Scientific Contribution

Moral Reflections on How to Improve End-of-Life Decisions Facing Patients and Care-Givers in Japan

Confusions and Dilemmas of Dying with Dignity

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ABSTRACT

The right to live and, more recently, the right to die, the subject of this article, have been intensely discussed worldwide, no less so in Japan, yet discussions of medical, legal, and ethical viewpoints fail primarily as a result of inadequately defined concepts of dying and of dying with dignity. As a result of this definitional confusion, attending physicians and caring families in Japan have sometimes been judged guilty as intentionally shortening the life of critically ill sufferers at the end of life. Deconstructing the conceptual confusions swirling around concepts of dying and death with dignity is a particularly timely activity. More and more people today are having to consciously confront their own mortality, often in a healthcare setting and determine how best to proceed in the last phase of life. Considering these end-of-life topics is both highly personal and yet deeply social, since what each person does affects those involved in the situation and those in the greater society.

First, I suggest that the ‘terminal stage’ of a person’s life be defined as beginning with ascertaining the terminal stage of a disease or condition (terminal stage of disease or condition) precipitating the end of life (terminal stage of life). Predictability of survival time is surely uncertain at the beginning of the terminal stage of a disease or condition, but prediction becomes easier near the end of the terminal stage, when very close to death (terminal stage of life). This article reconsiders the concepts of dying and of dying with dignity and other related terms, first by visiting benchmark laws, rules, and guidelines found mainly in Japan and in the USA, by outlining some original and fundamental principles often overlooked in medical, legal, and moral controversies. In the course of this analysis, the article also touches on the currently evolving patient-physician relationship, the role of the family member(s) in determining a patient’s will to survive, and the role that government plays in making caring for terminally ill patients a part of the larger formula for a more nearly just society.

Keywords: dying with dignity, imminent death, life-prolonging procedures, terminal stage of disease, terminal stage of life, palliative sedation, murder, suspension from medical practice, medical governance

1. Introduction

Discussing matters of life generally and, more particularly, matters of dying, without considering some concept of dignity is nearly unimaginable, since dignity has become a core concept of the ethical conversation relating to dying. However, too many people enduring a terminal illness have found just that: dying without dignity. The fact of dying, the last part of a person’s life, confronts patients and healthcare professionals with theoretical problems relating to fuzzy and changeable definitions of dignity and medical futility as well as more practical problems relating to deciding when to withhold or withdraw life-sustaining medical procedures, and when and how a patient’s living will should be honored.

My own medical professional experience has shown me that terminally ill patients become confused when they are informed that they have only about six months to live. What is worse, they do not understand how best to live and die through the terminal stage, even if they are physically and mentally competent to decide these difficult matters. Physicians and their medical team also become flustered, sometimes compromising their medical performance. These problematic concerns are also found in the relationship between patient and family. Because of his or her position, the attending physician is intimately and seriously involved, regardless of personal sentiments and specialized medical knowledge, to terminal patients. One of the ways to approach contemporary issues in dying with dignity is to examine old and new concepts, by reviewing important and representative judicial cases.

2. Leading judicial decisions regarding death of terminal patients in Japan

The following summary of judicial cases relating to terminal patients in Japan is by no means exhaustive, but the cited cases are important because they have affected and colored how discussions of dying and dying with dignity take place in Japan.

2.1 Yamauchi criminal case in 1962

The Nagoya High Court sentenced a son to one year in prison and three years of probation in 1962. Article 202 of the criminal code, contract murder was applied. The son's father had developed cerebral bleeding, with extremities frozen in a flexed position, resulting in severe pain when he moved. His agony was so terrible that he demanded to be killed; in desperation, the son tried to terminate his father's life by giving him lethal doses of insecticide. According to the attending physician, the patient would die within seven to ten days.[7,10,22] The Nagoya case is the first in which judicial requirements were issued for legalizing euthanasia. Partly as a result of this Nagoya case, the world's first legal attempt to define criteria for the lawful use of voluntary active euthanasia was articulated. The definition of lawful euthanasia is as follows: 1) In a terminal stage in which death is unavoidable and imminent. 2) Unbearable pain and no alternative measure for removing pain. 3) Just to alleviate pain. 4) At the sincere request or with the permission of the patient when conscious and competent. 5) A doctor, in principle, must perform the task of euthanasia. 6) The method of euthanasia must be ethically acceptable. However, the adaptability and further application of these criteria have never been considered until recently.

