning of "family's role in end-of-life care.

- The family, who loves the patient the most, stays by their side to support and spend the final moments together.
- Providing care so that the patient has no lingering regrets.
- Receiving the patient's final message.
- Passing on their final message to the patient.
- Watching the patient weaken gradually, and accepting the process of their death.

Among these, "receiving and passing on the final message" is incredibly important. Even if a parent and child had been estranged, sometimes the act of sharing a heartfelt message, like "Actually, I’ve always been proud of you," can dramatically change the relationship. Therefore, I have considered who the main actor)of end-of-life care is. Through end-of-life care, family members not only give but also receive intangible gifts. In some ways, this is similar to parenting. Thus, I believe the main actors in end-of-life care are the family, while the role of the medical staff is to support the family in this process.

Now, let me share the final case.

A 71-year-old woman with recurrent rectal cancer, liver metastasis, and liver failure. At first, she had a primary care physician, but after some difficulties with her family, I was asked by a visiting nurse to take over her care. The first thing I did was ensure she had no pain by starting continuous subcutaneous injections. When I asked what she wanted to do once her pain was under control, her daughter said, "That’s it, that's exactly what we wanted!" She explained, "The previous doctor asked, 'We think she has about two weeks left. Would you want us to perform CPR when she dies?'" The daughter was upset, saying, "I wish they had asked what kind of death my mother wanted."

If the pain were to subside and you started feeling better,
what would you like to do?

My Requirements for a "Good Death"

1. **Community Requirements:** The local medical system must be in place.

2. **Patient Requirements:** The patient must have a sound understanding, be free of pathological anxieties or misconceptions, and build a trusting relationship with the care team.
3. **Family Requirements:** The family should be able to think flexibly and consider the best interests of the patient.
4. **Physician Requirements:** The physician should be able to control pain, provide 24-hour support as part of the care team, and have strong communication skills.
5. **Care Staff Requirements:** The care staff should build trust, practice Advance Care Planning (ACP), and share the same direction for care.

Death is an extremely personal experience, and it is presumptuous to judge one person's death as better or worse than another's. However, if the patient can reflect on their life and feel that their end was not bad, and if those who were involved in their life—whether through tears, smiles, or warm feelings—can take something valuable from the experience, then I believe we can call it a "good death."

Results of the 2024 "Bereaved Questionnaire

85% of respondents communicated the Living Will (LW) to healthcare providers, and 95% of those family members recognized its effectiveness.

Living Will was an important condition for spending a peaceful old age.

Family members who shared their experiences reflected on the emotional difficulty of making decisions about life-prolonging measures, especially when it is a decision that families feel should be made by them. In those difficult moments, they felt that the "Living Will prepared by the individual" in some way provided them with relief.

There were mixed feelings regarding the rejection of life-prolonging measures, from both the individuals and the family members. One family member shared that the person who had always said, "Life-prolonging measures only cause trouble for the family," eventually marked every box for the medical (life-prolonging) measures they wanted, as their condition worsened. The survey highlights various real-life experiences of the "final moments."

- My husband (83 years old) was always outspoken about being a member of the association and studied aging and death. He often said, "Shinoda-san says 'there is a time to die' (Newsletter No. 178)," and I thought to myself that perhaps the time had come. Yet, we managed to communicate, my physical strength to care for him lasted, and before going to bed, he would say, "Thank you today, and please take care of me tomorrow." This helped both of us remain mentally calm. I believe we were supported by the Living Will and the association's newsletter. (Tokyo)
- It seemed that by presenting his membership card and Living Will, my father (91 years old) was able to have his wishes understood by healthcare providers, who supported him through this process. He passed away peacefully, like leaves falling from branches. It's unfortunate that the association is not better known, as it was through being a member that both my parents were able to pass away peacefully. (Kanagawa)
- My father (93 years old) had always told me not to prolong his life, but when the time came, I found it emotionally very difficult to make the decision as a family member. The presence of his Living Will was very reassuring for both him and us. I believe my father was able to live with peace of mind because of the Living Will. (Nagano)

