Excerpts from

Japan Society for Dying with Dignity Newsletter

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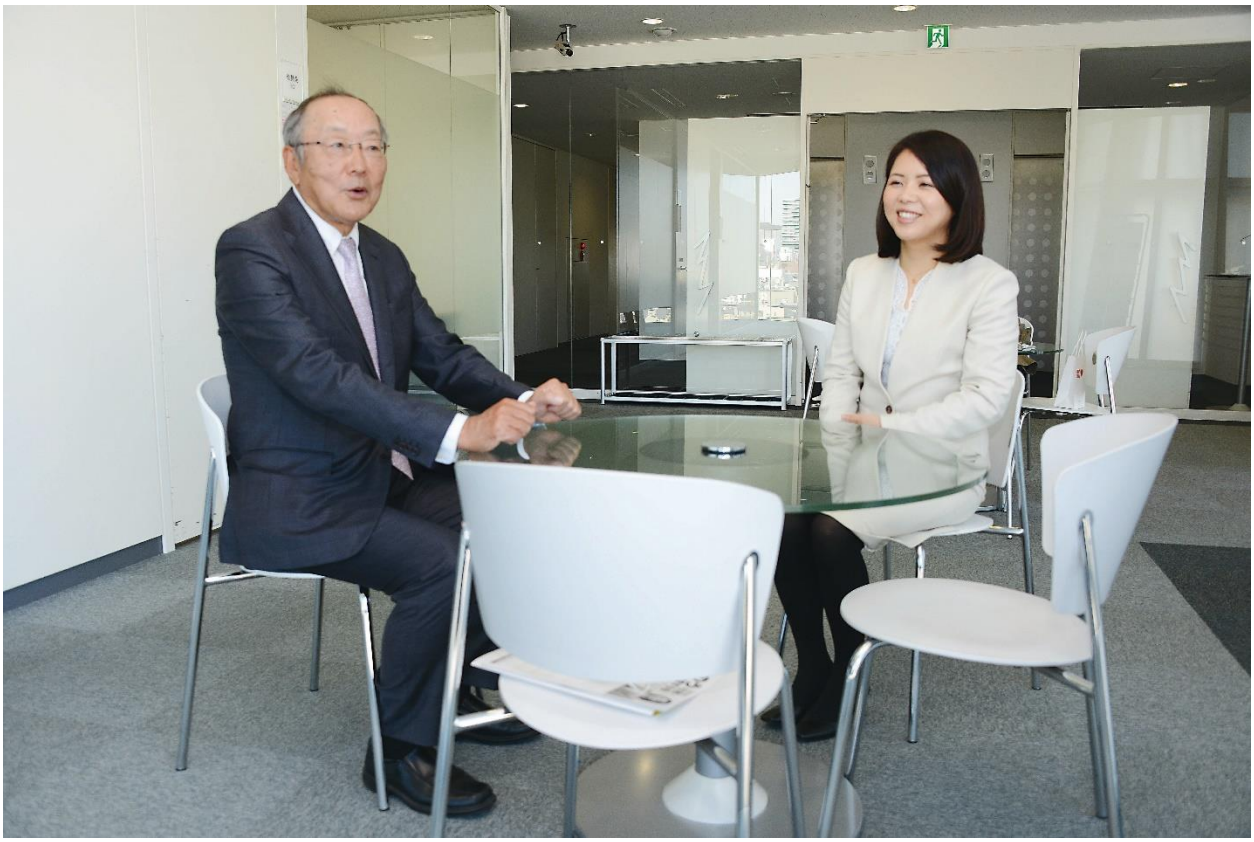
Main Contents:

- Special Talk: Legalizing dignified death
- Conference Report: The 10th session of Japan Living Will Study Workshop

Special Talk

Dr. Soichiro Iwao – JSDD President
Ms. Rio Tomono – JSDD Director

The prospect of legalizing dignified death
It is a choice of how to die - legalization is absolutely necessary



Ms. Tomono worked behind the scenes for the secretary of Diet Coalition Members Federation for legalization of dying with dignity for nearly ten years. She talked with Dr. Soichiro Iwao, on the prospect of legalization with the intent of making our society more open to honoring patients' self-determination.