2.2 Tokai University Hospital case in 1995

The Yokohama District Court issued a ruling to a doctor in 1995, with two years in prison and two years of probation. Article 199 of the criminal code, murder, was applied. In response to the ruling, the medical ethics council of the Ministry of Health, Labor and Welfare suspended the doctor from medical practice for three years.

In the 1991 Yokohama District Court case, the patient rapidly deteriorated and went into coma, resulting from advanced multiple myeloma. An attending physician estimated imminent death within one to two days. Nevertheless, the eldest son demanded to immediately end to the patient's agony, so the attending physician injected potassium chloride to cause death, after administration of several other sedatives failed to allow the patient to die.[7,10,19]

The Yokohama District Court issued four legal requirements for lawful euthanasia: 1) The patient must be suffering from unbearable physical pain. 2) Death must be unavoidable and imminent. 3) Every possible palliative treatment and care must have been provided to ease the patient's pain and suffering, and no alternatives must be available. 4) The patient must have expressed a clear and voluntary desire to have his or her life shortened. The court extended its criteria which admitted the withdrawal of treatment based on the patient's close family, acting as surrogates.

The Yokohama District Court case is thought to have derived from poor team medical practice in which the attending physician alone was pressed to act, using all his medical knowledge. The attending physician alone was left to take all responsibilities to handle medical decisions. At the time, the patient's situation seemed to

be medically futile and death was imminent. Therefore, taking extenuating circumstances into consideration, I find that the attending physician experienced sympathy with the patient's condition and succumbed to the strong demand by the family to stop or withhold ongoing treatment, which allowed the patient to die without any more burdens. Although the patient's imminent death was not specifically explored in the trial, from the ordinary clinical standpoint, the patient seemed to be in imminent death. To terminate his unbearably miserable state, the life-prolonging procedures could be withdrawn in compliance with the family's demand with presumed knowledge of the patient's will, before going into coma or into some mentally incompetent state. Such a situation described in the Yokohama District Court case highlights the temporal limit of a physician's duty to treat a patient.

2.3 Kawasaki Kyodo Hospital case in 2009

In the Kawasaki Kyodo Hospital case, a patient was rushed to ER due to a severe bronchial asthma attack on November 2, 1998, and later died on November 16, 1998. The physician was arrested and prosecuted in 2002. The Yokohama District Court ruled three years in prison and five years of probation, in 2005. The Tokyo High Court ruled one and a half years in prison and three years of probation, in 2007. The Supreme Court ruled one and a half years in prison and three years of probation, in 2009, finally, seven years after her initial arrest, eleven years after the patient's death. In accordance with Article 199 of the criminal code, murder was applied. The medical ethics council suspended the doctor for two years of medical practice. This is the first case of the Japanese Supreme Court conclusion relating to wrongful termination of life.[7,12]

This patient had bronchial asthma and had been under the care of the sentenced physician for about 14 years. After admission, the patient was kept under sedation with temporary use of a respirator and subsequent use of an endotracheal tube with spontaneous breathing, to prevent airway obstruction. The patient was clinically diagnosed with pneumonia and signs of disseminated intravascular coagulation, based on observing conditions consistent with cerebral death. The attending physician conveyed her message to the family that the limit of medical practice had been reached; the patient deteriorated progressively. Fourteen days after admission, his endotracheal tube was extubated with the consent of the family to bring natural death. Subsequently he developed signs of bronchial spasm. The physician tried to ease the obstruction by giving muscle relaxant. Muscle relaxants ordinarily help reduce spasm of bronchial muscles, with an appropriate dose, as well as respiratory muscle paralysis resulting in respiratory arrest, even when the dose was thought to be appropriate. The Supreme Court confirmed the doctor's medical error in 1) premature decision of the imminence of death, because the patient was in hospital only 14 days after admission; 2) medical determination of withdrawing the endotracheal tube at her own discretion, with no consultation with other physicians; and 3) an excessive amount of muscle relaxant.

