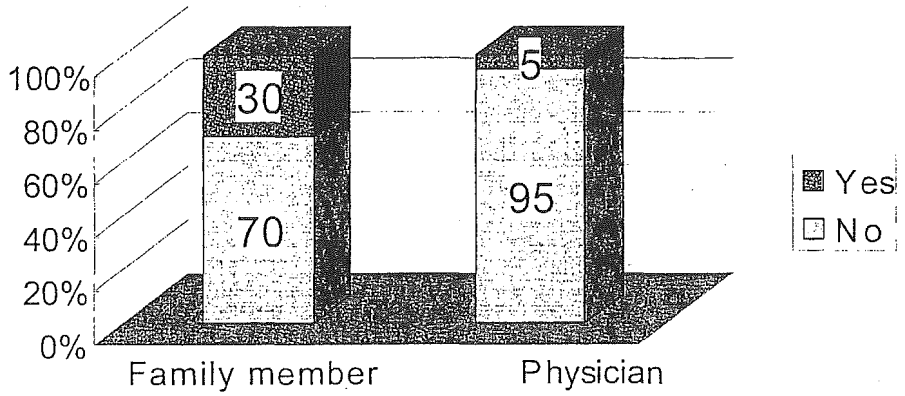

Fig 2. Patients' answers for the question, "Have you ever discussed your preferences regarding CPR with your family members or physicians?" For family members, $n = 385$; physicians, $n = 391$; all numbers in figure shown as percentages.

approximately 47% of all patients with dialysis treatments were older than 65 years, and 32% were 70 years or older.[16] Approximately 15% of Japanese patients undergoing dialysis treatment require special supportive care because of disability.[17] Some of these Japanese patients may not want to continue their dialysis treatment because of their dependence or poor quality of life. Several studies suggested that most Japanese do not desire mere prolongation of life by aggressive intervention.[12] Japanese physicians may pursue more aggressive life-prolonging treatment than in other countries and also tend to give priority to the wishes of a patient's family to prolong the life of the patient despite the patient's own advance directives or informed preferences.[9,13,18] Another study reported that a patient's family tended to consider that termination of life prolongation is abandonment of their duties.[19] Do-not-resuscitate orders rarely are documented and sometimes ignored.[20] Under these circumstances, the unconditional introduction of dialysis treatment for dependent and disabled patients without direct consultation with the patient to establish their wishes could constitute a serious infringement of the patient's dignity and preferences. A patient may want to have dialysis treatment continued regardless of his or her medical condition or quality of life, while the family and physician believe that the patient's wishes are the opposite. In this case, a lack of valid communication of patient preferences and intentions could lead to premature termination of life-sustaining efforts. We believe that one of the important goals of

Table 7. Reanalysis of κ Coefficients for Each Scenario With Only the Limited Results

	Overall	A: Patient's Estimation: Accurate or Almost Accurate	B: Former Discussion: Yes
Patient and family			
Now: CPR	0.1445	0.3549	0.3378
Demented: dialysis	0.1254	0.3020	0.2730
Demented: CPR	0.1430	0.2914	0.2581
Cancer: dialysis	0.1067	0.2675	0.2641
Cancer: CPR	0.0851	0.2652	0.2495
	Overall	C: Patient's Estimation: Accurate or Almost Accurate	
Patient and physician			
Now: CPR	0.0434	0.0828	
Demented: dialysis	0.0859	0.1321	
Demented: CPR	0.0960	0.1879	
Cancer: dialysis	0.0122	0.1349	
Cancer: CPR	0.0742	0.1243	

NOTE. For A, B, and C; see patient questions 4, 7, and 5.

medicine is to satisfy the rational health-related preferences of patients. Such a target cannot be achieved if family members and physicians continue to believe that their decisions are in agreement with what patients want or might want.

The second interesting finding is the low expectation of participating patients regarding the ability of their family members or physicians to predict their wishes about CPR or continuation of dialysis therapy. As results indicate, only half the dialysis patients expected their family members to make satisfactory substituted decisions, and less than one third believed that about their physicians. Confidence by physicians and family members in the accuracy of their judgment was greater than patients' perceptions. This result suggests that Japanese patients, at least in the clinical setting, have begun to recognize that individuals have different preferences and it is impossible to know these preferences intuitively or to make tacit decisions. In other words, Japanese physicians and even their family members may now be perceived as "strangers at the bedside" by some patients.[21] Our results support this possibility. For satisfactory decision making regarding quality-of-life and end-of-life decisions, explicit communication and inquiry therefore are essential.

Third, our findings are in agreement with outcomes of previous studies about communication among patients, family members, and health care professionals, conducted mainly in the United States,[1,3-5] and the previously mentioned survey by Kai et al.[6] This agreement suggests that despite cultural differences in human relationships between the United States and Japan, family members and physicians are poor substituted decision makers in clinical settings. There seems to be no justifiable reason for the continuation of substituted judgment based on "Japanese specific intuition" without serious reconsideration.

There are several limitations to our study. First, the generalizability of our results is limited, mainly because participants were chosen consecutively and on the basis of convenience by their nephrologists and the survey was performed with physicians in 15 hospitals who also were selected for reasons of convenience from an informal group. Subjects therefore may not be representative of others receiving dialysis care, although the response rate of pairs consisting of a patient and a family member was as high as 88%. Our results are based on assessment by 18 nephrologists. The ability to judge patient wishes may differ depending on the specialization of the physicians. Another point is that patients with other illnesses may have different communication patterns with their family members or physicians. It also should be noted that answers to the questionnaire may not necessarily reflect respondents' actual preferences or opinions; thus, actual agreement might be different. Finally, we did not ask participants to what extent they had actually discussed their preferences regarding termination of dialysis therapy or CPR under various medical scenarios with their family members or physicians.

