Japanese Guidelines for End-of-Life Medical Care

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Background Cases

Tokai University Hospital Case

Yokohama District Court, March 28, 1995

Kawasaki Cooperative Hospital Case

Yokohama District Court, March 25, 2005

Tokyo High Court, February 28, 2007

The Supreme Court, December 7, 2009

Tokai University Hospital Case

[Summary of the facts]

The 58-year-old male patient who was suffering from multiple myeloma and expected to die in several days were making rough and difficult breathing. His son persistently asked the attending physician to liberate his father from the apparent pain (that he felt his father was suffering from) and to allow him to take his father home (after leaving him to die).

Tokai University Hospital Case

[Summary of the facts]

The attending physician at first refused to accept his request, but soon acquiesced and (1) terminated intravenous nutrition and hydration and removed the airway tube, (2) injected diazepam (anxiety medicine) and haloperidol (antipsychotic medicine), both of which have side effect of breathing restraint. However, the patient's condition did not change.

(3) The physician finally injected potassium chloride (KCL), which worked to stop the heartbeat of the patient to his death.

Yokohama district court convicted the doctor of murder and sentenced him to two years in prison with two-year's probation.

Opinion of the Yokohama Dist. Court

◆Elements for justification of active euthanasia

The court opined that four requirements had to be satisfied for a fatal act by a physician to be justified as active euthanasia.

(1) The patient is suffering from the intolerable physical pain.

(2) The patient's death can't be avoided and is imminent.

(3) Other means to remove or ameliorate physical pain have been exhausted.

(4) The patient expressly indicates their willingness to accept the termination of life.

In this case, only element (2) was satisfied, so that defendant's administration of KCL could not be justified.

Opinion of the Yokohama Dist. Court

◆In dictum, the court conditionally justified withdrawal of terminal treatment, saying that:

Withdrawing medical treatment can be permitted under (1)the theory of patient's right to self-determination and (2)the conception of the limits of the doctor's duty that providing futile treatments is not included in their obligation.

◆The court enumerated requirements for justification of treatment withdrawal as follows:

(1) The patient is suffering from incurable illness, has no hope for recovery, and in the terminal stage, and their death cannot be avoided (desirably confirmed by more than one doctor).

(2) There exists the patient's intention to request the withdrawal of treatment. Where there is no explicit expression, their intention can be presumed. In this case, this element was not found.

Kawasaki Cooperative Hospital Case

[Summary of the facts]

The 58-year-old male patient lapsed into a vegetative state after multiple attacks of asthma. The defendant (attending physician), believing that leaving the patient to die naturally would good for him and his family, removed the tracheal tube. However, with his air way closed, the patient showed rough and painful movements. The defendant, after trying several medications to suppress his suffering in vain, administered fatal dose of Myobloc (muscle relaxant: neuromuscular blockade) and let him die.

Kawasaki Cooperative Hospital Case

Yokohama District Court, on March 25, 2005, closely following the reasoning of the same court's judgment ten years before, convicted the defendant of homicide and sentenced her to three years in prison with five year probation (denying the existence of the family's request to remove the tube).

Second instance Tokyo High Court, on February 28, 2007, affirmed the conviction but reduced the sentence to 1 and 1/2 year in prison with three year of probation (affirming the existence of the family's request to remove the tube). The Tokyo High Court emphasized the necessity of legislation or administrative guidelines addressing death with dignity problems.

The Supreme Court, on December 7, 2009, affirmed the High Court's judgment.

Police Investigation of Treatment Withdrawal Cases

◆By the way, in the decade of the 2000s, several cases were reported where doctors involved in the withdrawal of treatment, especially the withdrawal of mechanical ventilation, from terminally ill patients, were subjected to police examination.

◆None of them were indicted. However, it became widely believed that a doctor who withdrew mechanical ventilation from a terminally ill patient, even with the approval of their family and an ethics committee, might face criminal prosecution.

◆Medical personnel and institutions became intensely concerned about starting mechanical ventilation for the terminally ill, for fear that they might be interrogated and prosecuted for its eventual withdrawal.

Development of Guidelines

◆In the late 2000s, governmental departments, professional groups, and academic societies began to publish policies and guidelines for the end-of-life medical care. Namely,

- The Ministry of Health, Labor and Welfare (MHLW), Guidelines for the Decision-Making Process of the End-of-Life Medical Care (May 2007)

  It aimed to provide the terminally ill patient, their family and attending medical personnel with frame of reference for the best medical treatment and care.
- Japanese Society of Intensive Care Medicine (JSICM), Recommendations for Terminal Care of Critically Ill Patients in Intensive Care. (August 2006).
- Japanese Association for Acute Medicine (JAAM), Statement for End-of-Life Care in Emergency Medicine (Guidelines) (November 2007).

Development of Guidelines

◆Other academic and professional associations followed suit and issued their own guidelines around the same period.

- Science Council of Japan (SCJ), On End-of-Life Medical Care (February 2008).
- Japan Medical Association (JMA), Report of the Tenth Colloquium on Bioethics, Guidelines for End-of-Life Medical Care (February 2008).
- Japanese Circulation Society (JCS), Statement for End-Stage Cardiovascular Care (2010)

Basic Principles of MHLW Guidelines (May 2007)

(1) The end-of-life medical care should be tailored primarily according to the self-determination by the patient after the close talks between them and the medical personnel based on adequate information provided by them [autonomy and IC].

