Excerpts from

Japan Society for Dying with Dignity Newsletter
No. 201, April 1, 2026

Main Contents:

- Abstracts from the 14th Japan Living Will Study Group
  "At the Threshold Between Dignified Death and Euthanasia"
- Results of the 2025 "Bereaved Questionnaire"
- From telephone and e-mail medical consultations



the 14th Japan Living Will Study Group

"At the Threshold Between Dignified Death and Euthanasia"

The 13th Japan Living Will Study Group was held on December 13 last year, in a hybrid format combining an on-site venue on the University of Tokyo campus with online participation. The theme of this meeting was "**At the Threshold Between Dignified Death and Euthanasia**". It marked the Society's first attempt to address, in a nearly direct and comprehensive manner, the various issues surrounding euthanasia. This document presents a summary of the proceedings.

(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):

- Jun Matsuda (Professor Emeritus, Shizuoka University)
- Yasuhiko Miura (Physician; Professor, Iwate University of Health and Medical Sciences)
- Satoshi Mitsuoka (Director of Mitsuoka Internal Medical Clinic, Director of Japan Society for Dying with Dignity)

【Introductory Remarks by the Coordinator】

What choices are available at the end of life?
— The need for societal discussion —

Satoshi Mitsuoka



Today, I would like us to consider what kind of shared social understanding and consensus are necessary to realize a society in which individuals can live true to themselves until the very end, while maintaining their dignity.

I would like to raise three key issues concerning dignified death.
First, the increasing prevalence of dementia associated with an aging population.
Second, the fact that withdrawal of life-sustaining treatments, such as mechanical ventilation—even when requested by the patient—is not always permitted.
Third, the relationship with euthanasia. There are cases in which it is judged that suffering cannot be

alleviated except through death, yet how to address such situations has hardly been discussed in Japan.
Let me present some data on euthanasia. The number of deaths attributed to euthanasia was 13,291 in the Netherlands (2023), 13,241 in Canada (2022), 1,791 in Switzerland (2023), and 367 in the U.S. state of Oregon (2023). In Japan, euthanasia is treated as a criminal offense, classified as homicide or assisted suicide. However, around the world, there are individuals who seek euthanasia due to unbearable suffering and ultimately die as a result. It has been observed that patients who wish to die often experience distress from being unable to care for themselves and feeling they are a burden on others; they find little to look forward to, and suffer from symptoms such as dyspnea, pain, and profound fatigue. Even when palliative care is provided, there remains a need for societal discussion on what options should be available when patients are in severe psychological distress.

【Desire for Death and the Search for Meaning in Life】

"How can we increase moments of peace even amid suffering?"

Jun　Matsuda



I will proceed in line with the issues raised by Professor Mitsuoka.
The first issue concerns decision-making support for people with dementia.
On this point, Japan's Ministry of Health, Labour and Welfare has issued guidelines stating that even in cases where decision-making appears difficult at first glance, every possible effort should be made to interpret the intentions of people with dementia, including through their gestures, facial expressions, and other nonverbal cues. Such intentions are not limited to treatment preferences—such as whether to undergo procedures like gastrostomy—but also broadly include everyday preferences in daily life. Moreover, since a person's intentions may change over time and depending on their circumstances, repeated confirmation is necessary.
Let me introduce a case from the Netherlands in 2016. A female physician secretly mixed a sedative (Dormicum) into the coffee of a 74-year-old woman with dementia. After she fell asleep, the physician attempted to administer a lethal injection. However, when the patient awoke and resisted, the physician asked family members to restrain her and proceeded with the injection, resulting in her death. From an external perspective, this appears to be a case in which a resisting patient was restrained and given a lethal injection. The woman had, however, previously written an advance euthanasia directive. Still, her intention at the time of the procedure was not clear.
The physician interpreted the woman's frequent anger and nighttime wandering as signs of "unbearable suffering," thereby concluding that one of the legal criteria for euthanasia in the Netherlands had been met. However, such behaviors—frequent anger and wandering—are known in dementia care as behavioral and psychological symptoms of dementia

(BPSD). Preventing the worsening of these symptoms is a key aspect of dementia care. This raises serious questions about the appropriateness of the care provided in this case. The woman had forgotten that she had written the advance euthanasia directive, had lost the ability to understand the meaning of "euthanasia," and could no longer comprehend the significance of a lethal injection. In the Netherlands, one of the essential requirements for euthanasia is that the patient's request be voluntary and well-considered. This case raises profound questions about whether an advance directive written when the patient had decision-making capacity is sufficient, and ultimately, what constitutes the patient's true will. This became the first criminal trial under the euthanasia law enacted in 2002. The physician was acquitted by a court in The Hague, and in 2020, the Supreme Court upheld the final verdict of not guilty.

Next, I turn to the second issue: how to respond when a patient requests the removal of a mechanical ventilator. This is addressed in the 2025 position statement of the Japan Geriatrics Society on medical care and care at the end of life. In summary, it emphasizes the importance of a palliative care perspective and respect for the patient's dignity. It states that when medical interventions may compromise dignity or increase suffering, both withholding treatment and withdrawing treatment already initiated should be considered as options. Underlying this is the ethical view that withholding and withdrawing treatment are equivalent.