Iwao: This time, I planned a special talk with Ms. Tomono on the subject, the prospect of dignified death legalization. Ms. Tomono is a registered nurse and an attorney, and she has made a great contribution when we were changing our organization's legal status to a public interest corporation. In 2017, our application to the Prime Minister of Japan was rejected. We started a court battle at the Tokyo District Court which resulted in our victory, however, followed by an opponent appeal at the Tokyo High Court. In 2020, the Tokyo High Court dropped the case, and we finally won the case and were recognized lawfully as a public interest corporation who enables a tax incentive (income tax deductibility) for donations. I would like to hear about how

you contributed to helping JSDD achieve the public interest corporation status and what you think about the final decision made by the Tokyo High Court in retrospect.

Ms. Tomono: Dr. Iwao said that this win was contributed by our efforts, but we are just your legal agents. I believe that real credit goes to all of you who worked hard endlessly to support us so that we were able to fully accomplish our mission and exercise the purpose of our activities. It is usually said that winning against an administrative litigation is very rare, but we never lost our confidence. During the court battle, the opponent's main argument was that if we accept that one of the public interest activity goals was management of the living will registry, then it might give a legal disadvantage to the doctors who guide their patients to withdraw their life prolonging

measures. They claimed that this point would be a big error. We could not allow them to have such a misleading interpretation and understanding. We argued that the living will is an important document from the aspect of honoring the wishes made by patients, but it is also an important document for the doctors because this is the only evidence for doctors to determine the patient's true wish in terms of terminal medical treatment and care. We were not going let them decide based on erroneous interpretation of this point. As a result, both the Tokyo District Court and the Tokyo High Court reversed the previous decisions as you know. In particular, the Tokyo High Court admitted that the living will would serve more positively as a tool to protect the doctors who aim to honor the patients' living wills by terminating or not administering life prolonging treatments based on their self-determination.
Furthermore, they added that the existence of the living will can be considered immunity from pointless lawsuits by the patients' families. Consequently, this will guarantee patient's self-determination as the patient's terminal medical care treatment plan is generated by the doctor.

Iwao: I understand this legal battle was jointly conducted by you and your husband who runs Doi Attorney office.

Ms. Tomono: Yes. My husband and I worked together on this case. He mainly took care of the constitutional aspect, specifically the Certification Act and its interpretation. I specialized in how we allocate all the clinical facts into the existing law since I have more background in the medical aspect of this case which was needed to present our case.

This is kind of a side story, but this was the very first federal case in which the high court overruled the decision made by the lower court, and there was a lot of legally important points in the argument. Our opponent had about ten witnesses including one of the spectators. From our side, only three or four witnesses took the stand including me, my husband and one or two from the JSDD staff. Our colleagues congratulated us for winning this case just by ourselves. As I mentioned earlier, we were confident that we had a strong case for JSDD, so we did not have to worry excessively although our workload was quite a bit. Another thing I would like to point out is that the meetings JSDD allowed us in regularly was very useful and worthwhile.
It was also very helpful that Dr. Iwao as the President, Ms. Aoyama of former high court judge and clinician Dr. Nagao as Vice Presidents attended to provide their comments from both medical and legal professional points of view. It created a strong feeling of teamwork and solidarity.

Iwao: Now let's get to the topic of legalization. We started a nationwide movement in 2003. In June 2005, we submitted a petition to the Speakers of both Lower and Upper Houses. The petition had 138,176 signatures. Around the same time, the Diet Coalition Members Federation was established. In June 2007, a drafted bill, physicians' immunity to withdraw and/or withhold any life prolonging measures for terminal stage patients was announced. The draft was revised many times, and finally in 2012, this became the bill for patient's right of self-determination for end of life medical treatments. However, this was not submitted to legislature. Ms. Tomono was the policy secretary to Ms. Toshiko Abe, a Diet Member who was the Secretary General of the Diet Coalition Member Federation from 2014 to 2016. You were involved in preparing all necessary materials for this process, correct?

Ms. Tomono: Yes. I was working with the people from the Legislative Bureau of the Lower House. My work was to create a bill that matched the image the Diet Members had in mind and

to put it in the text of the law and figuring out the placement of the criminal law in relations to other laws over many meetings.

Iwao: In many countries, the living will is legalized as the right of the patient to self-determination for terminal medical care. In Japan, there is a movement to legalize patient's right to the whole comprehensive medical care, but do you think legalizing the living will limits the right of medical choice only to terminal medical care?