3. Traditional definition and my favored views of terminal disease, dying with dignity, and patient's living will

A terminal disease is semantically comprised of two stages, the terminal stage of disease and the terminal stage of life. The terminal stage of disease is a period when physical and mental functions decline considerably; the terminal stage of life is a period when life is ending.[2,3,4] According to the California Natural Death Act of 1976, dying with dignity (originally natural death) is defined as withdrawal or withholding life-prolonging procedures that only help postpone impending death, the moment of death. Dying with dignity is limited to the natural death of a patient who refuses life-prolonging procedures in advance, but willingly accepts life-prolonging treatment while it is in effect. In the original definition of life-prolonging procedures - not treatments - physicians ethically and medically may be allowed to withhold or withdraw life-prolonging procedures only during the terminal stage of life.[15] Presumably, even in a fairly stable terminal stage of disease, a physician may rationally eliminate absurd and intractable sufferings, but may not intentionally hasten a patient's death.

I would like to emphasize the term

'procedures' instead of 'treatments', because the term 'procedures' is the most thoughtful expression. Considering the original description, the physician may withdraw or withhold life-prolonging procedures that only postpone the moment of death. An indirect consequence of withholding or withdrawing a procedure terminates life as a life would naturally end, without intervention. The act of withdrawing or withholding a procedure no longer shortens life, but makes that life end naturally at the expected time. When death is imminent and the limit of a physician's moral and legal obligations to treat the patient are fulfilled, then the artificial life-prolonging procedures may be withdrawn or withheld.

Even if the original definition of dying with dignity simply involves a patient refusing life-prolonging procedures, requesting or producing a living will, I propose a broadened interpretation to include the wishes of immediate family members who know the patient well and on a daily basis. This extension of family surrogacy seems to be rational, practical, morally defensible, medically prudent, and acceptable at the levels of the judiciary and government, since the patient is already in imminent death and life-prolonging procedures simply postpone the moment of death. The patient will die shortly thereafter; at any rate, dying in this context is an unavoidable outcome with no effective medical procedure available. This special instance to let the patient die by means of withdrawing or withholding a procedure might be allowable in Japanese criminal law. Medical practices resulting from withdrawal or withholding a procedure might be ethically defensible. However, it seems certainly prudent for medical professionals to be more conservative about applying criteria from criminal law on such occasions.

4. Textbook-like definition of euthanasia

There are surely some ways to remove uncontrollable pain. One extreme measure is to shorten life explicitly by giving lethal injection or by taking a proven lethal sedative. In order to appreciate the complexity of such a scenario, let me briefly introduce definitions of euthanasia.

Voluntary active euthanasia intentionally shortens life by injecting a lethal dose of sedatives to reduce suffering. In several countries, such a practice is legally permissible when death will occur within six months; in Japan, however, such a scenario would be acceptable only when death is imminent. Physician-assisted death, a fairly new concept in Japan and the only such concept presently accepted, intentionally shortens a patient's life by taking lethal sedatives, unassisted, which are prescribed by a physician. Such physician-assisted death is an instance of euthanasia. Although the scenario described is an apparent suicide, the scenario depicts a deliberate shortening of life; this practice has been described by some ethicists as dying with dignity.

Voluntary passive euthanasia hastens death intentionally by actively withholding or withdrawing medical treatment.[13] Non-voluntary euthanasia (sometimes known as mercy killing) is conducted when the explicit consent of the individual concerned is unavailable, such as when the person is in a coma. Involuntary euthanasia is performed against or without the expressed will of the patient.

5. Death by euthanasia and in dying with dignity

The terminal stage of the chronically and seriously deteriorating patients facing imminent death is the time to withhold or withdraw the artificial measures which are only useful in postponing the moment of death. Needless to say, the terminal stage of life is also a reasonable time to let the patient die because the end of life is imminent. This medical conduct, however, must be practically, ethically, and medically approvable conduct. In this phase of imminent death, determining when to quit the life-prolonging procedures, even at the end of life, is difficult. As well, determining when to quit continuing medical treatment which is still useful in alleviating suffering and saving life, even if personal entreaty of forgoing treatment is explicitly expressed by the patient and family members, is far more difficult.[11] These determinations are apparently not within the scope of dying with dignity but within the scope of euthanasia.

6. Fundamental subjects to be elucidated

6.1 Death as imminent in euthanasia and in dying with dignity

Sometimes called Death with Dignity Acts or Living Will Acts, the world's first natural death law, enacted in 1976, the California Natural Death Act considers situations when death is imminent, meaning when the person is facing unavoidable death[5,9,15]. While the term "imminent" is not clinically defined, it is generally understood to be about two weeks.[5] I would like to emphasize the term 'procedure', contrasting it with 'treatment', because I believe the term 'procedure' is a more thoughtful and helpful expression. Namely, under these situations, any medical practice is no longer a medically beneficial treatment, but only a procedure utilized to postpone the moment of death.