At the same time, medical care at the end of life does not exclude curative interventions. In situations where the effectiveness of treatment is uncertain—such as unexpected acute deterioration—a "time-limited trial (TLT)" should be conducted to evaluate its effectiveness, which is important for safeguarding the patient's life.

Furthermore, as a prerequisite for implementing TLT, it is necessary that discontinuing a treatment once it is no longer needed be accepted as a standard option. Some clinicians hesitate to withdraw treatments once initiated, and as a result, may choose to withhold treatment from the outset. This, however, risks missing opportunities for recovery and runs counter to medical ethics. If there is freedom to discontinue treatment once started, then choosing to initiate interventions such as mechanical ventilation also becomes a more viable option.

Finally, I turn to the third issue: how to respond to individuals with decision-making capacity who request euthanasia. This is an extremely difficult question. From the perspective of clinical care providers, the goal may be to find ways to increase moments of peace even in the midst of suffering. In other words, this is about the "search for meaning in life." Experts have noted that home medical care is a search for meaning, and visiting nursing is support for meaning in life. The aim is to help individuals find what they can still do and support them in living fully.

But what is "meaning in life"? The late psychiatrist Mieko Kamiya, in her classic work *On the Meaning of Life (Ikigai ni tsuite)*, describes it as a sense of purpose in living, joy in being alive, inner vitality, and a feeling of fulfillment in existence.

The neuroscientist Kenichiro Mogi, in his book *IKIGAI*, writes that ikigai is "a reason to wake up in the morning," something that gives one motivation to look forward to a new day, and "the small joys that make life worth continuing." In recent years, the Japanese word *ikigai* has entered European languages, where it is understood as finding joy in life's small rewards and receiving them with humility.

Next, I would like to consider the relationship between autonomy, independence, and dependence. One of the well-known four principles of bioethics in the United States is respect for autonomy, which includes individual agency, decision-making by the patient, and self-determination with responsibility. However, the concept of the "autonomous

individual" is rooted in a cultural background that emphasizes the "strong individual," and differs somewhat from Japanese cultural perspectives. Even within the United States, this concept has been subject to criticism.

Is it not one-sided to emphasize only autonomy and independence? Human beings are born as helpless infants, entirely dependent on others—especially their mothers. They grow into autonomous adults, but eventually, due to illness and aging, they once again become fully dependent on others at the end of life. In other words, in the final stage of life, no one can remain fully autonomous or independent. We cannot die alone. We begin life as completely dependent beings and end it in the same way.

Another scholar, Eva Feder Kittay, has argued that growth, decline, and illness are inevitable aspects of human existence. Her core idea is that "we are all someone's child." A completely dependent infant is cared for by the mother, who herself requires support after childbirth; with that support, she is able to care for the child. Kittay further states that no society can survive for more than one generation if it resists the demands of dependency. This presents a moral framework based on human vulnerability and calls for a social structure grounded in mutual support, including support for caregivers. It is a system of "nested dependencies," in which those who need care are supported by caregivers, who in turn are supported by others.

Human infants are born in an extremely immature state compared to other mammals and remain dependent for a long period. Yet it is precisely this dependency that has enabled the development of human culture. In particular, dependence on the mother has served as a foundation for cultural transmission. Moreover, nested relationships of dependency have made it possible to build cultures of human connection, as well as systems of healthcare, long-term care, and social security.

Rather than viewing independence and dependence as opposing concepts, Fumihiro Kumagai has suggested that increasing the number of sources of support is essential for achieving independence. Instead of emphasizing autonomy and independence in a one-sided way, it is important to pursue them within a framework of mutual support.

【Clinical Guidelines and Experience in the Management of Renal Failure】



"Withholding or withdrawing dialysis has become one of the options"

Yasuhiko Miura

Let us consider "terminal extubation." A 2022 report by the Japanese Society of Intensive Care Medicine on palliative extubation in the broader context of end-of-life care describes its application in 20 patients. In addition, there is the so-called joint guideline of three academic societies: the 2014 *Guidelines for End-of-Life Care in Emergency and Intensive Care Medicine*, issued by the Japanese Society of Intensive Care Medicine, the Japanese Circulation Society, and the Japanese Association for Acute Medicine. According

to these guidelines, discontinuation of life-sustaining treatment may be considered acceptable when: (1) there is no reasonable prospect of recovery and death is expected within a few months; (2) the patient has previously expressed a wish not to receive life-prolonging treatment under such circumstances; and (3) the family consents.

These guidelines are currently under revision, and with the participation of the Japanese Society for Palliative Medicine, they are expected to become a joint guideline of four societies. One anticipated addition is the principle that "enhanced palliative care should follow the cessation of active treatment."

Next, I will discuss euthanasia from the perspective of dialysis care. When dialysis is discontinued, patients typically develop uremia and die within about ten days. For this reason, dialysis is regarded as a form of life-sustaining treatment, and there are currently approximately 340,000 patients receiving dialysis in Japan.