Ms. Tomono: I also think that it is necessary to legalize the living will in Japan. Japan's constitution stipulates the right to pursue happiness as one of the fundamental human rights, and it is necessary for humans to live humanely. Although there is no concrete definition of happiness, it is understood to be included as a new human right. Making one's own decisions is a vital aspect of living your own life and is directly linked to the existence of one's whole being. This is the right to self-determination. It is important because it is related to my own way of life.

As one of the important things about the way we live my life is how to dispose of my body and my life. Is the right to die recognized as righteous? In Japan, it is not considered righteous at this time. For example, there was a well-known court case known as the Tokai University Hospital Case in which Yokohama District Court (court decision made on March 28, 1995) ruled that although the termination of medical treatment stems from the patient's right to self-determination, the right is not to choose death but only the process of dying. There was another case that happened at the Kawasaki Coop Hospital (Yokohama District Court Decision on March 25, 2005) which ruled that to honor and respect patient's self-determination for terminal medical care did not include suicide or the right to die. It stated that the decision only applies to how you wish to spend the last part of your life as a result of completing the life as an extended expression to pursue happiness, which is a fundamental human right stipulated by the constitution. Dr. Iwao mentioned that the legalization of the living will honors the right to choose medical care, but only limited to terminal medical care. This is exactly the same as the above mentioned court decisions. The right to choose the process of dying or the right to self-determination for the last segment of your life. This is a very important point of living a full life.

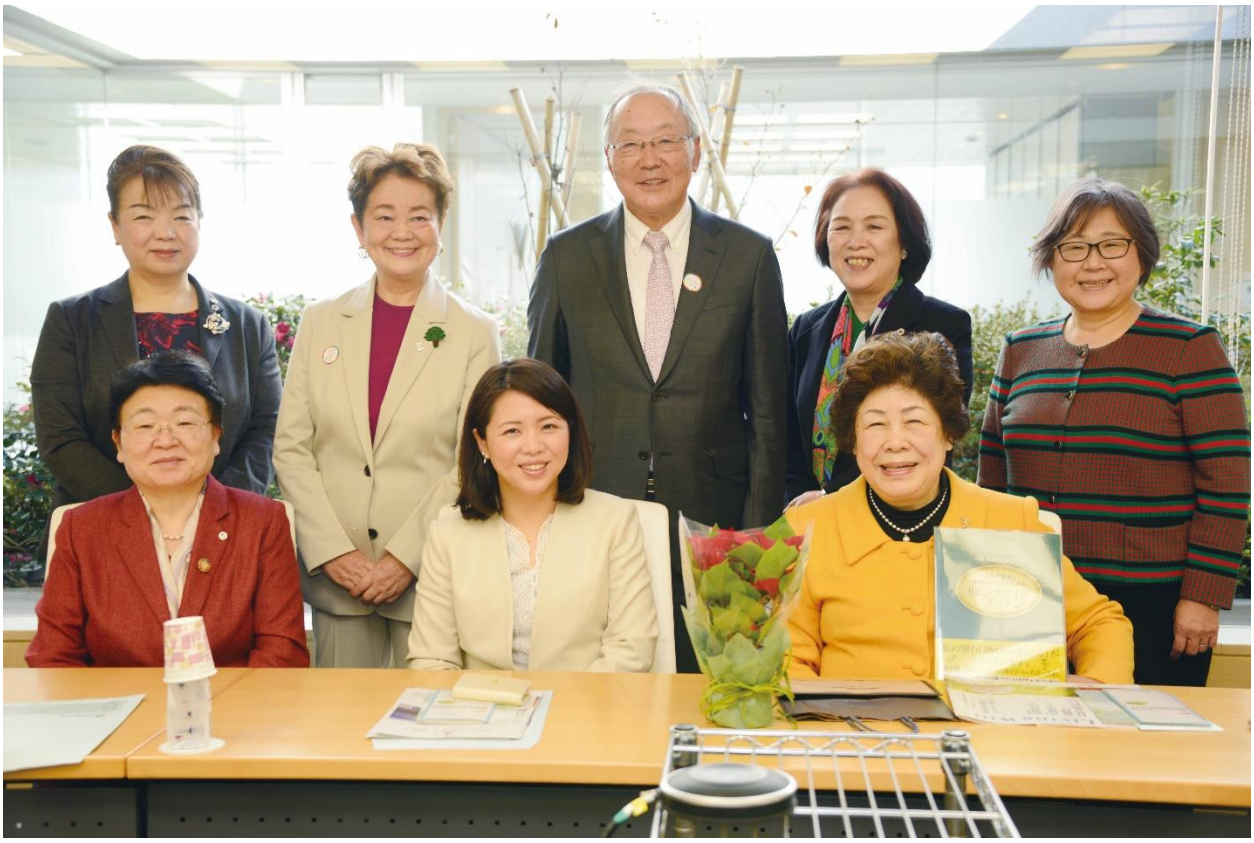
Iwao: From the past cases when a patient dies from the removal of a respirator, the physician is the one who gets sued by the survivor family. The court has to review each case to determine the presence of any criminal element. In other words, there is no precedence unless someone officially files a case. There is currently no legal precedent to follow for future cases, which means that physicians are always at risk (either civil or criminal) of a lawsuit. Therefore, it is absolutely necessary that we legalize terminal medical care decisions.