In the Yamauchi criminal case in Japan, the attending physician informed the patient of impending death within seven to ten days. According to that rule, the court seemed to accept that seven to ten days met the demand of one of the six requirements for active euthanasia: death being imminent. This is the first judicial suggestion of imminent death in relation to active euthanasia in Japan.[22]

In palliative care medicine, if the estimated mean survival of the patient is within two to three weeks, and it has been unanimously agreed among patient and family as well as care team, then deep sedation may be employed. This is not physician-assisted suicide, but natural death.[14,16] Following this definition, death is imminent when the expected mean survival days are within two to three weeks. Palliative sedation is defined in scientific documents and guidelines as the use of sedatives to reduce a patient's level of consciousness until the time of death, with the aim of relieving symptoms from a terminal illness that cannot be controlled by any other means.

6.2 Death will occur in euthanasia

In the Oregon Death with Dignity Act, enacted in 1997, terminal disease means an incurable and irreversible state that has been medically confirmed and will, with reasonable medical judgment, produce death within six months.[17]

In Japan, a governmental formal opinion does not define the numerical period of terminal disease uniformly and prudently suggests that the physician and care team decide what condition is a terminal stage for the patient by consideration of the particular conditions of the patient, by providing a multi-dimensional perspective, emphasizing medical validity and appropriateness. The government opinion mentions that life expectancy can sometimes be estimated as from several days to two to three months in cancer patients. However, in chronically debilitated patients, it is often difficult to estimate life expectancy because they tend to repeat exacerbation and recovery and gradually migrate to the end of life. In these latter cases, the period of transition is relatively long and unpredictable.[6]

Japan Medical Association (JMA), the largest association of medical doctors in Japan, defines the terminal stage of life as when the disease progressively deteriorates and the medical team decides that the patient will die, even with the current best practice of medicine. JMA does not propose the period of terminal disease. Noteworthy for this discussion is the definition of terminal stage as not applicable as long as the process of clinical conditions stably and gradually changes, even when death will occur within several months.[20]

Recently, most organizations concerned do not describe the terminal phase as a numerical expression. This seems to be prudent because of the difficulty in predicting chances of survival; however, broadening of the concept of terminal illness should not be pushed to an ambiguous limit. It is risky if the terminal period is extended beyond the ordinary limit of life in the common sense. Defining the terminal stage too broadly may be unsafe when death will occur, but imminence of death is unpredictable. If the terminal stage were so broadly defined, people might be insidiously forced to lose the right to live.

7. Several unanswered points of views

7.1 Self-determination on how to die

At first sight, acts of physician-assisted-suicide appear to pay great respect to the right of self-determination by the patient. However, self-determination in this end of life context should not be forced by surroundings such as family, economy, society and others. End of life situations are full of problems when considering whether to withdraw or withhold medical treatments still considered effective during the terminal stage of disease. Nonetheless, withdrawing or withholding life-prolonging procedures which are merely effective in prolonging the end of the terminal stage of life facing imminent death is morally and medically defensible.

7.2 Why patients choose physician-assisted suicide in Oregon

The most recent reasons(2016)for patients choosing physician-assisted suicide in Oregon are loss of ability to engage in activities making life enjoyable (96%), loss of autonomy (92%), loss of dignity (75%), perceived burden on family, friends, and caregivers (48%), loss of control of bodily functions (36%), inadequate pain control or concern about it (29%).[18] I am disappointed that patients seek death in order to avoid annoying their family members, rather than seeking a good death without suffering or a natural death. Not wanting to be a burden or glorifying a premature death are insufficient reasons to end one's life.

7.3 When should we withdraw or withhold treatment?

The 1976 California Natural Death Act defines a life-sustaining procedure in the following manner: "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent, whether or not such procedures are utilized.[15] The California Natural Death Act does not distinguish between withholding and withdrawing life-sustaining procedures. For example, removing a respirator from a patient is considered the same as never having started it. This lack of distinction encourages heroic measures be taken in times of uncertainty, with the understanding that a patient can be discontinued at a later point if the heroic measure was ineffective, of little benefit, or even a burden to the patient.