Let us now consider the "withholding and withdrawal of dialysis." This is often categorized as so-called "passive euthanasia." In Europe and the United States, the right to refuse dialysis based on patient autonomy is widely recognized. Moreover, when there is an unfavorable balance between the burdens imposed by dialysis and the benefits it provides, discontinuation is considered ethically permissible. However, such decisions are expected to be made through shared decision-making based on mutual understanding between the nephrologist and the patient.

Can such perspectives be accepted in Japan? In the United States, discontinuation of dialysis accounts for a major cause of death among dialysis patients (approximately 18%). In this context, in 1996, Dr. Seiji Ohira of the Japan Association of Dialysis Physicians proposed a private draft on the discontinuation of dialysis.

This draft set out four conditions, including that "the performance of hemodialysis is medically dangerous or impossible." It also included supplementary recommendations: that discussions regarding dialysis discontinuation should be documented as thoroughly as possible, and that decisions to discontinue treatment should not be limited to dialysis alone, but should involve an institutional ethics committee with input from legal counsel. In the United States, a book titled *Shared Decision-Making in the Appropriate Initiation and Withdrawal from Dialysis* had already been published in 2000.

In Japan, a case involving the discontinuation of dialysis became a major social issue in 2018. As a result, the 2014 *Recommendations on the Decision-Making Process for the Initiation and Continuation of Dialysis* were revised in 2020. Newly incorporated concepts included shared decision-making and advance care planning (ACP), in addition to advance directives. A particularly significant development was the explicit recognition of "conservative kidney management (CKM)"—that is, not initiating or discontinuing dialysis—as one of the available options. In such cases, the provision of palliative care for dialysis patients was also emphasized.

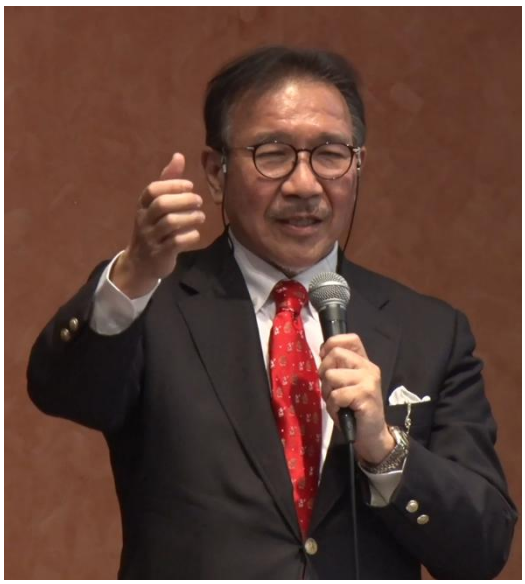
The revised recommendations also address how to respond when a patient with decision-making capacity, or the family of a patient without such capacity, requests withholding dialysis. They further stipulate that a "withdrawal form," paired with the confirmation document for advance directives, should always be provided.

Now, CKM may fall within the category of passive euthanasia. This, in turn, can create ethical dilemmas for the healthcare professionals involved. In response, I published in 2018 a set of considerations to bear in mind when a request is made to withhold or withdraw dialysis. These include questions such as: "Is the patient's wish to discontinue dialysis firm, and what are the underlying reasons?" and "Are there ways to address the main factors behind this wish, and have all possible measures been exhausted?"

【The Current State and Future Prospects of Dignified Death and Euthanasia】

"Toward a Social Consensus: The Need for Concrete Discussion"

Satoru Mitsuoka



First, I would like to clarify the concepts of euthanasia and dignified death.

Euthanasia can be divided into two types: "active euthanasia," in which death is intentionally brought about through the use of drugs or other means, and "passive euthanasia," in which life-sustaining treatments are withheld or withdrawn.

Dignified death, on the other hand, can be regarded as being almost equivalent to palliative care.

Let us now turn to the issues surrounding dignified death.

The first issue concerns the increase in dementia associated with an aging population. In clinical settings such as home medical care, it is constantly felt that communication with patients with dementia is extremely difficult. They may be unable to understand what is said to them, may remove intravenous lines on their own, or may refuse to eat. How should we respond in such situations?

In 2018, the Ministry of Health, Labour and Welfare issued the *Guidelines on the Decision-Making Process for Medical Care at the End of Life*. A key challenge arises when the patient's wishes cannot be confirmed. In such cases, the medical and care team must carefully determine the best course of treatment for the patient, while also engaging in thorough discussions with the family.

To support such decision-making, we often use in clinical ethics conferences what is known as the "four-box method" proposed by Jonsen and colleagues: (1) medical indications, (2) patient preferences, (3) quality of life (QOL), and (4) contextual features. By examining each of these elements, we aim to reach the best possible decision. At the same time, we must remain mindful of whether what is considered "best for the patient" may in fact be "best for the family." It cannot be assumed that families always make decisions solely in the patient's best interests.

Here, it is worth considering the multiple, coexisting goals of elderly care: relief of suffering, cure of disease, pursuit of individuality, preservation of dignity, and maintenance of daily functioning, among others. Which of these should take priority? If curing disease is regarded as paramount, treatment such as intravenous infusions and oxygen therapy would be pursued. But if the patient removes these devices, should their limbs be restrained? Can we truly speak of preserving dignity or individuality in such circumstances? These situations inevitably involve ethical dilemmas. In other words, there is no single "correct" answer in care. The key concept is what constitutes "the best for the patient."