Ms. Tomono: I think there will be a lot of different opinions on this issue, and we need to have careful discussions. What is important is that we establish a system in which the patient's wishes are properly recognized through the living will and the ACP (Advance Care Planning) and fully honored with respect. The discussion needs to include physicians' legal responsibilities.

Iwao: Thank you very much.

The Nursing Association and systematic collaboration

Ms. Tomono (attorney) will run in the upcoming election in July. She will be the candidate representing the Japan Nursing Federation. She is a registered nurse, as well as a public health nurse. She said that she will do her best to make new laws by embracing a new range of vision as she has a unique dual background in the medical and legal fields. Dr. Iwao (JSDD president) visited the association and talked about effective ways for a collaboration in the area of in-home terminal care, as well as his full support to her election.



Conference Report: The 10th session of Japan Living Will Study Workshop

Resilience = Strength to overcome the pandemic

The 10th session of the Japan Living will Study Workshop was held virtually on December 11th last year during the fifth wave of the Covid-19 pandemic with the Ominicron variant surfacing. The topic of the workshop was “Resilience = Strength to overcome the pandemic.”
Life is a continuation of unexpected events such as separation, death, illness, unemployment, earthquake, typhoon, flood, etc. How can we overcome all these uncontrollable events?

In this session, we focused our discussion on gaining the strength to overcome not only this pandemic, but all other unfortunate and disastrous occurrences from many angles. The list of participants and the summary of discussion is below.

Soichiro Iwao: Physician, JSDD President
Chihoko Hirabayashi: Registered Nurse; JSDD medical consultant
Satoru Mitsuoka: Mitsuoka Internal Medicine Clinic Director, JSDD Director
Akane Shabbot: Researcher in the field of euthanasia; author of "Positive health from The Netherlands"
Jun Matsuda: Professor Emeritus at Shizuoka University; philosopher; author of "Current status of euthanasia and dying with dignity: terminal medical care and self-determination"
Yusuke Takamiya: Showa University School of Medicine Professor, president of Clinical Study Group of Deaths in Japan

A video message

Dr. Soichiro Iwao, JSDD President

The importance of the Living Will resurfaced

We conducted the tenth session of the Living Will Study Workshop. Many discussions have been held on the issues of terminal medical care, but the topic selected for this workshop was resilience. For the last two years during the pandemic, some infected patients received discriminatory behaviors even after they recovered. On the other hand, some patients who died of this virus were obliged to have a solitary departure without being able to say a face to face farewell.

This unexpected situation of the lonely and inhumane departure made us realize the importance of preparing a living will in advance. We were reminded that our most urgent and important task

is to educate our citizens and promote the importance of the living will. We chose the topic of resilience with a strong message that we will come back no matter how desperate this pandemic has become. I sincerely hope to receive a lot of responses from all of you.

Introduction and explanation of the topic

By Satoru Mitsuoka

How can we nurture a flexible mind?

We would like to deepen our thinking by discussing the topic of "Resilience = strength to overcome the pandemic." A year and nine months have passed since March 11, 2020 when the new type of Coronavirus was recognized as a pandemic by the WHO. In Japan, vaccinations were provided nationwide, and the number of infected people had rapidly decreased after the fifth wave. However, the omicron variant has replaced the old virus now, and we are on alert once again. In the meantime, we are now experiencing a paradigm shift for the first time since JSDD was founded in which our national medical system once considered to be the best is in question. Medical care that was available anytime to anyone has become not so guaranteed, not only life prolonging medical care, but also urgent lifesaving treatments have become unavailable at times.