I argue that it is reasonable to withdraw or withhold life-prolonging procedures when a patient's death is imminent, and it is also the time when the limit of medical practice has been reached.

7.4 Prediction of survival time

The palliative prognostic index is being used to estimate the survival prediction of terminally ill cancer patients. This index is a scoring system, defining performance status, oral intake, edema, dyspnea at rest, and delirium. Survival between six to three weeks can be acceptably predicted. This estimation of mean survival period, also supported by many other similar studies, is used to perform palliative or total sedation (formerly called terminal sedation) by following a flow chart. First, patient, family, and palliative care team jointly evaluate the patient's conditions. When the estimated mean survival time is within two to three weeks and patient and family as well as care team are in unanimous agreement, it is a time to employ deep sedation. This latter situation is not physician-assisted suicide, but natural death. Following this key concept, I define death as imminent when the expected mean survival time is within two to three weeks, at least in the case of cancer patients.[8,14,16]

In the terminal period, life expectancy is approximately estimated by considering the median survival time studied, including disease stage and related health conditions (age, complication, comorbidity), particularly the terminal stage of disease. Actual patient death occasionally precedes or postdates a medical estimation. Medical practice in this context shows that life expectancy is less accurate at the

beginning of the terminal stage of disease and more accurate at the beginning of the terminal stage of life.

7.5 Self-determination for patients and the limit of treatment obligation for the physician.

At the end of a patient's life in which the limit and fulfillment of the physician's obligation as a matter of professional and practical decision-making has been fully expressed, physicians are allowed to withhold or withdraw life-prolonging procedures, as long as the estimated will of the patient is repeatedly conveyed by the entire circle of close family members or designated surrogates.

7.6 Transition of a patient's will from the stable period to terminal stage of disease and of life: fluidity of patient's wishes and family surrogacy

Throughout examination and treatment in long-term outpatient clinics, physicians generally have a chance to talk with patients about how to meet the end of life. It is not infrequent for patients not facing life-threatening disease to thoughtlessly say they want to die rapidly, in order to avoid suffering and dependence on others for basic bodily care. However, once they develop a life-threatening disease, dying patients expend much energy in frankly exchanging information and consent. Even in cases of the closing moment to the terminal stage of life, physicians can confirm the patient's immediate consent to withdraw or withhold medical treatment. Consequently, once we can define that current life-prolonging treatment is no more than life-prolonging procedures, it is time to decide to let the patient die naturally with the expressed wishes of the dying patient conveyed by close family members or friends, acting as surrogates.

It is, however, not realistic and even inhumane to demand immediate consent from a dying patient. Physicians at least do not have to intrude to actively hasten death. When the patient is facing imminent death, when the physician and medical team have reached the current limit of medical practice, family members can give their consent to withdraw on-going medical treatment with the patient's presumed wish or with the best interest for the patient in mind. Both criminalized physicians in the two criminal cases in Japan discussed above unfortunately engaged in medical misconduct, despite their good intentions. Let us hope there will be chances for both physicians to be exonerated from the homicide murder convictions.

Physically and cognitively frail patients are prone to be induced to decide a matter. A deteriorating patient tends to clearly decline a life dependent on others, especially when the patient was previously fairly active. A previously empowered person, now a deteriorating patient, is often frightened when life-threatening illness occurs. The patient is still relatively independent; however, as the disease advances and the patient becomes frailer, he or she finds it difficult to make and articulate decisions. Finally, the dying patient tends to be dependent and implicitly prone to be induced by others. At this complex and vulnerable stage, immediate wishes are influenced largely by environment and sometimes fairly different from the wishes formed during less threatening health conditions. The patient's estimated wishes or estimated benefits are sufficient enough or even more compassionately expressed when conveyed and confirmed by close family of the patient.

7.7 Fragile and fragmented relationship of trust between patient and physician

In both criminal cases cited above, physicians were claimed to have neglected or failed to care properly for the patients in their care. Namely, they did not properly explain the highly probable restoration of life and of quality of life resulting from medical progress. Family members tend to waver, particularly between prolonging life and preventing intolerable suffering. Commonly, patient and physician exchange views on benefits, burdens and prospects of treatments. The most inconclusive issues are when to withdraw current treatment, when to withhold new treatment, when death is imminent and when the limits of current medical practice have been reached. Even after the repeated explanations and consents given in the Kawasaki Kyodo Hospital case, the physician extubated the endotracheal tube, fully expecting natural death, but family members of the patient

appeared still hesitant to face death, striving instead to avoid the burden of decision-making themselves.