In conclusion, family members and caregiving physicians of dialysis patients appear to have very little knowledge of patients' preferences regarding life-sustaining treatment in current and future situations. There seems to be a need for more explicit communication about preferences regarding health care and for more discussion to understand the real wishes of others. It also can be concluded that regardless of cultural differences with respect to an individual's autonomy, routine use of informed consent and advance directives should be expanded for more effective expression of patient health care preferences and greater patient satisfaction.

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CRITIQUE

A VALUABLE UP-TO-DATE COMPENDIUM OF BIOETHICAL KNOWLEDGE

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ABSTRACT

In this brief article, we examine the document entitled Universal Draft Declaration on Bioethics and Human Rights, published by UNESCO in June 2005. We examine it in terms of its content and its appropriate role in global bioethics movements in the future. We make clear our view on the Declaration: the Declaration, despite a variety of serious problems, remains a valuable bioethical document and can contribute in substantial ways to the happiness of people throughout the world.

In this brief article, we examine the United Nations Educational, Scientific and Cultural Organization's (UNESCO) *Universal Draft Declaration on Bioethics and Human Rights (UDDBHR)*[1] in terms of its content and its appropriate role in global bioethics movements in the future.

First, the *UDDBHR* includes many extremely diverse bioethical norms and concepts as its central principles. For this reason, we must simultaneously take into account a series of seemingly contrasting values as we make decisions concerning specific ethical issues. For instance, evaluations of specific situations must attend to, and respect, rival values such as liberty and equality, universal human rights and local cultural traditions, and independence and solidarity/cooperation. Furthermore, the *UDDBHR* approaches individuals, families, and larger social groups as stable entities

[1] United Nations Educational, Scientific and Cultural Organization (UNESCO). 2005. *Universal Draft Declaration on Bioethics and Human Rights*. SHS/EST/05/CONF.204/3REV. Paris, 24 June 2005. UNESCO.

united by a community of interest. This is in some ways problematic, as various conflicts of interest and ethical dilemmas arise from within the relationships among individuals, families, groups, and communities. However, there is no practical way to resolve these dilemmas within the parameters of the *UDDBHR*. In *Article 26*, the *UDDBHR* states, 'Each principle is to be considered in the context of the other principles, as appropriate and relevant in the circumstances.'[2] This does not provide a practical solution in all cases.

Second, although the *UDDBHR* initially seems to have been written in a manner that satisfies all engaged parties, it is in fact framed by a particular philosophical and ideological logic that embraces the value of universal human rights. In other words, it clearly claims that the central bioethical principle in the world must be human rights. Because of this distinguishing characteristic, those parties who do not accept the universality of human rights – including those local cultures that do not perceive human beings as individuals but rather as part of a larger social fabric, as well as those communities in which the majority of people do not recognize the existence of human rights as such – will offer a serious and rapid rejection of the *UDDBHR*. These parties may even refuse to test the substance of the *UDDBHR* in order to evaluate its efficacy. Moreover, because its central principle is respect for human rights, the *UDDBHR* necessarily exhibits all problems inherent in the idea of human rights. These problems, such as how to define human rights, how to defend the concept of human rights, who decides the rights that constitute human rights, and how to resolve the conflict of different human rights, in our opinion, remain unanswered.

Third, we take note of the first sentence in the *UDDBHR*, 'Conscious of the unique capacity of human beings to reflect upon their own existence and on their environment; to perceive injustice; to avoid danger; to assume responsibility; to seek cooperation and to exhibit the moral sense that gives expression to ethical principles.'[3] This sentence indicates that all humans have a unique and morally laudable capacity to act in specific ways. Do humans have such capacity? We think not. On the one hand, we feel that human beings are very good at perceiving injustices that present threats to the rights and interests that benefit them and those they care about, but on the other hand, their sensitivities to injustices that infringe on others' rights and interests are rather

[2] Ibid. Article 26.
[3] Ibid. Preamble.

dull. A quick glance around the world reveals many wars of aggression, territorial disputes, acts of discrimination against the weak, cruel crimes that bring suffering to innocent people, and evasions of social responsibility. Therefore, we feel compelled to argue that, in order to understand what is actually going on in the world, human beings often act in ways that are selfish, irresponsible, and inconsiderable in terms of ethical rights and wrongs.

However, we would argue that it would be too hasty to conclude that the *UDDBHR* is useless because of these problems. The *UDDBHR* should not be considered either as an ethics manual, designed to resolve individual problems, or as a practical guideline designed to respond to specific bioethical issues. The *UDDBHR* should rather be regarded as an up-to-date and well-organized compendium of bioethical knowledge in today's world. The *UDDBHR* draws attention to all points of moral worth – ethically preferable attitudes, behaviors, and states of things – that must be considered, as humans take into account the bioethical point of view. The document usefully makes people aware of the importance of thinking ethically about matters of human concern, of recognizing the significance of the concept of solidarity/cooperation, of acknowledging social responsibility, and of respecting the values of autonomy and individual rights.

We believe that the world would be a better place for everyone to live, if human beings would become aware of the serious implications of every sentence in the *UDDBHR* and acquire the habit of making all possible efforts to identify ethical action in the midst of the mutually conflicting norms and principles. We also believe that people who live in a world where some people care about the norms expressed in the *UDDBHR*, would be happier than those who live in a world where no one cares about these norms. In the same vein, people would be happier in a world where people were willing to accept the idea of universal human rights, than in a world where no one does so. In this sense, the wide scope of the *UDDBHR* is appropriate, i.e. its principles apply and are relevant to literally everyone, including individuals, professional groups, public and private institutions, corporations, and states. Although we are aware that rigorous philosophical analysis reveals the theoretical inconsistencies and practical limitations of the *UDDBHR's* framework, we feel that judging the *UDDBHR* worthless on the basis of these inconsistencies and limitations is a narrow-minded attitude.

In order to make good use of the *UDDBHR*, people in the world need to be convinced of the importance of attempting to live ethically, and in accordance with that belief, even though it is often

difficult to know the most ethically appropriate action in a given situation. We hope that the bioethics education, training, and information referred to in *Article 23* of the *UDDBHR* will enable people to acquire the virtue of making all possible efforts to determine ethical actions on a daily basis.