We were forced to prepare for life threatening situations such as the pandemic and other natural disasters. It brought to light the necessity to prepare the living will well in advance. For the last two years, we have had discussions and deliberations to set up a task force that looks into such issues as how the JSDD should operate, which direction the JSDD should be going, and what the living will should look like, etc. We came to the realization that dying with dignity is not the result of refusing life prolonging treatments or completion of sufficient palliative treatments, but

it is beyond living with dignity. What is living with dignity? Simply put, living with dignity it is a state of maintaining a positive outlook on your life with self-respect. In our current society, we see a lot of heart breaking events and occurrences such as separation, death, illness, unemployment, poverty, solitude, cruelty, discrimination, hatred, not being recognized, loved or rewarded, as well as natural disasters such as tsunami, typhoon, flood, etc.

While encountering these unhappy situations, some people are able to keep positive attitudes towards life and not lose their spirit or self-respect, but some people are unable to do so unfortunately. How we can foster resilience or the strength to overcome all the negativities? We would like to narrow down the point of the discussion to the key word, resilience. Also, we would like to extend the discussion of this word to not only that gained through your own efforts, but also social hindrance against resilience such as the lack of tolerance and compassion.

Resilience and positive health movement originated in The Netherlands

By Akane Shabbot

Building resilience from accumulating small successes

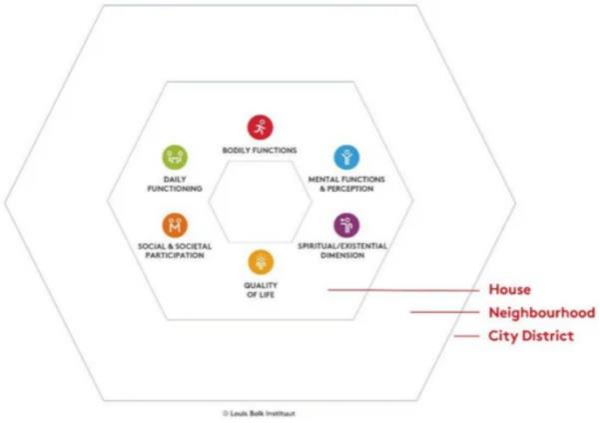
“The positive health movement originated in The Netherlands” started with healthcare, but what is special about this concept is its holistic approach. It is now implemented widely in the sectors of education, workplace and welfare. Currently, more than 50% of municipalities in the Netherlands adopt this concept as a municipal policy. Positive Health started as an individual health concept, but now it is used for promoting health and resilience for a group, namely, the community.

The definition according to the WHO (World Health Organization) states that “health is a state of complete physical, mental and social well-being and not merely the absence of disease and

infirmity." However, a new concept for the 21s century was introduced in 2011 by a doctor by the name of Machteld Huber, and she called it "Positive Health." According to Huber, "health is an ability adapted by self-governance and management when faced with social, physical and emotional stress.

WHO defined health as a state of static being, but she defined it as a dynamic being, as the ability to adapt; that is the major difference. This positive health seeks support from the outside, but the important part is the self-governance and self-management.
The word resilience means coming back, overcoming and to be mentally flexible. This word was used in reference to a city. Rockefeller Foundation once selected 100 cities from the world and called them "Cities Rich in Resilience." From Japan, Kyoto and Toyama were included on this list. What requires resilience is a sudden external tremor like an earthquake or a pandemic, and a slow and gradual stressor.

There are seven factors of resilience we learned from the resilient cities: introspective, witty, inclusive, comprehensive, stable, surplus, and flexible. According to Huber, resilience has six dimensions and 42 indexes of resilience.



1) Physical condition
2) Mental condition
3) Willfulness to live
4) Quality of life
5) Social interactions
6) Daily functioning

Under these 6 dimensions, there are 42 indexes. A full mark is 10 points which is placed in the hexagon (below) and connected with a line. The inside space becomes your health space, which shows your state of health at that time. You may see a different state of health at a different time. This is only based on your subjective feeling, and it is a tool to for you and your supporter to facilitate communication. One physician who had difficulty seeing a patient in person during the pandemic used this chart and the concept successfully over the phone.

This hexagon chart is used for palliative care and is very useful for terminal care as well. In fact, when used with elderly terminal patients, their health spaces were unexpectedly large. What this indicates is that sometimes family members evaluate the patients' health status to be rather low just from observing them externally, but their inner side is hard to see. You may find that your mother is quite satisfied with her life. The supporter's job is to find out what is most important to the patient and what brings them satisfaction. You can't force or guide them. You must be patient and wait for them to Positive Health, you will find great training opportunities through having conversations with your patients or local citizens. In simple terms, don't interrupt them!