(2) The starting/withholding, change, and termination of a medical procedure should be considered carefully based upon medical validity and appropriateness by a multi-professional medical and care team [treatment and care by a team].

(3) Comprehensive treatment and care should be provided by the team that includes the alleviation of painful and uncomfortable symptoms and the emotional and social assistance of the patient and their family [palliative care and emotional/social assistance].

(4) Active euthanasia is not dealt with in the Guidelines.

Summary of MHLW Guidelines (May 2007)

[Where the wishes of the patient can be known]

(1) The end-of-life care should be essentially determined according to the decision-making of the patient based on the informed consent after expert medical scrutiny, and the professional involvement should be made as a multi-professional team.

(2) The patient should make the decision after full consultation with medical personnel, and the record should be kept of the determination of agreed course of treatment.

(3) During the above process, it is desirable that the determination is conveyed to the family, if the patient does not object to its disclosure.

Summary of MHLW Guidelines (May 2007)

[Where the wishes of the patient can not be known]

(1) Where the family can presume the wishes of the patient, the end-of-life care should be essentially determined according to the presumed wishes in the best interests of the patient.

(2) Where the family cannot presume the wishes of the patient, the end-of-life care should be essentially determined according to the best interests of the patient after full consultation with the family.

(3) Where the family cannot be found or would not be involved in the determination, the end-of-life care should be essentially determined according to the best interests of the patient.

Characteristics of Guidelines

◆Other guidelines, which were more elaborate in terms of the conditions for withdrawal and the kinds of treatment allowed to forgo, mostly, adopted the same basic principles as contained in the MHLW Guidelines, emphasizing the autonomy of the patient.

◆ However, a prominent difference could be found in the guidelines of the JSICM, the JAAM and JCS. All of them were focused on acute care medicine. JSICM guidelines provided that the family's consent was essential, and the latter two provided that, even if the patient had expressed their wish not to continue active care at terminal stage, where the family desired its continuation, accommodating their wishes would be appropriate.

Profession's Reluctance to Withdraw Ventilator

◆The publication of these guidelines in the last ten years seems to have barely or only slowly changed the practice of medical personnel. They have continued to show strong reluctance to withdraw mechanical ventilation from the patient.

◆One reason may be that the compliance with guidelines will not assure medical personnel of immunity from criminal prosecution. Guidelines, even if issued from the MHLW, could not grant legal protection from liability.

Bill to Respect Patient's Will for End-of-Life Medical Care (June 2012)

- In June 2012, a group of legislators advocating for death-with-dignity legislation announced a Bill to Respect Patient's Will for End-of-Life Medical Care.
- The bill provides that a physician shall not be subject to civil or criminal liability for withholding or withdrawing life-sustaining procedure for terminally ill patient if the patient has expressed their wishes to forgo it.
- However, the bill limits its application to the patient who is fifteen years of age or older and does not allow the family or other proxy to make a decision for the patient.
- Further, the bill has not yet been proposed to the parliament, and if proposed, its chance to pass is supposed to be small.

2014 Guidelines of JAAM, JSCIM & JCS

- In November 2014, the JAAM (Japanese Association for Acute Medicine), the JSICM (Japanese Society of Intensive Care Medicine) and the JCS (Japanese Circulation Society), jointly announced a new single Guidelines for End-of-Life Care in Emergency/Intensive Care Medicine.
- They provide "where the patient is competent or has left their advance directive, their decision, as a matter of principle, should be obeyed. The medical team should carefully assess the patient's competency. In principle, there should be no objection among family members. If objection was voiced from the family, medical team, respecting the wishes of family, should extend appropriate support so that the family's approval can be obtained."
- In the new Guidelines, the wishes of family is no longer made determinative. However, although expressed in a circumscribed way, the family's approval in effect seems to remain essential.

Profession's Reluctance to Withdraw Ventilation

- Professor Aita pointed out that Japanese physicians showed a strong resistance to withdrawal of mechanical ventilation that requires them to halt the treatment when continuation of its mechanical operation is possible, while there was little resistance to the withdrawal of percutaneous cardio-pulmonary support (PCPS) when its continuation was mechanically or physiologically impossible.
- She suggested that Japanese physicians shared a desire for a "soft landing" of the patient, that is a slow and gradual death without drastic and immediate changes, which serves the psychosocial needs of the patient's family and the physicians.
- Her suggestion seems to explain why they have been slow to change the practice, which is deeply embedded in our view of death and dying.

(Aita, K. et al. Soc. Sci. & Med. 70:616. 2010)

Profession's Reliance on the Family

- In Japan, treatment plan for a terminally ill patient is usually determined by their family. Often, a key person will be identified among family members and become a proxy for the patient.
- As Dr. Makino indicates, the patient's family generally requests continuing of the current treatment, and it is difficult for physicians to decline the offer. (Makino, J. et al. J. Intensive Care. 2:9. 2014)
- Dr. Makino suggests that this mode of decision-making might have come from Confucianism, which is defined in a dictionary as a Chinese way of thought which teaches that you should be loyal to your family and friends and treat others as you would like to be treated.

Profession's Reliance on the Family

・Although I am not confident about their origin of Confucianism, heavy reliance on the family and the profession's reluctance to make a noticeable withdrawal of treatment, as well as the subdued but persistent reference to the family in guidelines, will not change in the near future in Japan.

Thank you for your attention!