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日本発のエビデンスを促進するために

EBMを倫理的視点から検討する

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Asai Atsushi

POINT

- EBMは入手可能なベストの研究結果（エビデンス）を基本として，それらに医師の臨床的専門性と患者の価値観を統合させることによって診療に関する意思決定の最善化をめざす．
- EBMの導入は医療の質を向上させる．根拠に基づいて，共通の手法とプロセスを用い個人的恣意的でない意思決定が行えるようになった．
- 医療政策や医療資源の配分はきわめて複雑な意思決定を必要とするが，アウトカムに基づいた費用効果・効用分析は明確な一つの選択肢を提示することができる．
- EBMは大きな利点と同様，問題点や限界をもっており，それらを十分認識して使用することが求められる．商業主義の影響や過度に硬直した医療の標準化，エビデンスに基づいたパターナリズム，費用効果・効用分析のみに依拠した偏りのある医療政策も派生するおそれがある．
- 医療の目的は多面的であり，患者の利益のために広い視野をもって意思決定が行われる必要がある．

evidence-based medicine（EBM）は，入手可能なベストの研究結果（エビデンス）を基本として，それらに医師の臨床的専門性と患者の価値観を統合させることによって臨床現場での意思決定の最善化をめざす活動である[1]．EBMの理念によれば，医学的介入は効果と費用効果分析に関する最も信頼できるエビデンスに基づいて評価・選択されなければならない[2]．診断，予後予測，治療などすべての医療行為はベストの臨床疫学的研究によってもたらされた量的エビデンスに基づいて行われなければならず，経験や基礎医学からの推論だけに基づいた行為には注意を要すると考えられている[3]．そして，EBMが用いる具体的手法には，ランダム化比較対照試験（randomized controlled trial; RCT），研究結果の重視，研究論文の批判的抄読，メタアナリシス，そしてシステマティックレビューが含まれ，臨床意思決定の重要なプロセスとして世界に普及している．

本論では要点を表にまとめつつ，EBMが医療にもたらした変化を倫理的側面から簡潔に評価する．EBMという概念・手法がもつ限界，EBMの使い手である医師が陥りやすい傾向，EBMに基づく意思決定が引き起こす可能性のある問題を検討し，意思決定のあり方と医療の目的を再確認しつつEBMのよりよい活用法を考える．

EBMがもたらしたもの

EBMが日本の医療にもたらした変化には次のようなものがある（❶）．①診療行為の意思決定に一定の枠組みとルールを提供することで診療行為に一貫性をもたらした，②医療における医学研究

❶EBMがもたらしたもの

- 診療行為に一定の枠組みとルールを提供
- 医学研究の重要性の再認識
- 権威主義的診療スタイルに警鐘
- インフォームドコンセント取得過程における情報開示内容の変化
- 診療ガイドラインの策定・確立を促進
- エビデンスに基づいた医療政策と医療資源配分を促進

の重要性を医学界に浸透させ，RCTを始めとした臨床研究の重要性を認識させた，③医師の権威主義的な診療スタイルに楔を打ち込んだ，④インフォームドコンセントにおける情報開示のスタイルや内容を変えた，⑤一定の科学的根拠を援用した各種診療ガイドラインの策定・確立を促進し，診療行為の質の格差を是正することに貢献した，⑥信頼できるアウトカムを用いた費用効果分析，費用効用分析を可能にし，エビデンスに基づいた医療政策と医療資源配分を可能にした．要約すれば，一定の根拠に基づいて共通の手法とプロセスを用い，個人的恣意的でない意思決定が行えるようになったといえる．

EBM導入は間違いなく医療の質を向上させる．医療の目的は患者の最善の利益を実現することであり，質の保障された根拠に基づいた診療行為は，それがたとえ担当医が特定領域の「権威」であったとしても，一個人の恣意的判断のみに基づいた医療より，患者にとってよい結果が生み出される可能性が高い．EBMが医療という領域を越えて社会的に認知されることで，一般市民にも医学研究の重要性が認知されるであろう．診療行為に対するインフォームドコンセントの過程においても，具体的なデータに基づく説明は患者に信頼できる判断材料を与え，患者と医師が共有できる意思決定の土台になる．医療政策や医療資源の配分はきわめて複雑な意思決定を必要とするが，アウトカムに基づいた費用効果・効用分析は明確な一つの選択肢を提示することができる．

❷EBMそのものがもつ限界

- 「有効性」，「エビデンス」の多義性
- ベストアウトカムの定義の困難さ
- エビデンスの不在
- 再現困難な現実の複雑さ
- RCTがもつ問題点・限界

❸ランダム化比較対照試験（RCT）の倫理的問題

- 研究行為の二義的目的
- 医師の二重の義務
- 社会的に弱い立場にある人々の参加
- 研究対象者および家族の理解，希望
- ランダム化についての情報開示
- プラセボ使用の必要性と是非
- 標準治療の地域格差
- 治験薬へのアクセス

EBMの限界と医学研究の倫理的問題

EBMは問題点も併せもっている．主な例を❷にあげた．この世に確実なものはなくEBMも例外ではない．完全無欠なエビデンスは存在せず，「ベスト」の医学的介入も一つとは限らない．倫理的には誰がどのような手順でなにをもって，一つの医療行為を「最も好ましい」と決めたかが常に問題になる．たとえ医師がベストと考えても患者や患者家族は違った考え方をもつかもしれない．また，医学領域のすべての領域にエビデンスを発見できるとは限らず，有効性のエビデンス不在が無効の証拠にはならないことは論をまたない．