A conscientious and compassionate physician closely conducts treatment of the patient and informs family members; however, all too frequently, a physician may also misunderstand the last wishes of the patient and family members. The relationship of trust between patient and physician suddenly and easily sours, and in the cases cited above, unforeseen circumstances led to criminal prosecution of the medical staff, with prison, probation, and suspension of medical license.

The preceding statement accords with what many ethicists regard as dying with dignity. However, in the original description of death with dignity that appeared in the California Natural Death Act, demanding the withdrawal or withholding of medical treatment, only when death is imminent, the life-prolonging procedures merely postpone the moment of death.[15] The period prolonged by artificial life-prolonging procedures is not during the terminal stage of disease, but in the terminal stage of life. In this regard, this act of withdrawal or withholding treatment terminates the life as ending naturally. During the patient's terminal stage of life, the physician expects and anticipates the end of life and limits of the use of current medical procedures to continue or restore life.[2,3,4] This medical act no longer shortens life, but ends life naturally at the expected time. This is a traditional concept of dying with dignity, and physicians should not be considered abusing their medical professionalism by abiding by this more natural and traditional approach to dying.

In situations of voluntary passive euthanasia, the competent patient—or at least competent when signaling expressed wishes—acquiesces to withholding or withdrawing life-sustaining treatments, even when daily life is still nearly entirely practicable, leading to premature death. The described scenario is a deliberate act to shorten life; this is not a natural death, but euthanasia. This immediately preceding scenario is really self-determined death and is regarded as euthanasia because of intentional shortening of life or as a modified form of dying with dignity. This scenario places first priority on the patient's right to self-determination; precisely in such scenarios, how best to practice medicine is actually very intricate. When the patient is mentally incompetent for his or her immediate decision, people closely involved, usually family members, have to seek the best interest of the patient as to whether the treatment is futile or beneficial. This method of death is self-determined death and is regarded as euthanasia because of intentional shortening of life or at best a modified dying with dignity.

7.8 Transition from the terminal stage of disease to the terminal stage of life

With a strict definition of life-prolonging procedures—not treatments—physicians ethically and medically may be allowed to withhold or withdraw life-prolonging procedures during the terminal stage of life. Even in a fairly stable terminal stage of disease, a physician may rationally eliminate absurd and intractable sufferings, but may not intentionally hasten a patient's death.

I would like to emphasize the term 'procedures' instead of 'treatments', because the term 'procedures' is the most thoughtful expression. Considering the original description, the physician may demand to withdraw or withhold a procedure, when death is imminent, withdrawing or withholding life-prolonging procedures that only postpone the moment of the death. An indirect consequence of withholding or withdrawing a procedure in order to alleviate suffering in effect terminates the life as a life would naturally end, without intervention. The act of withdrawing or withholding a procedure no longer shortens life, but makes that life end naturally at the expected time. Traditional dying with dignity (natural death) is defined to mean natural death without shortening life. When death is imminent and the physician's moral/legal obligations to treat the patient are fulfilled, then the artificial life-prolonging procedures may be withdrawn or withheld.

The definition of the term when life is coming to an end is inherently vague. The broad public discussion concerning end-of-life decisions for people experiencing the terminal stage of disease or in an otherwise terminal stage of life too often exaggerates and oversimplifies concepts of dignity and absence of dignity. Even

in the terminal stage of disease, decent daily life can be promising. Public discussions of this topic appear to talk in stark dichotomies, such as existence as 'worthy' or 'unworthy', 'living in dignity' or 'living without dignity'. These simple dichotomies do not serve the more complex discussion about how to handle the question of withholding or withdrawing life-sustaining treatments. We should also be careful of the tendency to glorify dying with dignity, and we should not hasten death, even in the terminal stage of disease. There is no need for patients to feel morally or socially diminished to live with the proper social support of professionals and family members, nor should patients feel they are a burden. As a physician and as a layperson, I suggest that patients remain indifferent to questions of dignity or indignity, until the artificial prolongation of death starts. Suffering patients should have no hesitation in availing themselves of medical and social assistance.