Next, let us consider the second issue: terminal extubation. This raises the question of how to address the current situation in which life-saving mechanical ventilation may not be initiated in the first place because it cannot later be withdrawn. Under advance care planning (ACP), it is recommended that discussions be repeated if a patient's wishes or circumstances change, with the aim of achieving what is best for the patient. However, in the case of terminal extubation, the removal of a ventilator once initiated has been avoided—except in emergency settings—due to concerns about potential criminal liability. In the United States, the withdrawal of life-sustaining treatments, including ventilators, is now legally permitted in all states. In light of such international developments, Japan's Ministry of Health, Labour and Welfare issued the *Guidelines on the Decision-Making Process for End-of-Life Care* in 2007.

Professor Norio Higuchi, Professor Emeritus of the University of Tokyo and chair of the committee that compiled these guidelines, has noted that "since then, there have been no cases in which a physician was found guilty for withdrawing treatment from a terminally ill patient," and has argued that concerns about criminal prosecution for extubation are outdated. Nevertheless, those of us working in clinical settings do not necessarily share this sense of reassurance.

To summarize this issue: the withdrawal of mechanical ventilation (terminal extubation) should be recognized as permissible based on the fundamental human right of self-determination. When a patient requests withdrawal, repeated discussions should be held among the patient, family members, and the care team, and shared decision-making should be pursued. This requires communication skills for conducting ACP and providing palliative care, as well as education in clinical ethics for the care team. The involvement of a palliative care team is also essential.

Finally, I turn to the issue of euthanasia. At present, euthanasia is not permitted in Japan, but an increasing number of countries around the world allow it. Surveys of physicians involved in palliative care report that approximately 9% have experienced requests for euthanasia from patients. It is also true that there are cases in which suffering cannot be alleviated except through death. However, in Japan, there has been little discussion of how to address such situations. How should we respond to the reality that some individuals travel abroad in search of euthanasia?

First, it is necessary to confirm whether the patient has an accurate understanding of euthanasia. It is also important to explore the reasons behind the wish to die: what specifically is causing such distress, and whether the desire is truly for death itself or for relief from unbearable suffering. After carefully assessing these factors and providing appropriate responses, if the patient still expresses a wish to die, the next step may involve consultation with specialists.

As I have outlined, the issue of euthanasia is by no means simple. Moving forward, more concrete and multifaceted discussions will be necessary in order to build a social consensus on euthanasia.

Contributing to the Realization of "Living True to Oneself Until the Very End"

Soichiro Iwao
Honorary President, Japan Society for Dying with Dignity



The Japan Society for Dying with Dignity, a public interest incorporated foundation, marks its 50th anniversary this year. In this milestone year, the World Federation of Right to Die Societies will hold its world conference in Tokyo, the birthplace of our movement. This signifies that our half-century of efforts to achieve a "dignified end of life" is deeply connected with the global community and is opening up new horizons.

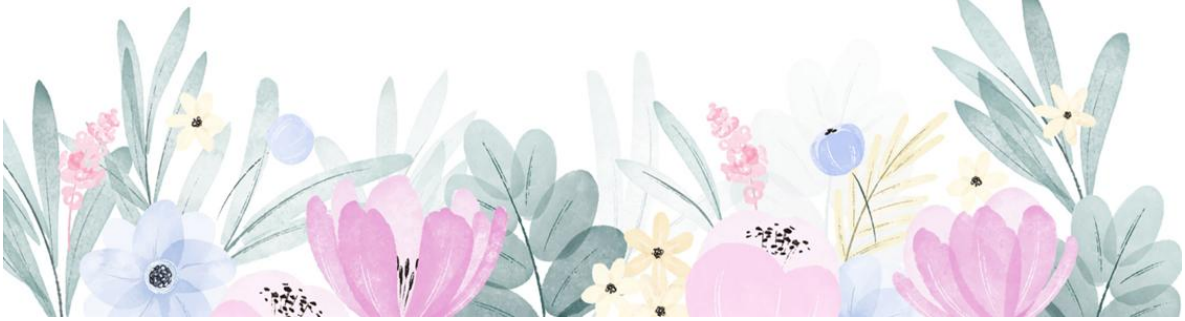
In August 1976, we hosted an international conference in Tokyo. Twelve experts invited from the United States, the United Kingdom, the Netherlands, and other countries, together with 19 representatives from Japan, gathered to affirm that decisions regarding end-of-life choices should be entrusted to individual self-determination, and that advance directives—known as "living wills"—are a fundamental personal right. Furthermore, we issued the "Tokyo Declaration," which called for efforts toward the legal recognition of living wills, the establishment of a communication center for information exchange, and the continued holding of international conferences. This declaration became the origin of our movement for a dignified end of life and laid the foundation for the global living will movement.