医学研究，とりわけRCTに強く依存するEBMは，医学研究に内在する倫理的問題，特にRCTにまつわる解決が容易でない問題に直面することになる（❸）．「ランダム化」，「二重盲検」，「プラセボ」，「臨床的中立（clinical equipoise）」などの概念は一般の人々には理解が困難であり，理解できた場合でも研究参加を躊躇させる結果になることも多いといわれている[4]．また，将来の多くの患者のために行われる医学研究ではあるが，研究参

加者には直接的利益がないことが多い．研究対象になりやすい患者層や対象にされにくい小児や高齢者などの存在も研究結果の臨床応用を困難にさせる．医療のレベルに格差がある複数の国家で共同して行われるRCTでは，プラセボ使用を倫理的に正当化する既存標準治療の有無にバラツキが発生し，日本では許容されないプラセボ使用RCTが発展途上国では問題視されにくくなるという問題が起きる．加えて，研究参加者に「治験薬の割付はランダムに行う」という事実を説明しなくてはならないという点を理解していない研究者が今でもいる現状（結果的には倫理委員会で訂正を求められるが）は，早急に改善されなくてはならないだろう．

EBMの使い手の問題

EBMを使う側，つまりEBMにおけるエビデンス作成に関係する製薬会社や医学研究者，および公表されたエビデンスを臨床現場で利用する医療従事者―主に医師―が陥りやすい傾向，さらには医療政策を策定する立場にある人々がEBMに基づいた方針決定で起こしうる倫理的問題を❹に列挙する．

エビデンスをつくり出す人々は経済的な動機づけが大きな研究テーマを選ぶであろう．その結果，稀少な疾患や先進国における罹患率が低い疾患に対するエビデンスを提供する研究が行われにくくなる危惧がある．また，エビデンスの社会に対する公表に関するパブリケーションバイアスはすでによく知られている[5,6]．あまりにもEBMを過信する医師はエビデンスのない診療行為を軽視したり，代替医療に対する不寛容な態度を取ったりするかもしれない．インフォームドコンセントの過程でEBM的にベストな選択肢しか示さないという事態も起きうる．

逆にEBMは経験ある良心的な医師の自律性，豊かな経験に裏打ちされた直観と推論の価値を認識できないという事態も引き起こす可能性がある．医療政策策定においてもエビデンスのある医学的介入や一定効果あたりより安価な診療行為だけが医療保険の対象となり，エビデンスがないもの，根拠の度合いの弱いもの，効率の悪い方法が保険適応されず，それらを必要としている人の医療に悪影響を及ぼすこともありうる．

EBMはきわめて有用な医療ツールであるが，それ自体が目的化してしまうと上記のような問題

❹EBMの使い手の問題

- 商業主義の影響
- EBM空白地帯の存在
- エビデンスのない診療行為を軽視
- 代替医療に対する不寛容
- 過度に単純化し硬直した医療の標準化
- エビデンスに基づいたパターナリズム
- 医師の自律性への介入
- 費用効果分析・効用分析のみに基づいた医療政策の問題点

❺意思決定における重要因子

- 医学的状況の確認
- 関係者間のコミュニケーション
- 患者の意思決定能力
- 家族の意向，誰が最終的に決定するのか
- 患者の事前の希望・リビングウィルなどの存在
- 患者の最善の利益の内容
- 判断の合法性・社会性
- 倫理カンファレンス，倫理委員会での検討

❻医療の目標と期待される恩恵

- 健康促進と疾患予防
- 疾病の治癒
- 症状，痛み，苦痛の緩和
- 患者に対するケア
- 寿命のまっとう（早すぎる死の予防）
- 穏やかな死
- 機能改善と維持
- 医学的状況に関する患者教育
- 診療過程での患者への害を避ける

(Jonsen A, et al. Clinical ethics. 4th ed. NY: McGraw-Hill; 1998[8]より)

が起きる．また❺に挙げたように診療方針に関する十分な意思決定には医学的エビデンスだけでは不十分であり，ほかにもさまざまな事項が勘案されなくてはならないだろう[7]．医療がめざすべきことはさまざまである（❻）[8]．EBMの価値と限界そして問題点を十分認識して賢く使うことが求められる．

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Development of a Clinical Guideline for Palliative Sedation Therapy Using the Delphi Method

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ABSTRACT

Background: Although palliative sedation therapy is often used in palliative care settings, no clinical guideline is available.

Objective: To construct a clinical guideline for palliative sedation therapy

Design: The consensus methods using the Delphi technique on the basis of a systematic literature review was used.

Setting/Subjects: A national multidisciplinary committee (five palliative care physicians, four nurses, two oncologists, two psychiatrists, two anesthesiologists, two bioethicists, a medical social worker, and a lawyer).

Measurements: Validity scoring based on the Delphi method and feasibility.

Results: After three sequential sessions of discussion by the Delphi method, an external review by specialists, end-users, and bereaved family members, and a field test, a clinical guideline for palliative sedation therapy was constructed. This guideline includes definitions of palliative sedation therapy, description of the ethical basis of palliative sedation therapy, recommendations about clinical practices in continuous-deep sedation, and diagrams illustrating the clinical application of continuous-deep sedation.

Conclusion: We constructed a clinical guideline for palliative sedation therapy using the Delphi technique. The clinical efficacy of this guideline should be tested in the future.

INTRODUCTION

TERMINALLY ILL PATIENTS with cancer often experience intolerable suffering refractory to standard palliative treatment, and palliative sedation therapy is one of the therapeutic options for such suffering.[1,2] However, the frequency of sedation varies widely among physicians and institutions, and physicians' knowledge and attitudes could affect their decisions about sedation.[1–5] Inappropriate use of sedation could cause unnecessary reduction in consciousness levels leading to poor quality of life. On the other hand, if sedation is not applied to patients with truly refractory suffering, they may suffer unnecessarily.

Therefore, a valid clinical guideline for palliative sedation therapy is strongly required. This report describes a summary of the clinical guide-

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line developed by a Japanese national task force. The original paper (available from the authors, Japanese version) includes a the result of systematic literature review, issues to be addressed in the future, and examples of communications with patients and families, in addition to complete references.