Once the patients find out their health conditions, they will make goals and try to achieve them. The supporter's responsibility is to just be there for them. The accumulation of small successes gradually will build their confidence and resilience.

Diverse values and clinical attitudes

By Jun Matsuda

Gaining the strength to start life over by telling your own story

From the medieval ages to the present, it has been said that the nature of our illnesses has changed from “infectious diseases” to “lifestyle-related diseases.” I would like to restate this phenomenon as the characteristics of illnesses have changed. In other words, current illnesses have become much slower in terms of progress. Times have changed from treating patients with infectious diseases through advanced medicine to treating diseases that progress slowly and not easily curable. In such cases, treatment approach with something other than medicine is desirable, for example, improving the quality of life for elderly patients by providing the combination of medicine and the nursing care.

This new approach of medicine and patient care will be needed that is completely different form a traditional model of medically treating everyone who is sick to be cured. The important question becomes what exactly is health? The definition of health according to the World Health Organization (WHO) is “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Here is a question: Is it possible to be in a state of complete physical, mental, and social well-being?

Let’s look at the negative aspects of being in a state of complete wellness. If health is a state of complete well-being, and the purpose of medicine is to cure diseases and recover health from it, medicine is meaningless unless it can cure diseases. Then the logical conclusion is to eliminate this useless medicine and shift our focus on dying with dignity and even euthanasia. Here, I would like to emphasize that the mission of medicine is not only to cure diseases and restore

health, but another important mission is to provide palliative care to alleviate the pain and suffering. When I mention palliative care, most people would probably imagine a totally separate ward of a hospital strictly for terminal stage cancer patients. However, palliative care alleviates all the pain and all the suffering, not only of terminally ill patients. Nursing care to reduce pain and suffering is also an important part of healthcare. If medicine is considered useless including the necessary part of medical care, it is depriving the terminally ill, disabled, and elderly patients their right to proper medical treatment. Therefore, in view of today's society in which our population is comprised of overwhelmingly large number of elderly people and the changing of our illness model, the WHO definition may no longer be appropriate or applicable. The new definition of health as Dr. Machteld Huber proposed, may be a better fit. If I can propose my own definition of health, it would be "the strength to adapt to, overcome and recover from any stressors by using all available methods, which is what resilience is."

Instead of keep looking at the old traditional model of "illnesses, treatment and cure," taking a different definition and approach of "health" as a whole, we can expect new possibilities. In other words, health is not the state of complete well-being, but it is the strength to adapt and overcome. Health is not a stationary state, but a dynamic power for adaptation in response to stressors. It is the strength to make life positive and move forward with the support of medicine and healthcare to alleviate pain and suffering. This new approach is different from the traditional medicine of only curing illnesses in that it adds the functions of treating and supporting to medicine, which leads to enhancing one's quality of life. How to honor, respect and support the kind of life the patient wants is an important point of view. Medical providers must now provide medical care based on the patients' values what is clinically available.

What is quality of life? The patients are probably not sure themselves. Their illnesses show certain symptoms, and they deepen their thoughts about how they want to live the remaining days of life. In other words, the patients themselves must clarify the target of their remaining life including what kind of medical care they want to receive. ACP (Advance Care Planning) is this process so that medical providers can find the right support aid for that individual. I think this revolutionary change of concept is the first time in 160 years when modern medicine in Japan emerged.

This change does not only apply to healthcare providers, but also patients themselves. Patients need to stop the old simple thinking that if they get sick, they'll just go to the hospital and ask the doctor to cure them. Frankly, modern medicine cannot cure all diseases, so we all have to think about how we want to continue living possibly with an incurable disease. You need to talk to your doctors and loved ones about how you wish to spend the remaining days of your life. Having deeper communications with people around you will improve your quality of life greatly. Reaching a viable, fully explained medical policy decision based on consent is not just a formality. ACP (Advance Care Planning) is not just another piece of paper. The most important point of it all is that we have to communicate repeatedly.

The last thing that I would like to talk about is where resilience comes from. We as people gain a lot of things in life such as family, job, career, status, position, treasure, partner, etc. At the same time, we lose a lot of things as well such as health, active capacity, job, money, loved ones, and at last, our own lives. One can say that life is a sequence of losses. We spend a lot of energy and time to avoid losing them, but we end up losing some of them unfortunately. How should we cope with these losses? Where does resilience come from?