Half a century has passed since the Tokyo Declaration, and global trends surrounding dignified death have advanced significantly. In more than 20 European countries, as well as in many countries and regions in the Americas and Asia, legal frameworks for living wills—under such names as "patients' rights laws" and "end-of-life directives acts"—have been established, ensuring that end-of-life care respects patients' wishes. In Japan, however, despite the fundamental importance of this issue for elderly care, legislative discussions in the Diet have not progressed. Meanwhile, euthanasia and physician-assisted dying have been legalized in some countries and regions, including the Netherlands, Belgium, Switzerland, Canada, and certain states in the United States.

A Critical Opportunity to Address Japan's Challenges

The 26th World Congress of the World Federation of Right to Die Societies, to be held in Tokyo from November 25 to 28, 2026, in commemoration of our 50th anniversary, represents a crucial opportunity to address these challenges in Japan. By returning to the principles of the Tokyo Declaration and sharing the experiences and knowledge of countries around the world, we aim to significantly advance momentum toward the legal recognition of living wills in Japan.
The conference will bring together experts and citizens, including participants from overseas, to discuss the latest developments and challenges in end-of-life care. The conference poster has already been completed, abstract submissions have begun, and inquiries from around the world are steadily increasing. Learning from the diverse approaches shaped by differences in culture and legal systems will provide valuable stimulus for deepening discussions on dignified death in Japan.
Through this conference, we seek to contribute to the realization of a society in which each individual can live true to themselves until the very end of life. In this milestone year marking our 50th anniversary, we sincerely hope that the message of dignified death, conveyed from Tokyo to the world, will resonate widely. We respectfully ask for the understanding, support, and endorsement of all our members regarding the purpose of this international conference.

Results of the 2025 “Bereaved Questionnaire



81% of respondents communicated the Living Will (LW) to healthcare providers, and 96% of those family members recognized its effectiveness.

It became a strong assurance that ‘one can live until the very end according to one’s own wishes.

“When I was called to the hospital to take part in ACP (advance care planning), I contacted the Society’s telephone medical consultation service in advance and received helpful advice. Thanks to that, I was able to speak calmly at the hospital.”
Such comments were also included in the survey responses.
When faced with a loved one who has reached the final stage of life, family members’ emotions are often unsettled. Even when they understand that the patient’s wish is “no life-

prolonging treatment," they may still hope to "extend life as much as possible." They struggle, waver, and hesitate, and opinions may differ even within the family.
In such moments, responses such as "The living will became a source of emotional support" remind us once again of the significance of the Society's work.
Here, we share the authentic voices drawn from a range of bereaved family surveys.

◆ We joined the Society as a couple many years ago, and I truly feel it was the right decision to place our trust in it. I cared for my husband (87) through our later years together and saw him off at the end of his life. I now live alone, but I feel fulfilled and confident, and I hope to spend the rest of my life positively. (Wakayama Prefecture)
◆ My husband (76) had his right kidney removed due to renal cancer and began dialysis. Three years later, both of his legs developed gangrene, and due to severe pain and declining strength, he expressed his wish to discontinue dialysis, informing his home-visiting physician that he was a member of the Society. We are deeply grateful that the doctor respected his wishes. (Tokyo)
◆ For my mother (82), being a member of the Society became a strong assurance that she could "live until the very end according to her own wishes." It gave her the strength to live by her own will, rather than merely being kept alive. It was like a protective charm for her. (Tokyo)

Presenting my husband's living will helped me find resolve, rather than being overwhelmed by grief.(Chiba Prefecture)

◆ While still in good health, my mother (89) often said she wanted to make her own choices in order to face a dignified death. For our family, her words became our guiding principle and foundation. After she entered a care facility and her cognitive function gradually declined, presenting her living will and membership card helped others understand her wishes, which was a great support to us. (Kanagawa Prefecture)
◆ My mother (96) shared her final wishes only with me, her youngest child. Because she was a member of the Society, it became much easier to communicate her wishes to the facility, hospital, and relatives. It was especially helpful during family meetings when discharge timing and facility acceptance deadlines were approaching. Although all of us wished for her to live as long as possible and struggled with our decisions, we now feel proud that we were able to honor her final wishes, and we have no regrets. (Hyogo Prefecture)
◆ When our family was called to the hospital for ACP (advance care planning), we contacted the Society's telephone medical consultation service in advance and received appropriate advice. Thanks to that, we were able to calmly convey both my husband's (84) wishes and the family's feelings to the hospital. It was also a comfort that my husband was able to live with the reassurance that his understanding of dignified death would be respected. (Ibaraki Prefecture)

I am proud of my mother, who made a firm decision about how she wished to face her own passing. (Osaka Prefecture)

◆ Without a living will, I think we would have struggled in many situations over how best to handle my mother's (85) final days. I feel nothing but gratitude that she made her own decisions in advance. (Tokyo)
◆ In my mother's case (90), the hospital accepted her living will, and she passed away peacefully. In contrast, my father, who died some time ago, was repeatedly given medication to raise his blood pressure whenever it dropped, prolonging his life through cycles of decline and temporary recovery. Both he and our family suffered for a long time. When we think of life-prolonging treatment, we often imagine major interventions, but even something as simple as a single blood-pressure medication can prolong suffering. I believe we need to better understand this. (Tokyo)
◆ During my father's (97) final stage of life, we were repeatedly asked by hospitals and care facilities to confirm the family's wishes whenever something happened, and each time we had to decline life-prolonging treatment. It was extremely painful. At those times, his living will was a source of emotional support. When the physician who attended him said, "I believe this was a very dignified death," it brought us a sense of relief. (Tokyo)