METHODS

Framework

The aim of the guideline is to help clinicians adequately perform sedation and ensure better quality care for terminally ill patients. The target population is adult patients with cancer with incurable cancer treated in palliative care units or by palliative care teams. The targeted users are health care professionals in palliative care units or on palliative care teams.

The health objective for this guideline is quality of life, dying, and death. Determinants of the quality of life, dying, and death vary among individuals, and thus there are no uniform criteria. However, palliation of physical distress, peace of mind, feeling meaning and value of life, strengthening relationships with the family, preparation for death, and life completion are important factors for many patients and families.

This guideline stresses respect for individuality and humaneness, the necessity for reevaluation, and the responsibility of primary clinicians.

Development process

The Sedation Guideline Task Force developed this guideline, The members of the Task Force were selected from national distinguished experts, and consisted of five palliative care physicians, four nurses, two oncologists, two psychiatrists, two anesthesiologists, two bioethicists, a medical social worker, and a lawyer (Table 1).

First, the Task Force performed a systematic literature review and obtained 114 articles. The full texts of all articles were distributed to the members. Because the evidence levels of the majority of the articles were grade 4 or 5 by the Oxford Centre for Evidence-based Medicine Levels of Evidence (2002), we decided to use the Delphi technique to construct the guideline.[6,7] On the basis of literature findings and clinical experience, six members drafted the guideline.

Next, the draft was divided into 145 sentences, and all members were requested to rate the validity of each sentence on a 9-point Likert-type scale from 1 (not appropriate) to 9 (appropriate). The median value was 8 or more in 138 items (the difference between the minimum and maximum was 5 or less in 107 items and 6 or more in 31 items), and in the remaining 7 items the median values were 7 or 7.5. The median, minimum, and maximum values were disclosed to each member, and the differences in opinions were discussed and resolved in a face-to-face conference.

Third, the revised guideline was divided into 137 sentences, and the validity was evaluated by the same method. In all items, the median value was 8 or more and the difference between the minimum and maximum was 5 or less. We determined that the major difference had been resolved, and adopted the draft as a provisional version by the Task Force after minor revision.

Fourth, five external reviewers selected from national experts who had not been involved in this project (a palliative care physician, an oncologist, a psychiatrist, an anesthesiologist, and a palliative care nurse), five end-users (three physicians, and two nurses working in palliative care units or teams), and five bereaved family members reviewed the provisional version and provided free-form comments.

Fifth, after dissemination of these free-form comments to all members, the revised guideline was segmented into 137 sentences. In all except 2 items, the median value was 8 or more and the difference between the minimum and maximum was 5 or less. For the two items in which the difference between the minimum and maximum was 6, reevaluation of the revised items achieved the median value 8 or more and the minimum value of 7. We adopted this as the final version. Five care teams from five palliative care units agreed that this guideline was feasible as a result of field test on 31 patients.

DEFINITIONS

There is no international consensus about the definition of palliative sedation therapy.[8]

Palliative sedation therapy

Palliative sedation therapy is defined as (1) the use of sedative medications to relieve suffering by the reduction in patient consciousness level or

TABLE 1. MEMBERS OF SEDATION GUIDELINE TASK FORCE

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Mikako Okada, R.N., M.N.	Nursing	Palliative Care Unit, St. Luke's International Hospital
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Masayuki Ikenaga, M.D.	Palliative Medicine	Hospice, Yodogawa Christian Hospital
Yasuo Shima, M.D.	Palliative Medicine	Palliative Care, National Cancer Center Hospital East
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Noriko Futami, R.N.	Nursing	The Life Planning Center Foundation, Peace House Hospice
Yasuko Oyagi, R.N.	Nursing	Palliative Care Team, Showa University Northern Yokohama Hospital
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Tetsuro Shimizu, Ph.D.	Philosophy	Graduate School of Arts and Letters, Tohoku University
Masashi Shirahama, M.D.	Ethics	Mitsuse Village National Health Insurance Clinic
Hideki Onishi, M.D., Ph.D.	Psychiatry	Department of Psychiatry, Kanagawa Cancer Center
Yukie Kurihara, C.S.W.	Social work	Department of Palliative Medicine, Shizuoka Cancer Center
Kazuto Inaba	Lawyer	Center of Life Science and Society

(2) intentional maintenance of reduction in patient consciousness level resulting from symptomatic treatments.

This definition excludes the administration of hypnotics for sleep disorders. When the reduction in patient consciousness level unintentionally occurs, if physicians provide interventions to reverse the consciousness disturbance, it is excluded; however, if physicians intentionally maintain the reduction in the consciousness level, it is included.

Classifications of palliative sedation therapy

Palliative sedation therapy is classified according to duration and degree of sedation, and is described as a combinations of these classifications (e.g., continuous-deep sedation, intermittent-mild sedation).

Duration of sedation. Continuous sedation is sedation in which a reduced level of consciousness is maintained without specifying plans to discontinue.

Intermittent sedation is sedation to reduce patient consciousness levels for prolonged periods, but also to provide some periods when the patient is alert by discontinuing or reducing sedative medications.

Degree of sedation. Deep sedation is sedation that causes near or complete unconsciousness so

that patients can not communicate with caregivers verbally or nonverbally.

Mild sedation is sedation to maintain consciousness so that patients can verbally or nonverbally communicate with caregivers.

Other definitions

Family is defined as "(1) people related to the patient by marriage or birth such as the spouse, parents, children, and siblings; and/or (2) people who support the patient and/or are supported by the patient emotionally, functionally, or financially and are perceived by the patient as family members." Care team is defined as, "a multidisciplinary team consisting of physicians, nurses, mental health care professionals, medical social workers, and pharmacists who provides patient care." Euthanasia is defined as, "patient death caused by the administration of a medication by a physician with the aim of terminating patient life."