I joined to live positively.（Saitama）

- Providing end-of-life care at home felt like guiding a person to the gates of heaven. But when you do that, it's difficult to return to reality. Additionally, when the caregivers who had been helping with the care stopped coming, it felt like we lost not just family but also friends. This experience made me realize the importance of grief care for those left behind. I hope the association will consider offering grief care and listening services. (Tokyo)
- My mother (92 years old) passed away quietly, lying face down on the evening newspaper, waiting for dinner at the table. Next to her was a textbook for studying ancient documents, which she had planned to work on over the next year. She passed away naturally in her daily life. I felt that her death was a reward for how she had lived, as mentioned in a previous newsletter of the association, "People die as they have lived." (Tokyo)
- My mother (95 years old) had a heart attack and was brought to the hospital in a state of cardiac arrest. When the doctor called me from the hospital, I was able to tell them clearly not to use life-prolonging measures, as she had prepared her Living Will. I believe it was beneficial for both her and our family. (Tokyo)

I have no regrets after caring for my mother. It's thanks to my mother preparing the Living Will.（Kumamoto）

- My wife (80 years old) read and kept the newsletters carefully. She communicated her wishes and thoughts clearly to me, our son, and her doctors. As a result, both she and our family felt a sense of peace and understanding. I am very grateful for the newsletters we received. Even now, they are carefully stored in her bookshelf. (Nagano)

- As the eldest daughter, I knew my father (91 years old) wanted no life-prolonging measures, but my brother, who had been indifferent, disagreed on the medical treatment for his final moments. Ultimately, the doctor understood both my father's Living Will and my caregiving perspective, but there were differences in communication and understanding within the family. (Kanagawa)

What helped my mother, who could no longer hold a pen or speak, was the association membership card and the Living Will. (Kanagawa)

- My husband (79 years old) always held his membership in the association as a cherished "amulet." Despite all the preparations, no one knows exactly how they will pass. However, the peace of mind he had knowing he held this "amulet" was significant. (Tokyo)
- My mother (91 years old) expressed her preferences for end-of-life care clearly, but discussions with doctors were often difficult due to the lack of clear standards for life-prolonging measures. Even though her care team provided adequate explanations, we were unable to remove all her pain at the end. It was a deeply challenging experience, even though we had decided not to pursue life-prolonging measures and opted for palliative care. (Hyogo)

For my mother, the Living Will was an important condition for spending a peaceful old age. (Hokkaido)

- My mother (91 years old) suddenly had difficulty breathing and asked for an ambulance. As the paramedics were searching for a hospital, I told them she had a Living Will and did not want life-prolonging measures. This delayed her hospital transfer by 30 minutes. When she stabilized and we were relieved, she passed away the next day. My sister later questioned if things could have gone faster if I hadn’t mentioned the Living Will. I know she wasn’t blaming me, but I still felt uncertain. I was comforted when one of the paramedics told me, “I agree with the spirit of the Living Will, so I understand how difficult this is.” (Tokyo)
- I wish I could have provided more treatment for my mother (89 years old). As her health deteriorated, I had to constantly convince her to go to the hospital or take an ambulance, which made me feel frustrated with the association. It may not have aligned with her wishes, but I requested IV drips, blood tests, MRIs, and gastroscopies to satisfy my own peace of mind. (Tokyo)
- My husband (72 years old) was healthy and had no illnesses until he was suddenly diagnosed with stage 4 cancer. When he joined the association, he had said that if there was no chance of recovery, life-prolonging measures would be a burden on others. But after his diagnosis and worsening condition, he checked every box for medical procedures and nutrition in his wish statement. It became clear that you can never know someone’s true feelings until faced with the ultimate situation. (Hyogo)

Since joining and having a Living Will, discussions about funerals, inheritance, and other topics are no longer taboo, and we've been able to talk about many things openly. (Tokyo)