Being able to focus on measures to prevent suffering was possible thanks to the living will. (Tokyo)

◆ At the facility where my wife (85) had been living for three years, the doctors and nurses shared a unified understanding, and she was able to have a good end of life. I believe the spirit of the living will was fully respected. (Shiga Prefecture)
◆ What my father (95) feared was life-prolonging treatment accompanied by physical and mental suffering, as well as the burden it would place on his family. He believed that continuing to live in such a state, unable even to express gratitude, would be nothing but cruel. Becoming a member of the Society gave him peace of mind that such a tragic future could be avoided. (Shizuoka Prefecture)
◆ As my mother's (88) dementia progressed, communication became impossible, and our family had to make various decisions on her behalf with the facility staff and physicians. We are truly grateful that she had joined the Society while she was still well. (Kanagawa Prefecture)
◆ My husband (76) has finally been freed from illness and is now, I imagine, walking through the mountains and fields he loved. Encountering the living will also allowed me to care for him with a peaceful mind. (Kagoshima Prefecture)

People in our community often say, "Your mother had the best possible passing." I believe this is thanks to the living will. (Hiroshima Prefecture))

◆ The Society's newsletter was always kept within my husband's (63) reach. I believe that reading it repeatedly helped him remain calm and at peace. (Toyama Prefecture)
◆ It was difficult to convey my mother's (89) wishes to the physician after she lost the ability to speak, but when I presented her membership card, they immediately understood. It was a great help. (Tokyo)
◆ In his written statement of wishes, my husband (81) said he wanted to spend his final days slowly, in a clean environment with the classical music he always listened to playing. The doctor agreed, and we played music in his room and covered the walls with cherished

photos. We were able to spend the last two weeks peacefully as a family. I truly feel this would not have been possible without the living will and his written wishes. (Ishikawa Prefecture)

◆ Even when my husband (86) required the highest level of care, I was able to continue home care without hesitation because I had a firm resolve rooted in being a member of the Society. I informed the doctors, nurses, care manager, and helpers of this, and I believe they supported and protected me wholeheartedly because they understood my commitment. In his final moments, my husband gazed steadily into my eyes and then passed away peacefully, as if falling asleep. (Shizuoka Prefecture)

Thanks to having a living will, we often say to each other that even past the age of 80, we can live with peace of mind—and perhaps that is why we are able to stay healthy and well. (Kanagawa Prefecture)

◆ Because there was a living will, I was able, as a court-appointed guardian rather than a family member, to convey the wishes of the individual (99) to the medical institution. (Kyoto Prefecture)

◆ Because my father (94) had joined the Society, it gave our family an opportunity to discuss life-prolonging treatment and share his wishes, which was valuable. However, medical institutions repeatedly told us, “If you receive medical care, treatment is mandatory. If you do not want that, please do not seek medical care.” (Hyogo Prefecture)

◆ When my husband (78) was hospitalized, the physician told us, “If hospitalization is required, we have no choice but to disregard the living will.” (Shizuoka Prefecture)

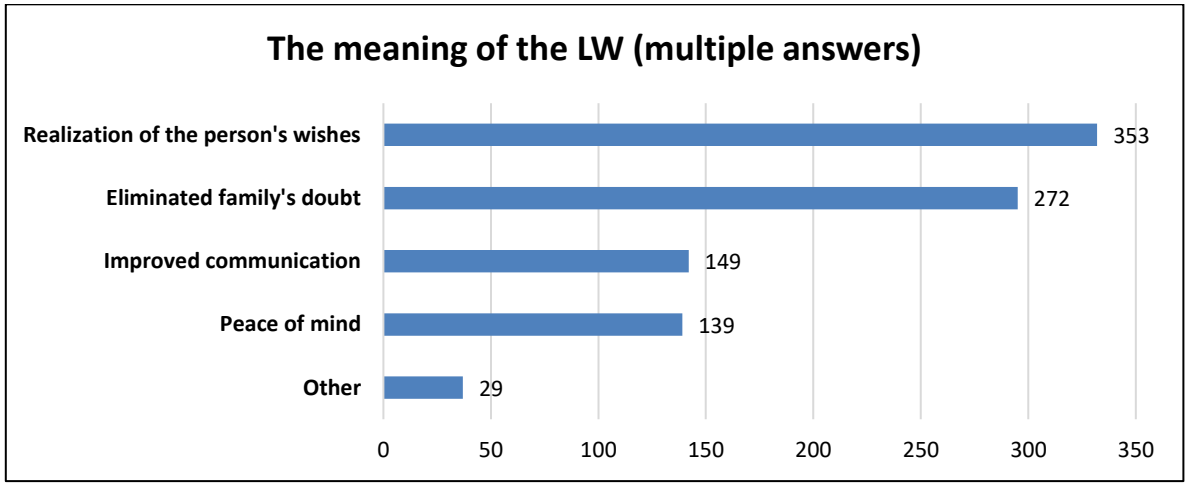
◆ When my mother (92) applied to enter a long-term care facility, we explained her views on dignified death, but the facility initially refused her admission. Nevertheless, by patiently explaining the importance of dignified death and presenting her membership card, we were eventually able to gain their understanding. She passed away peacefully in her sleep at that facility, which brought us great comfort. I hope that the concept of dignified death will become more widely understood. (Okinawa Prefecture)