ETHICAL BASIS OF PALLIATIVE SEDATION THERAPY

Differences between palliative sedation therapy and euthanasia

Sedation differs from euthanasia in the intention (symptom relief versus patient death), methods (use of sedative medications enough to achieve symptom relief versus administration of lethal medications), and successful outcomes (symptom relief versus patient death).

Desirable and undesirable effects of sedation

The desirable effect of sedation is palliation of suffering.

Undesirable effects of sedation are, in general, reduction in the consciousness level, inability to communicate, and shortened patient survival. However, some patients and families do not think that reduction in the consciousness level or shortened survival is undesirable.

Ethical basis of sedation

The Task Force agree that sedation is ethically justified under the following conditions.

1. Intention
   The aim of sedation must be palliation of suffering.
2. Principles of autonomy [(a or b) and c]
   Patient wish
   a) If the patient is competent, the patient should be adequately informed and express an explicit wish for sedation. b) If the patient is incompetent, it should be well assumed that the patient would wish for sedation. c) The family consents to sedation.
3. Principle of proportionality
   Considering the patient conditions (intensity of suffering, lack of other methods for palliation, and expected survival), expected benefits (palliation of suffering), and expected harms (effects on the consciousness and survival); sedation should be the most proportional action among all possible choices.

Role of the family

The family is an important recipient of care. Clinicians should care for families, as they do for patients, in the sedation decision-making process.

RECOMMENDATIONS ABOUT CLINICAL PRACTICE OF CONTINUOUS-DEEP SEDATION

Proposed criteria for continuous-deep sedation

The Task Force proposes the following requirements for continuous-deep sedation. Items A to C provide ethical grounds for sedation, namely, the intention of the medical professionals, principle of autonomy, and principle of proportionality, respectively. Item D reinforces the safety of sedation.

A. Intentions
   1) The care team should understand that the aim of sedation is palliation of suffering.
   2) The medication, dose, and administration method should be proportional to the aim of sedation (palliation of suffering).

B. Consent of the patient and family (1 and 2)
   1) Patient
      a) If the patient is competent, the patient should be adequately informed and express an explicit wish for sedation.
      b) If the patient is incompetent, it should be well assumed that the patient would request sedation, considering his/her values and previously expressed wishes.

2) (For patients with family members,) there should be consent from the family.

C. Proportionality

Considering the patient conditions (intensity of suffering, lack of other methods for palliation, and expected survival), expected benefits (palliation of suffering), and expected harms (effects on the consciousness and survival); sedation should be the most proportional action among all possible choices. That is;

1) Patient suffering should be intolerable.
2) Suffering should be diagnosed as refractory by the care team.
3) It should be estimated that death will occur within several days or weeks because of the underlying disease.

D. Safety

1) There should be agreement among the care team. A multidisciplinary conference is desirable.
2) If there is uncertainty in the evaluation of patient competency, refractoriness of suffering, and expected survival, consultation with experts (e.g., psychiatrists, anesthesiologists, pain specialists, oncologists, specialized nurses) is desirable.
3) The medical rationale for sedation, the decision making process, and the doses and administration methods of sedatives should be recorded.

DIAGRAMS FOR CLINICAL APPLICATION OF CONTINUOUS-DEEP SEDATION

Part 1. Medical indications (Figure 1)

Definition and assessment of intolerable distress. Suffering is defined as intolerable (1) when the patient describes it as intolerable or (2) if impossible, when the family and the care team sufficiently assume that the suffering would be intolerable to the patient in the light of his/her values.

Target symptoms of sedation include delirium (excluding delirium not accompanied by organ failure, such as delirium associated with dementia), dyspnea, excessive bronchial secretion, pain, nausea/vomiting, fatigue, convulsion/myoclonus, anxiety, depression, and psychoexistential suffering (e.g., hopelessness, meaninglessness). However, anxiety, depression, and psychoexistential suffering as a single indication of continuous-deep sedation is exceptional. The appropriateness of sedation for psycho-existential suffering should be very carefully addressed.

This guideline does not recommend use of poorly defined terms to describe target symptoms of sedation, such as "restlessness," "agitation," "confusion," "generalized suffering," and "mental anguish." If the suffering is not well specified, this guideline recommends use of the term "unspecified suffering."

Definition and assessment of refractory suffering. Suffering is defined as refractory (1) when all treatments have failed or (2) when, on the basis of the patient's wishes and physical conditions, there are no other methods that will be effective within the allowed time frame and the possibility of complications and degree of invasion are tolerable for the patient.

The care team should assess the treatable components of underlying etiologies, symptomatic treatments, and psycho-social and environmental factors contributing to tolerability. Suffering should not be diagnosed as refractory until thorough assessments are completed. If there is uncertainty about the refractoriness of suffering, time-limited trials of potentially effective treatments should be considered. Table 2 summarizes standard treatments for symptoms as indications of sedation. The list does not always cover all treatments, and it does not mean that all treatments listed must be actually performed before the initiation of sedation.

Assessments of patient's physical condition and prognoses. The care team should assess patient physical conditions using validated instruments (e.g., Palliative Prognostic Score, Palliative Prognostic Index), presence or absence of prognostic factors (e.g., Karnofsky Performance Scale, dyspnea, anorexia, degree of oral intake, delirium, edema), presence or absence of organ failure (e.g., respiratory, hepatic, renal, cardiac failures), in addition to clinical estimation of survival.