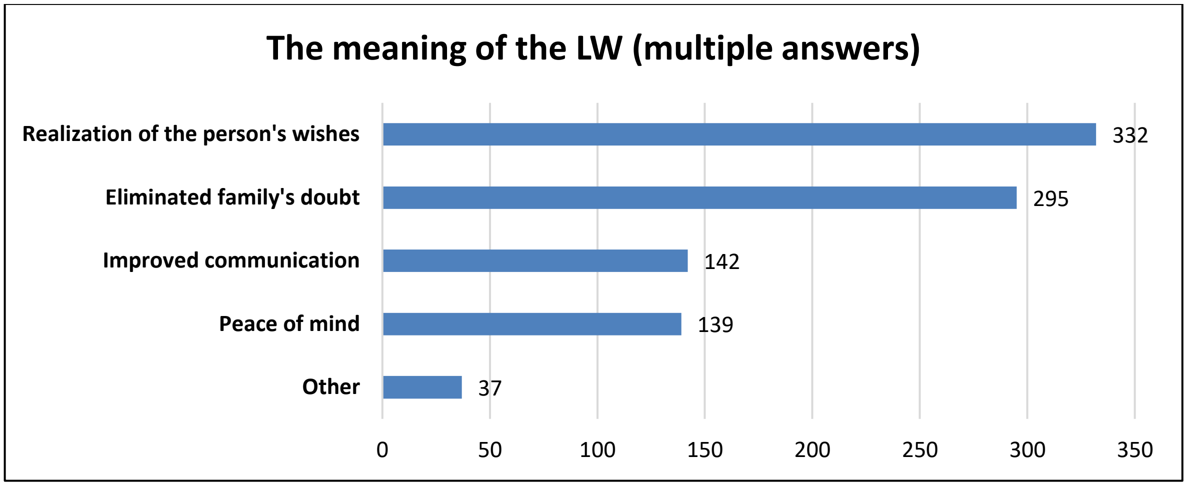
- My mother (73 years old) was in a vegetative state and kept getting pneumonia due to the nasal tube feeding. I requested that the tube be removed following her Living Will, but it was not accepted. The young doctor seemed apologetic, and I felt that permission from above was needed. Eventually, I found a nursing home that respected her wishes and removed the tube. She passed away peacefully 10 days later. This experience made me realize how difficult it is to find a compassionate facility unless I act actively. (Osaka)
- My mother (92 years old) was repeatedly told that "a hospital is for treatment, so we can't do nothing," and we eventually decided to have her receive tube feeding. Medical technology has advanced so that people are kept alive against their will. I once argued with the doctor, saying, "Looking at only the ceiling of the hospital isn't recovery," but I gave in to the words of others who said, "It's cruel not to provide nutrition." In the end, I believe I made her suffer unnecessarily. (Tokyo)

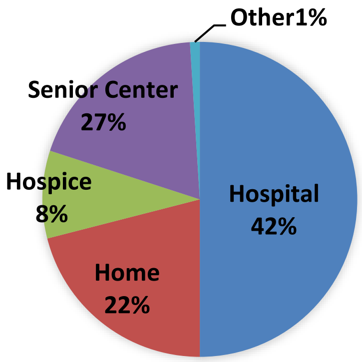
Most cases involved conveying the Living Will to family members.

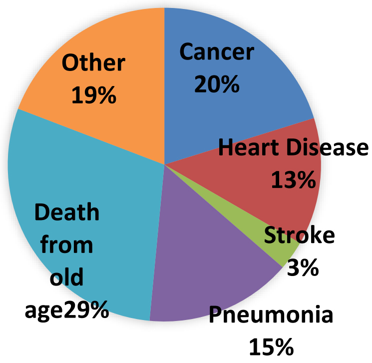
In the 2024 survey, with the easing of visitation restrictions due to the pandemic, more families were able to say goodbye to their loved ones in hospitals or facilities. However, parting from loved ones is still fraught with emotional conflict, and many family members are struggling with these decisions. Some respondents requested the association consider grief care and listening services, as well as the spread of correct medical knowledge. The association's "Small Lighthouse Project" offers support for those in the final stages of life, including advice and resources on emotional care.

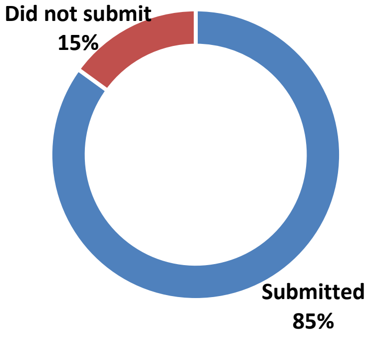
In 2024, we received responses from 523 people, 447 of whom (85%) communicated the LW to healthcare providers. When asked whether the LW was accepted by the medical team, 77% felt it was fully accepted, and 18% felt it was somewhat accepted. In total, 95% of the respondents recognized the effectiveness of the LW. It was also found that most people communicated the existence of the LW "regularly to their family."