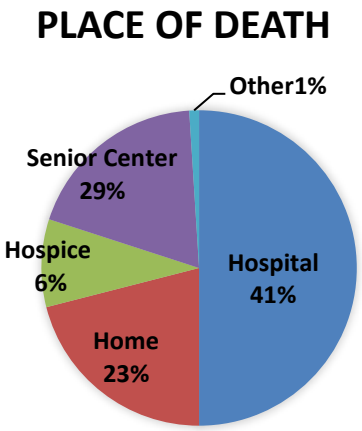
Our Telephone Medical Consultation Service and the “Little Lighthouse Project” Are Always by Your Side

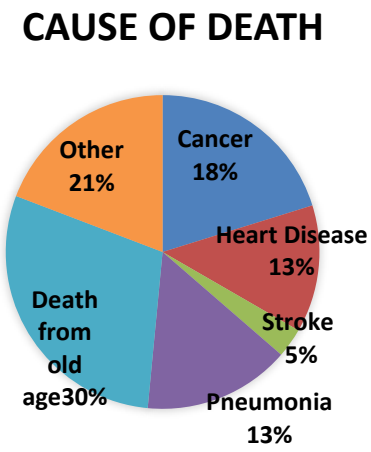
The results of the 2025 bereaved family survey have now been compiled. While some respondents shared that having a living will helped deepen family bonds and enabled a parting they could accept, others expressed distress over the reality of being unable to receive adequate palliative care. Since its founding, the Society has consistently advocated for a social system in which palliative care is available to address all forms of pain and suffering. This year, the Ministry of Health, Labour and Welfare revised its evaluation of palliative care for non-cancer patients, newly extending coverage to patients with end-stage respiratory diseases and those with end-stage renal failure.

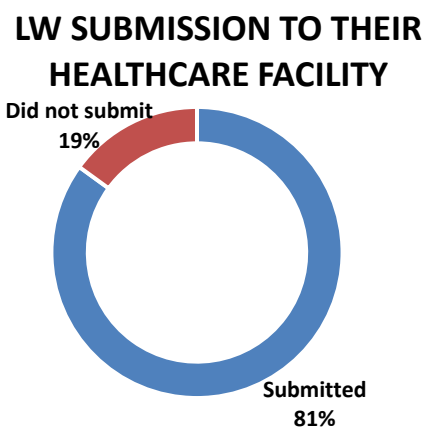
In 2025, we received responses from 523 individuals. Of these, 422 respondents (81%) had communicated the living will (LW) to medical professionals. In response to the question, “Was the LW accepted?”, 77% answered, “It was fully accepted,” and 19% answered, “It

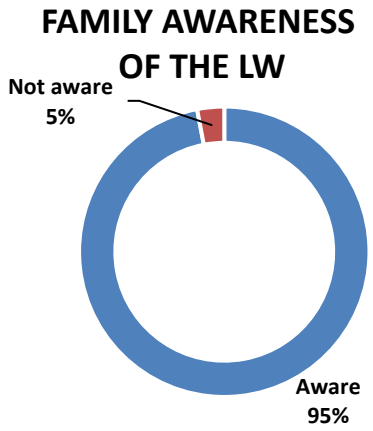
was somewhat accepted," meaning that a total of 96% of bereaved families recognized the effectiveness of the LW.
When one becomes aware of a loved one's approaching end of life, or when one begins to contemplate one's own final stage, emotions often waver and anxiety arises. At such times, the Society offers its telephone medical consultation service as well as the "Little Lighthouse Project." We sincerely hope to serve as a source of emotional support for all of you.
We extend our heartfelt gratitude to those who kindly responded to the survey despite being in the midst of profound grief.