Finally, I would like to provide the reader with some essential statements relating to end-of-life issues, taken from the WHO's definition of palliative care. WHO affirms life and regards dying as a normal process, and healthcare staff are charged with neither hastening nor postponing death, by providing patients with a support system to help them live as actively as possible until death.[21]

7.9 Insufficient total support in terminal care

A close cooperation within the medical team must be exercised to a greater extent. Social and even medical supports in Japan are still unsatisfactory for patients suffering from a terminal disease and their families.[2,22] Patients and families are often exhausted and bewildered, and families sometimes confusedly sanction the killing of the ailing family member. These incidents are not uncommon, particularly in cases of home care. The medical community in Japan is understaffed and overworked. Subsequently, unbelievable medical events occur; too often without guidance, novice staff must quickly analyze both the medical and moral implications of treatment, while the medical team works to mitigate the burden of the attending physician, deterioration of communication quality, excessive professional obligations of the physician, physicians' unjustifiable termination of life based on sentiments of sympathy for or empathy with the dying patient facing imminent death and the failure to communicate well with the patient's family members who want to stop the suffering.

Judicial decisions focus predominantly on the criminal aspect of purported misuse of euthanasia or even attempted murder. Such trials often progress without appreciation of the reality of the complicated conflict having occurred in the context of a healthcare facility dreadfully understaffed and underprepared for such medical-moral challenges.

To overcome the struggles in the medical field and to accomplish satisfactory outcomes in terminal care, comprehensive medical guidelines for terminal care are required, including how to withhold or withdraw the medical treatment or procedure in a morally justifiable and legally defensible manner. Such proactive moral justifications and legal defense of withdrawing or withholding a medical procedure should strive to clarify, through clear thinking and with a positive attitude, a rational interpretation of key concepts and documents relating to the terminal stage of life.

There has been controversy in the literature and in clinical practice regarding what constitutes medically futile intervention. This paper, however, limits itself to the use of interventions in patients experiencing impending death. Healthcare facilities in Japan, whether large or small, should adopt a policy on medical futility, to ensure that policies on medical futility are expressed by a fair way, as described above.

It is medically and ethically required that ordinary medical practice proceeds properly with the right of self-determination of patients, providing adequate medical information. In the judicial context, it is conceivably criminal to withdraw medical treatment, but not criminal to withhold medical treatment. It is thought rational for doctors, in reference to their professional responsibility, to either withhold or withdraw medical practice when the restoration of life is no longer possible or sustainable. It seems reasonable for doctors to do so as a conclusion to open and professional consultations with the patient, the patient's family members and within the care team. Sometimes, physicians cannot

definitely determine imminent death. Even if the practice is medically futile and physicians can terminate the procedure, it is morally required to obtain the approval of the family. When death is not imminent, but death will occur, withdrawal and also withholding treatment might be regarded as deliberate and hastening death and are likely to be considered criminal.

Physicians negotiate transitions from aggressive treatment to palliative care with patients and their families. Ultimately, respect for persons and beneficent approaches can lead to morally defensible resolutions. Such outcomes are not always possible, but with compassion and clinical expertise, physicians and the care team can frequently achieve a morally defensible resolution.

7.10 Suspension from medical practice: further distress for physicians

Let us consider legal liability of physicians in Japan, in the context of end of life decisions. Almost all physicians in Japan are authorized to treat patients covered by universal health insurance plans. Physicians are subject to a suspension measure under the provisions of Article 7 paragraph (2) of the Medical Practitioner Act. Indeed, in response to the ruling, the medical ethics council of the Ministry of Health, Labor and Welfare suspended a Tokai University Hospital physician for three years from medical practice and suspended another physician for two years in the Kawasaki Kyodo Hospital case. Although both physicians were deemed malicious murderers and sent to prison, their conduct still might be reduced to involuntary manslaughter. Curiously, to my certain knowledge, the facts of these cases do not seem to be seriously considered or well-known among medical practitioners, even in the largest medical professional societies. This absence of knowledge might be closely connected with medical governance in terms of medical proficiency in medical conduct.