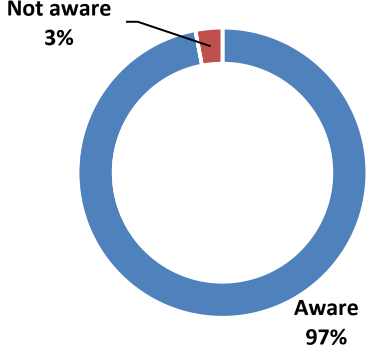
We are deeply grateful to those who participated in the survey during such a difficult time of mourning.

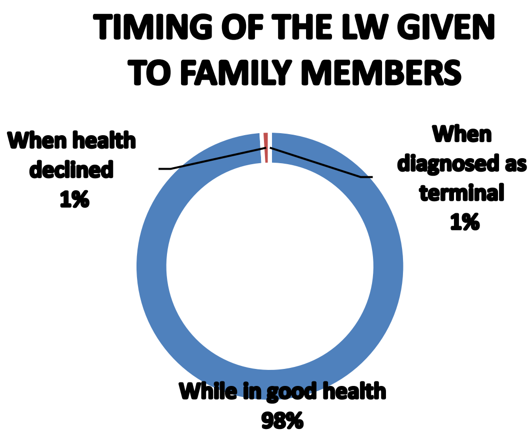

The meaning of the LW (multiple answers)

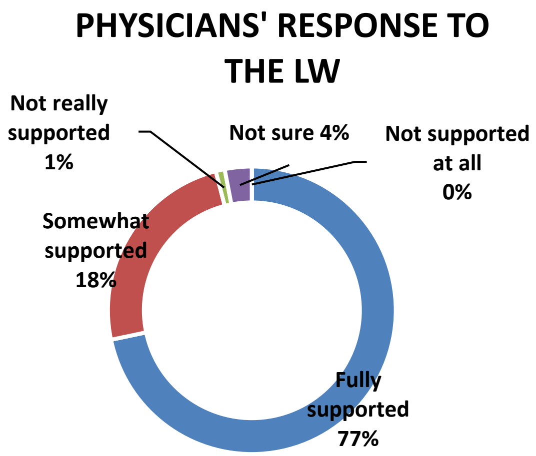

PLACE OF DEATH

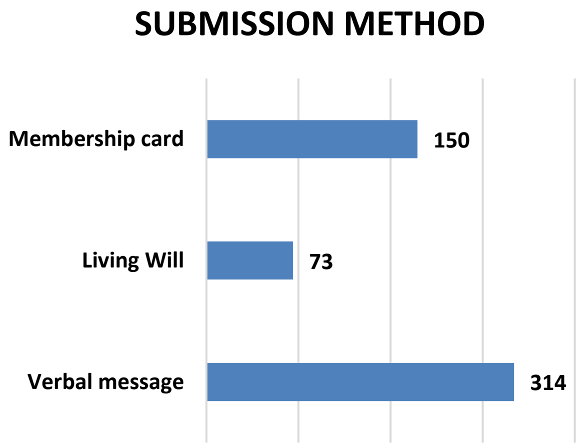

CAUSE OF DEATH

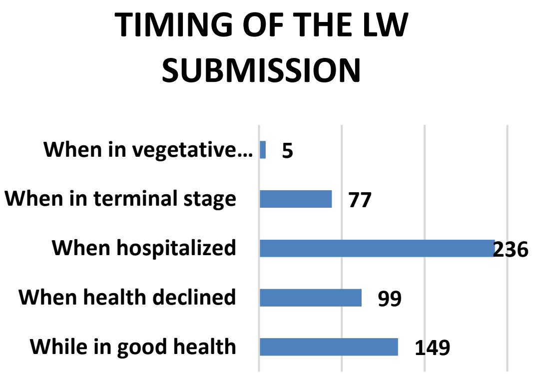

LW SUBMISSION TO THEIR HEALTHCARE FACILITY


FAMILY AWARENESS OF THE LW









Like-minded people from all over the country

LW Square

Decision to Close the Clinic

Anonymous, 70 years old, Hokkaido

I have been active as a physician who agrees with and cooperates with a living will, but I have made the decision to close my clinic. The reasons include the abolition of the health insurance card, which citizens have become accustomed to under the universal health insurance system, as well as the decline in my vision.