The answer is to make a story of your own life, a narrative. For example, if you are diagnosed with a serious disease, you will be devastated and emotionally depressed because you will feel the physical and mental decline due to aging and find yourself unable to maintain the quality of life you have enjoyed so far. You will start to think deeply about the meaning of the remaining life and what goals you should have. We are the author of our own life story and will try to explain the meaning of some of the important events in life. However, sometimes unfortunate events such as a natural disaster, an accident, or an incurable disease may halt your story making. What you will have to do is to revise your story or rewrite it because you want to make it to possess a valuable meaning. We are like characters living in a story destined to find the moral of the story.
You will need a support network and someone with whom you can consult. Your family, healthcare workers and religious leaders can give you a different perception and shine a light on experiences that you never had so that you can have a different story from what you would have on your own. This type of support to help you rewrite your story with valuable meaning is one of many important roles of palliative care.

The relationship between medical providers and the patient is changing. It is not the same relationship as between a care giver and a care receiver. Patients will have to write and rewrite their own life stories and the providers must be good listeners. This mutual relationship between the patient and the provider will be similar to that of coworkers or partners. The provider will witness the patient's life story, acknowledge its interpretation, and support its values through which process the patient will be able to gain the strength to overcome desperation and relive.

Take-away from JSDD medical consultation

By Chihoko Hirabayshi

Close and frequent conversations to heighten resilience

Today in the midst of a pandemic, I would like to talk about what the JSDD members are saying about their fears, sufferings, needs, what made them overcome obstacles, and what role the JSDD medical consultations played. First of all, the number of consulted cases during fiscal year 2020 was 557. The majority of callers were women with the average age of 78, both JSDD members and non-members. We had two consultants at the time, but currently have three. The first case was about the vulnerability of elderly people when they are infected with the Covid 19. I personally would like to refuse an artificial respirator even if I am seriously infected. I would like to make these respirators available to younger patient as I lived long enough. My very old mother is now in a special nursing home and no visitors are allowed. I wondered if end of life should be this way. Going out is not allowed, and I am losing my appetite. If I continue this, I am afraid that I will lose my physical strength and will be bed-ridden. My nursing home has a strict rule that we can't even say hello to anyone I meet in the corridor. During meals in the dining hall, we have to all face in the same direction and eat in my lonesome. I can't wait for this situation to end soon. I can talk with my friends over the phone, but in-person communication is not allowed.

I receive such calls every day. I would like to share with you some specific cases.

The call was from a woman in her 70s who wished to take care of her husband at home, also in his 70s, who is currently hospitalized with pneumonia. Her family consists of just her husband and their daughter who recently came back from abroad and temporarily living with them. Two months ago, her husband was diagnosed with metastatic lung cancer and started on radiation therapy. The progress was good, and the cancer was reduced, but ten days later he started having a high fever. He was put on a respirator and had a tracheostomy. Currently the respirator is removed, but the opening of the tracheostomy was not closed. He was started on a nasal duct nutrition, but there has not been much progress of getting rid of pneumonia or the congestion so they started suction of phlegm. He is now bed-ridden all the time. He has a clear consciousness, and his JSDD card was already submitted to the hospital.
The consultation was about her husband strongly wishing to leave the hospital, but the hospital did not allow him to leave because he still had pneumonia. Because of the ongoing pandemic, he could not see her or anyone in his family. Since he did not have much longer to live, she wanted to follow his wishes, but she did not feel confident that she or her family could provide the medical care he needed.

I gave her the following advice.
It would be difficult for his family to provide him medical care such as suction of phlegm and nasal duct nutrition, so I told her about the a new service called "visiting medical care" and gave her a reference list of registered LW supporting physicians who are available to provide visiting medical care. Since the hospital was not letting the patient go, and the hospital would not accept an outside doctor visiting the hospital, I suggested that they tell the hospital to release him since it is a strong wish of both the patient and his family to take care of the patient at home. Once he was released, the visiting LW supporting doctor can provide all of his medical care needs.

She and the family repeatedly requested the hospital, and after the third time they finally conducted a clinical conference and decided to approve his release. After ensuring that she found a clinic with LW supporting doctors who could serve as their visiting doctor and her husband was released from the hospital, my job was completed. What I learned from this case was that

the living will is not an individual document, but a product of many people involved in that individual's life through close communications and shared values.