This guideline does not recommend the use of vague terms to describe patient physical conditions, such as "terminal stage" and "imminently dying." The care team should not determine that the patient's survival is limited without throughout systematic assessment. The estimated prog-

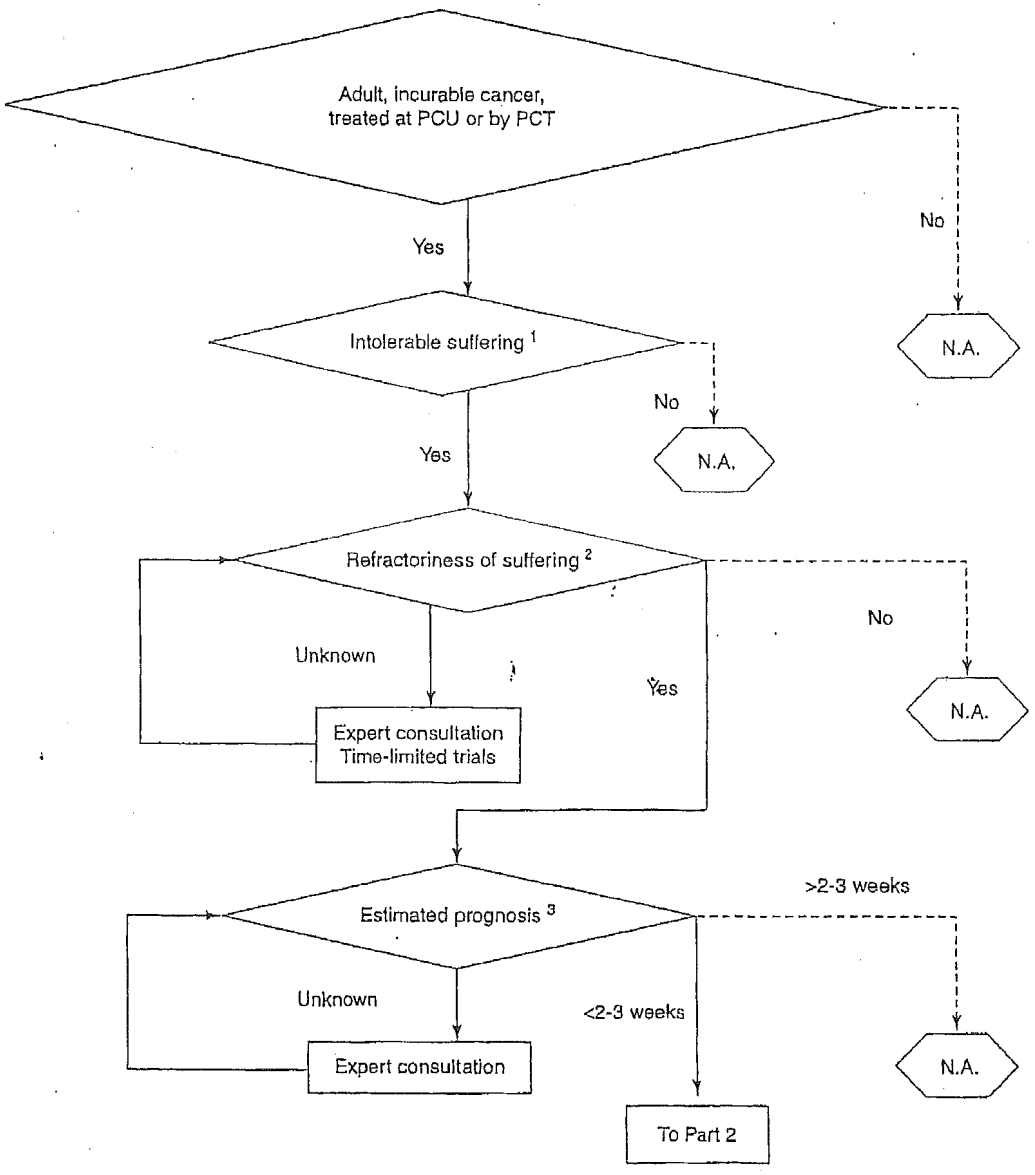

FIG. 1. Medical indication. PCU, palliative care units; PCT, palliative care team; N.A., not applied for this guideline.

nosis of patients requiring continuous-deep sedation is usually a few days or shorter.

Part 2. Confirmation of patient and family wishes (Figure 2)

Definition and assessment of patient competency. Competency should be evaluated according to (1) whether the patient can express his/her will, (2) whether the patient understands relevant information, (3) whether the patient acknowledge the implications of their choice, and (4) whether the patient choice is reasonable.

It is desirable that competency be assessed by an experienced care team with description of the assessment process. Particularly, depression and mild consciousness disturbance need appropriate assessments, because they are often underdiagnosed despite their high frequency and potential effects on the patient's competency.

Decision-making process for incompetent patient. When the patient is incompetent, the care team should carefully assess what the patient wants

TABLE 2. STANDARD TREATMENTS FOR SYMPTOMS

Delirium
- Adjustment of the environment
- Search for treatable causes and their treatments (e.g., hypercalcemia, hyponatremia, infections, hypoxemia, dehydration, brain tumor)
- Adjustment of medications (reducing, withdrawing, or changing unessential or neurotoxic medications)
- Treatments for unpalliated distresses such as pain and dyspnea
- Administration of antipsychotic medications

Dyspnea
- Search for treatable causes and their treatments (e.g., pleural effusion, pericardial effusion, superior vena cava syndrome, bronchial stenosis, asthma, pneumonia, pneumothorax, heart failure, anemia, ascites, anxiety)
- Oxygen
- Opioids
- Steroids
- Treatments for anxiety (anxiolytic medications, psychological support)

Excessive bronchial secretion
- Search for treatable causes and their treatments (e.g., pneumonia, heart failure, esophagobronchial fistula)
- Drainage
- Antisecretant medications
- Reducing or withdrawing artificial hydration

Pain
- Search for treatable causes and their treatments (e.g., fracture, abscesses, gastric or duodenal ulcer, intestinal perforation, acute pancreatitis)
- Opioids, nonopioids, adjutant analgesics
- Treatments for undesirable effects from analgesics
- Nerve block, radiotherapy, surgical treatments

Nausea/vomiting
- Search for treatable causes and their treatments (e.g., medications including NSAIDs and opioids, hypercalcemia, brain metastasis, intestinal obstruction, constipation, gastric or duodenal ulcer)
- Steroids
- Gastrointestinal secretion suppressants, gastrointestinal decompressing procedures (for gastrointestinal obstruction)
- Antiemetics (dopamine-, histamine-, serotonin-, or choline-blocking)

