Today’s Topics

• Problems of end-of-life care in Japan
  (In some cases, the physician who removed patients from the ventilator were accused of murder.)
  (Some cases I experienced as a family, physician, or as a teacher of clinical ethics)
• Are Living will or Advance directives enough to solve these problems?
• My recommendations to solve these problems.

End-of-life cases I experienced as a family member, physician or a teacher of clinical ethics.

“Do you really not need ACLS for the patient?”

• 75-year-old male with stomach cancer.
• In this admission, he became unconscious. He always said not to prolong the life if the disease is incurable. So his family asked the physician not to carry out ACLS.
• But in the night time, when the heart rate dropped below 40/min, nurse came to the patient’s room with ACLS sets and said the words above.

(The last words one patient wrote)

I want to drink beer or sake a little.

(after taste only one bite)

I feel drunken
Relatives tell the patient’s family members…

- “Why don’t you let that kind of terminal patient be admitted to the hospital?”
- “Doesn’t the physician in Mitsuse Clinic want to give the patient an I.V.?”

The Cultural background of Autonomy
(Rev. from Hiroshi Nakashima)

Individualism in western countries
Mutual dependence on family and close society in Japan

Physicians face a dilemma in end-of-life-care

- 75-year-old male. He has been suffering from hemiplegia and COPD. He said he did not want to live long with the help of medical machines.
- He suddenly felt dyspnea and became unconscious, so his wife brought him to the ER. SaO2 is lower than 60%; chest X-ray showed pneumonia. Antibiotics and mechanical ventilator were started with the wife’s consent.

The difficult case physicians feel dilemma in the end-of-life-care(2)

- The antibiotics and ventilator were not effective. The patient seemed uncomfortable. He tried to pull out the ventilation tube, so he needed restraints.
- The wife asked the physician to withdraw the ventilator, because “It is not the condition my husband wanted in his final days.”
- The only one son who lives in far away, wanted the physician keep the patient alive as long as possible.

Some Questions

How to evaluate the patient is in the terminal stage to determine if the treatment is futile?
Are the advance directives given when the patient is healthy, truly same as when the patient gets sick?
When there are disagreement in the life-prolonging treatment between patient and the family or family members, and medical staff, how should the physician choose?
How to use the scarce medical resources effectively?

What is Clinical Ethics?

The way of solving problems raised from the different sense of values among the Patients, Patient’s Relatives and Medical Staffs. To solve the problems, we need to recognize and analyze them and find consensus through good communication.

Masashi Shirahama
4Box theory by AR.Jonsen et al

<table>
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<tr>
<th>Medical Indication</th>
<th>Patient Preferences</th>
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<td>Contextual Features</td>
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Some aspects we need to address before withdrawing treatment

- **Medical Indication**
  - The effectiveness of the treatment. Is it really futile?
  - The evidence is needed (Ventilation, infusion, etc)

- **Patient’s Preferences**
  - The patient can make the end-of-life plan on the depending on the precise explanation understanding.

- **QOL**
  - Evaluate the QOL now. Is the QOL after the treatment better than now?

- **Contextual Features**
  - Family member’s desire
  - Medical Staff’s desire

Criteria for discontinuing treatment

- There are no clear criteria for discontinuing treatment for patients with no prospect of recovery.
- Therefore, a Health, Labor and Welfare Ministry study panel is discussing guidelines for terminal medical care, including those on life-prolonging treatment and confirmation of patients’ will.

Conditions for discontinuing treatment by Yokohama district court

- -- There is no prospect of recovery.
- -- The patient has expressed his or her consent to discontinuing treatment.
- The court added that even if a patient is incapable of giving consent, withdrawing treatment is legal as long as the family gives consent.

Plan for Death with Dignity Law

- A suprapartisan group to discuss new legislation for a dignified death that does not need life-prolonging treatment was established by 66 lawmakers from both chambers of the Diet in February 2005. A draft outline compiled by the group suggests that patients aged 15 years old or older should be able to decide whether to refuse life-prolonging treatment when there is no prospect of recovery and death is imminent. In these cases, doctors would not be held legally responsible for discontinuing life-prolonging treatment.

The research of end-of-life care

- According to a ministry survey on terminal medical care conducted in 2003, 86% doctors said they face a dilemma in life-prolonging treatment. 84% doctors favor respect for the patient’s will. But only 37% doctors favored the establishment of the Law of death with dignity.
Reservations about the death with dignity law

- The death with dignity law may make it too easy to discontinue treatment because of cost savings.
- The weak-handicapped persons may not be protected.
- The time for this most important communication with the patient and the family may be replaced by an attention to check lists & manuals.

My Proposal (1)

1) Accumulate general evidence about the effectiveness of end-of-life care not only for cancer patients, but also for patients with other terminal disease.
2) Before starting the life-prolonging treatment, the doctor should talk with the patient & family about the possibility of withdrawing the treatment if it is not effective within a certain period.

Medical Futility

When a patient is in the terminal and no medical intervention will improve the patient and/or any intervention makes the patient feel more pain or burden than doing nothing.

In these situation, the medical staff can decide they should withhold or withdraw medical intervention.

Withhold vs. Withdraw

Withhold and Withdraw are said to be ethically equal, but Withhold is easier than Withdraw.

If Withdraw is not permitted, we can not try a possible effective treatment.

I think the doctor should talk about the possibility of withdrawing the treatment if it is not effective within a certain period.

The family members feeling of sudden coma patient.

STOP:Withdrawing ACLS Criteria
(From the student’s handouts of ACLS)

- Satisfaction of the family
- Treatability
- ACLS OK?
- Persistency
My Proposal (2)

3) Talking with patients and families about how the patients want to live their final days.
4) The end-of-life care should not be decided only by one doctor, but with the patient and family and other medical staff to find the best way.
5) The primary care physician who knows the patient’s disease and also the patient’s way of life should join in making the decisions about the best medical treatment regarding end-of-life care.

The 95 years old patient’s desire
1. If I fall in my home, do not send me to the hospital.
2. If I fall unconscious, do not give me life prolonging treatment such as infusion.

The patient’s sign and thumb stamp

The content of Ending-note
(Will for medical treatment is one part)
- Memory of my life.
- How will I be remembered after death?
- What kind of care do I want and in what setting?
- The will for death with dignity, or organ donation.
- Desire for my funeral.
- Whom I want to contact in my last days.
- The content of my will.
- The record of my estate.
Patient’s note: visitors (Dr. Ns. PHN. Home Helper, etc) of this patient write something when they visit and check his condition.

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The similarity of Primary care and Clinical Ethics
(Nobutaro Ban, Nagoya University)

1. Treat the patient as one irreplaceable person, not as one of the patients who is suffering from the same disease.
2. Good Communication is necessary.
3. Not one-way direction from the physician, but dialogue and education are important.
4. The Final Goal is not to cure the disease, but to help the patient live a good life.

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The Advantage of the Primary Care Physician’s Informed Consent

1. The good relationship between the doctor and patient
   • The patient can easily tell his/her wishes to the physician
   • The doctor knows the ability to understand and the background of the patient.
2. PC physician can be a coordinator between the specialist and the patient. He/She can supplement the specialist’s explanation or understand the patient’s anxiety and help the patient to ask what the patient really wants to know.

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Teaching medicine in the community

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Prayer by Niebuhr

God
grant me the serenity
to accept the things I cannot change,
the courage to change the things I can;
and the wisdom to know the difference.

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Thank you for your kind attention
Mitsuse clinic and health care center