My role as a medical consultant is to have close and repeated communications with the callers and supply them with all necessary information and available resources in the medical service system and the healthcare system. By doing so, they are able to resolve some issues and eventually move on to the next step. I wish to keep helping patients heighten their resilience and dignity in living the remaining days their lives.

Mindfulness and GRACE to heighten the level of resilience

By Yusuke Takamiya

It's not the past or the future; it's now as it is, that we have to accept

I have been engaged in palliative care for 30 years, teaching students and young healthcare providers about the care of the mind and ways of communication.

First of all, I would like to talk about the care of the caregiver's mind. There is a saying "not doing but being." This was the first thing that I was taught when I visited the U.K. for hospice research and study. It means that it's not what you do, but being there is the most important thing. I would like to talk about an example of a "Red Blanket." There was a young man who was in a hospice because he was diagnosed with terminal stage of stomach cancer. He vomited red blood. His white bed sheets turned red. The nurse changed the sheets so they stay white. His blood pressure plummeted and he would die in a few hours. Instead of getting him new sheet to replace, you bring him a red blanket and wrap his whole body and the red sheets to show him that you are with him, and everything is alright. This is what I was taught as an example of being.

Here I would like to introduce some data on the symptoms of depression and depressed states suffered by doctors-in-training. At the beginning of their training, nearly 20% in Japan and 28.8% in other countries complain of such symptoms. At Showa University School of Medicine,

a medical student committed suicide some time ago. This incident prompted me to do some research and study in Canada, Australia and the United States. In 2015, I started a self-care educational program at Showa University. I would like to introduce a part of it today.

One way to care for the caregiver's mind is mindfulness (meditation, focusing on this moment). For example, let's say you had an argument with someone at work. It was not that bad, but you let it fester and all the anger, resentment and grudge started to occupy your mind when you got home. In this situation, mindfulness might be an effective tool for you. You should not carry around what happened in the past, and you should not worry excessively about the future. You just accept what is in the present. A professor from Massachusetts University Stress Reduction Center reported that mindfulness works well for people with chronic pain, as well as for recurrence of depression that is not entirely curable. In fact, mindfulness was originated by a Zen priest in Japan.

Mindfulness also works for cancer patients in the following aspects:
1) To improve anxiety and bad mood
2) To improve sleep, heart rate and blood pressure
3) Changes in immunity function
4) To improve quality of life
5) Change of gene related to inflammation

To summarize mindfulness, it can be explained as below:
When you are feeling depressed or worried, your mind is in the state that is not in the present. You start falling further and further down the path of the past and start worrying about what if something goes wrong in the future. In other words, your mind goes back and forth between the past and the future in circles. What you have to do here is to stop this vicious cycle and focus on the present. We are still in the middle of a pandemic, but you must try to find a moment of happiness and do it every day. Happiness is right here and now. The key to mindfulness is breathing. If breathing is interrupted, your body and your mind will be interrupted. Meditation or yoga can have the same effect as mindfulness. Humans must have known the importance of this fact thousands of years ago. Mindfulness is not something new for the Japanese people. Obtaining Zen through flower arrangement, tea ceremony, martial arts such as kendo, judo, and archery have the same principle of using the mind and breathing, which is mindfulness. In other words, it's all about focusing on what you have right now.

Next, I would like to talk about GRACE. G stands for gathering attention: drawing your attention to your body's senses, controlling your breath and standing firmly on the ground. R stands for recalling intention: remembering what your intentions are, what your role is, being aware of what your purpose and motivation are. A stands for attuning to self and then others: First, tune in to your own body, feelings and thoughts, and then tune in to others. C stands for considering what serves you best: have the attitude that you do not know the truth. Have an open mind. E stands for engaging ending: to end with the best.
For example, let's say you have a patient in the palliative care ward of a hospital who always throws his anger at you or keep telling you that he wants to die. What you have to do first is that you control your breathing and you stand firmly on the ground. The first thing you have to remember when you step in his room is why you became a doctor and why you are now confronting him. You tune in to yourself and then tune in to the patient. Make sure your mind is open and blank. Your attitude is like a blank sheet of paper. The patient may be difficult and

always angry, but imagine that he may show a different attitude if you see him with that in mind, and may have a completely different development. You do your best and end it. When you end it, and it comes back to your own world again, it may be a good idea to make it a routine to wash your hands. While you are washing your hands, you wash away the various things that happened to you on that day. By repeating this process every day, you can master mindfulness.