I would personally like to have open disclosure of the decision process at the ethics council concerned. Sympathetically and in regard to uncompromising application of the law, I would like to draw attention to the following: 1) In clinical settings, the term of mean survival is often determined from the clinical study. 2) The attending physician has enduring responsibilities for deciding how to treat the patient, by himself or herself, or with the help of others. 3) double-effect sometimes occurs unexpectedly. 4) It is not so difficult to expect a frank exchange of views in general between patient and physician, such as the preferred way to face the end-of-life situation in advance. It is curious and significant that the Supreme Court did not provide lawful criteria when and how to withdraw or withhold treatments or procedures. Articulating such criteria is always more heavily complicated in prospective estimation about the end-of-life than in retrospective estimation.

From my personal impressions, I find that the conditions of the patients in the two cases considered in this article appeared to be clinically compatible with imminent death. Further, to my regret, the two main treating physicians noted in the earlier described case were charged as criminally negligent. I would say both treating physicians were victims, because they performed every practice very conscientiously, without any corresponding benefit to themselves. Suppose they had proceeded with treatment without any compassion to the patients and families or with minimum sympathy, and had caused the death of the patients at the very beginning of bodily death. What would have happened? Particularly, in the Kawasaki Kyodo Hospital case, the physician has been a treating physician for years; it is usually and easily expected that the indirect or even vague wishes for end-of-life matters are expressed by the patient. This patient, however, was unconscious and with no chance to express his immediate wishes, and he seemed at the moment of imminent death, from a clinical perspective, even without electroencephalogram. In this case, the physician might have thought it time to withdraw continuing procedures (not treatments) which only prolong the moment of death. In this circumstance, the closest estimated wish of the patient delivered by family for the patient seems to be approvable. This situation is a tragic result which becomes ironic at the confused end of a patient's life, in determining the time to withdraw or maintain on-going treatment. For all people involved in these clinical situations, the conceivable best solution on the spot might be totally different from the conclusion made by

retrospective analysis at another occasion, such as in court.

Physicians have tremendous technical skill and are often compassionate and reflective about end of life decisions; however, these same physicians are woefully underprepared for such decisions, in terms of the law and ethical analyses. Given the legal liabilities and moral difficulties of such end-of-life situations, I, as a layperson, wonder if there is no other way to qualify or limit a physician's list of treatment options for patients at the end of life.

7.11 Medical Governance

Highly professional medical conduct should not be subjected to interrogation by police or prosecutor, as would be the case of a murder. Physicians handling medical events at a patient's end of life need to be performed consistent with the guidelines and rules of the medical profession and based on sound ethical reasoning. These guidelines and rules incorporate the language of patients' right to self-determination and the right to live or the right to die, when rationally examined criteria have been carefully applied.

When the patient is incompetent to express his or her wishes, the family and medical team must cautiously, repeatedly, and extensively exchange views seeking the best resolution in the best interest of the patient. Family members too have the right to convey the patient's rational wish estimated from his or her daily life before a sudden tragedy.

When treatment is in full progress, medical practice is generally considered rational. However, when the results of treatment are studied retrospectively, medical practice sometimes is judged as rationally unjustifiable. It is common to encounter friendly cooperation during treatment, but hateful conflict during trial. More importantly, effective clinical governance is essential for both patients and physicians. Patients will benefit by finding the best resolution to their particular case, and physicians will improve the patients' quality of care. An important effort, in this last regard, is to prevent corruption of the health care system, by assessing the level of transparency and developing a framework for just governance of medical practitioners.[1]

8. Conclusion

Terminal medical care faces one dilemma after another. Patients and families, even attending physicians, are deeply involved in the rather complicated questions that are not completely answerable in a rational sense, to maintain treatment to live or to forgo the procedure, thus hastening death. Sometimes, all participants in this situation fall into chaos, leading to an irrational and tragic end to a person's life. There are serious unanswered and unanswerable questions, such as informed consent, self-determination, limit of medical power, professional negligence, imminent death, to name a few. Finding morally defensible ways for patients, family members, and healthcare staff to move through the last stage of life is an urgent task, ethically, criminally, scientifically, and socially. The patient is not in the terminal stage if the physical condition deteriorates one-sidedly, but remains relatively stable, even at the terminal stage of disease. Basically, treating physicians and medical team as well as the patients and their considerate families and friends need to communicate consistently about the terminal condition. Once again, by visiting more stringent definitions found in important legal and moral assessments, acts, and cases in the history of refining end of life decisions, we can learn more humane and realistic resolutions for our time.

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