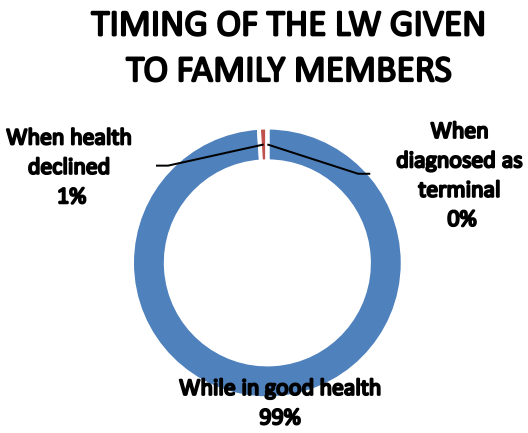


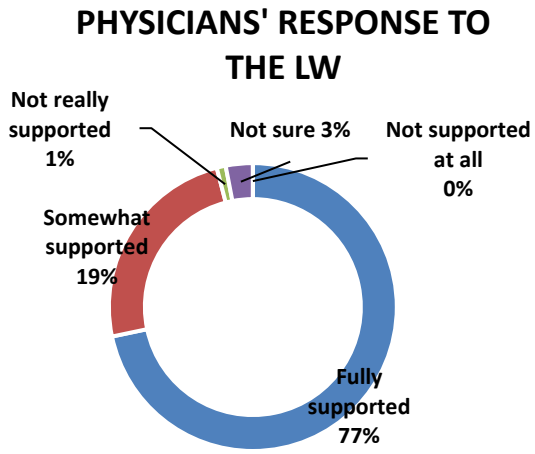


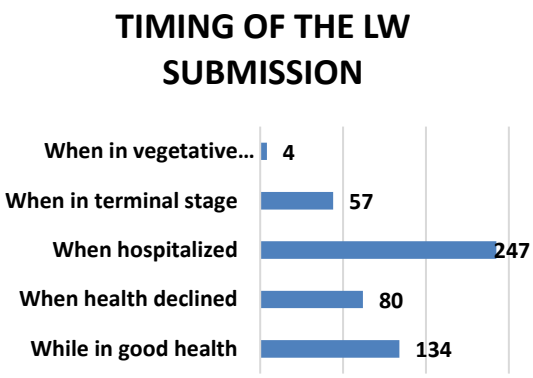


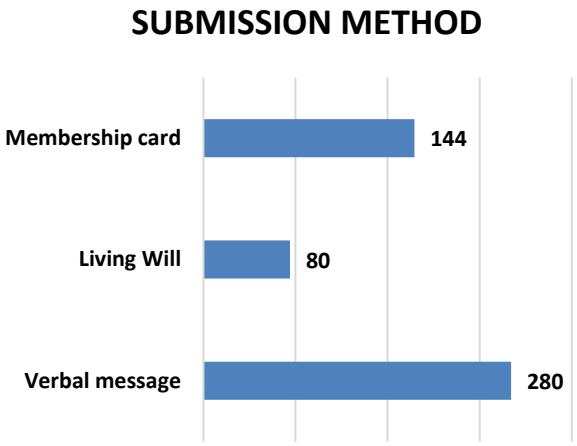

LW SUBMISSION TO THEIR HEALTHCARE FACILITY
Did not submit 19%
Submitted 81%


FAMILY AWARENESS OF THE LW
Not aware 5%
Aware 95%


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


PHYSICIANS' RESPONSE TO THE LW
Not really supported 1%
Not sure 3%
Not supported at all 0%
Somewhat supported 19%
Fully supported 77%


TIMING OF THE LW SUBMISSION
When in vegetative... 4
When in terminal stage 57
When hospitalized 247
When health declined 80
While in good health 134


SUBMISSION METHOD
Membership card 144
Living Will 80
Verbal message 280

From the telephone and email medical consultations

22

Advice on “Mental Health in Older Adults”

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.

We present a consultation received from an elderly individual and offer some basic perspectives and ways of coping.

Q: I am a 79-year-old woman. As I have grown older, I find myself feeling low and depressed more often. When I talk to my friends about it, they simply say, “It’s something that happens as you age.” In the mornings, I am able to stay busy with household tasks, which helps distract me. However, around 2:00 to 3:00 in the afternoon, worries about the future—such as whether I will be able to move into a care facility—begin to arise one after another, and my mood declines.
How can I cope with these feelings of depression?

A: As people age, it is not uncommon for them to feel low due to changes in physical strength, environment, and concerns about the future. In particular, even if one is occupied in the morning, having more free time in the afternoon can allow worries and anxieties to surface more easily. This is not unusual, but rather a natural emotional pattern experienced by many older adults. It is important not to push oneself too hard.
As a way of coping, it is first important to accept that “feeling anxious is natural.” Rather than trying to suppress anxiety, simply acknowledging, “I am feeling anxious right now,” can help bring some calm. It can also be effective to plan small activities in advance for the afternoon, when one is more prone to feeling low. These might include going for a walk, shopping, calling someone, listening to music, or enjoying tea time. Even small plans are sufficient. Creating moments that direct attention outward can help prevent overthinking.

It is important not to cope alone

If the anxiety relates to the future—such as concerns about entering a care facility—it may be helpful to consult a local comprehensive support center and obtain concrete information about long-term care insurance systems and estimated costs. Vague anxiety can weigh heavily on the mind, but gaining information can provide perspective and help organize one’s thoughts.
However, if low mood persists for more than two weeks, accompanied by symptoms such as loss of interest or pleasure, difficulty sleeping, or loss of appetite, depression may be a possibility. In such cases, it is important not to hesitate to seek medical advice.
Depression in older age often improves with appropriate treatment. Feeling anxious as one grows older can also be seen as a sign of caring deeply about one’s future life. Having days of low mood does not mean one’s life has been a failure. With age, there are naturally days

when the mind feels fatigued. These feelings are not a weakness, but something that arises naturally, especially for those who have experienced many losses over time. It is important not to carry these burdens alone, but to seek support from others and from professional services, and to gradually find ways to lighten the emotional load.
(Keiko Furuta, Medical Consultation Counselor)

Translation: Open AI. (2026). Chat GPT(April 17 version). https://chat.openai.com