The introduction of My Number cards and the digitization of medical records and receipts is part of the digital transformation of society. However, the current system does not yet provide adequate guarantees for its operation under national responsibility. There is a high risk that citizens' important information may not be protected, and I have judged that it would be difficult to continue medical care responsibly as a medical institution. Another reason is the decline in my physical strength, including my vision. I have also begun to feel a decrease in my energy to absorb the necessary medical knowledge. I am currently hurrying to prepare simple referral documents for my patients who need to visit other medical institutions.

Right now, the nature of healthcare, our thoughts on life, and various values are in turmoil. It is truly an uncertain era, but in this context, I believe the activities of Japan Society for Dying with Dignity are like the Polaris in the night sky. I sincerely wish for the continued development of your organization to protect a society where humans can live out their lives as human beings.

Agreement with the "End-of-Life Activity Proposal"

Miyuki Goto, 62 years old, Tokyo

I agree with Mr. Yuichi Sugiyama’s "End-of-Life Activity Proposal" from the previous issue of "Hiroba." I would like to receive "lifetime support," but I feel uneasy about private companies, and the adult guardianship system only manages finances; it doesn’t provide detailed services like "monitoring." I believe many people need reliable services that provide comprehensive support, from daily monitoring, living support, and care management to collaboration with public services, and even support for funeral arrangements, posthumous affairs, and inheritance.

If the Dignified Death Association, a trusted public organization, could implement an "End-of-Life Guarantee Project for Single Individuals," it would provide great peace of mind.

From the telephone and email medical consultations

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How do you want the final stage of your life to be?

This is a page where we introduce specific consultation cases and answers given over the phone or by email. A nurse will answer the questions, but sometimes, we will ask for the help of an advisor doctor.

As life expectancy surpasses 80 years for both men and women, people transition from a period of good health and independence to a time when they may require some form of medical care or assistance. While how and with whom we wish to spend our final moments differs from person to person, we would like to introduce some consultations from individuals seeking to make decisions they can feel at peace with in order to fulfill their wishes.

[Is at-home medical care during treatment impossible?]

Q: I have been hospitalized for stage 4 lung cancer for the past two months. I am receiving nutrition and chemotherapy through an IV drip, but I am uncertain about the effectiveness of the treatment. While the family agrees that I should spend my remaining time at home, the local physician has said that home visits are not possible as my condition is unstable. (78-year-old man)

A: Living in a familiar home allows for a more relaxed pace and provides the opportunity to spend precious time with family. Generally, chemotherapy often requires an inpatient stay to assess the effectiveness of the treatment. After receiving an update from the attending physician, it might be helpful to express a desire for home care and discuss possible timing.

[I don't want to be separated from my pet.]

Q: Recently, the pain in my right hip joint has worsened, and I had been visiting an orthopedic clinic, but it has become difficult to continue. I live alone and receive home care services such as visiting nurses and bathing assistance. However, my care manager is suggesting that I move to a facility. I don't want to be separated from my beloved cat and want to stay at home. Should I give up my cat? (91-year-old woman)

A: I completely understand the desire not to be separated from your pet. However, caregiving services are typically intended for personal care, and unfortunately, pet care cannot be included. Some senior care facilities now allow pets, so it might be worthwhile to consult your care manager to explore options that meet your needs.

● Becoming aware of your own needs●

It's essential to think and prepare while you still have the ability to make decisions and handle matters yourself. Have you heard of the "Moshi Bana Game" (a game to initiate conversations about end-of-life)? The association holds experience sessions at salons and lectures. This game helps individuals reflect on their values and personal outlook, and it can lead to important insights. I highly recommend it.

(Ms. Chihoko Hirabayashi, Medical Consultant)

Translation: Open AI. (2025). Chat GPT(April 25 version). https://chat.openai.com