Fatigue
- Search for treatable causes and their treatments (e.g., hypercalcemia, hyponatremia, infections, anemia, dehydration, depression)
- Methylphenidate
- Steroids

Convulsion/myoclonus
- Search for treatable causes and their treatments (e.g., medications, brain metastasis)
- Anticonvulsive medications

Anxiety, depression, and psycho-existential suffering (e.g., hopelessness, meaninglessness)
- Treatment for treatable physical causes (e.g., medications, unpalliated physical symptoms, hypoxemia, brain metastasis, akathisia)
- Minimization of loss of physical functions (e.g., rehabilitation, alternative measures)
- Psychological support (e.g., active listening, encouragement of emotional expression, life review)
- Diversion, environment adjustment, relaxation (e.g., progressive muscle relaxation)
- Strengthening of social support
- Pharmacotherapy (e.g., anxiolytics, antidepressants)
- Consultation with mental health professionals and religious experts

NSAIDs, nonsteroidal anti-inflammatory drugs.

in the current situation with the family, considering the patients' values and previously-expressed wishes. Clinicians should clarify to the family that (1) the expected role of the family is to estimate patient will and not to be totally responsible for all decisions and that (2) the care team shares the responsibility for the decision of sedation.

Information to be communicated. What the patient and family is informed should be determined individually, with careful consideration of patient and family preference and estimated benefits and harms of information disclosure. That is, if patients and families request full information, they should be informed. On the other hand, if they do not want to be told all the

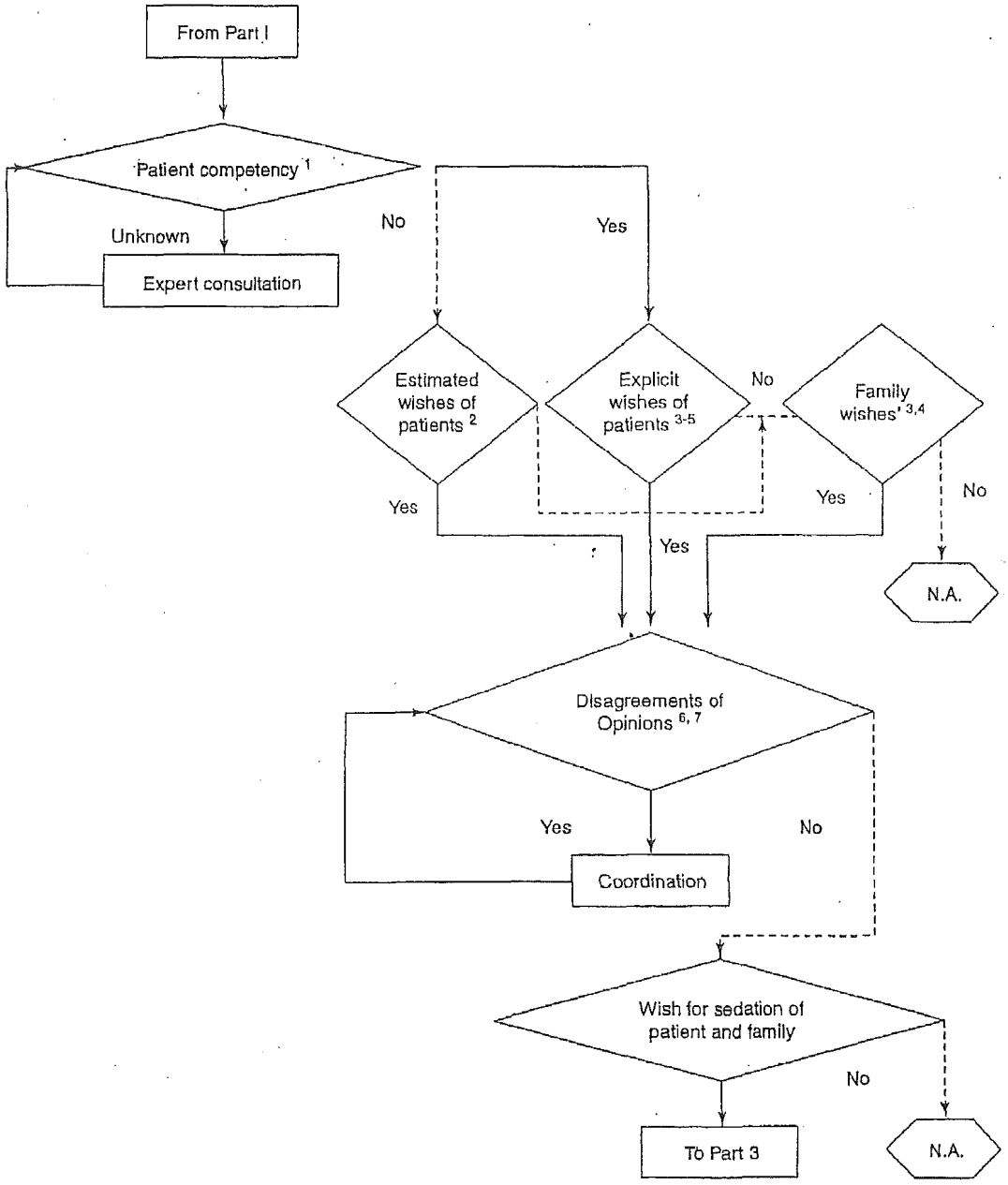

FIG. 2. Confirmation of patient and family wishes.

information, or the estimated harms surpass the estimated benefits, clinicians should carefully consider the quantity of information and the communication methods.

Items to be considered for disclosure are;

1. General condition: general explanation of the physical condition, incurability, and the expected conditions and survival.
2. Suffering: presence of refractory suffering, causes of suffering, treatments that have been attempted, and rationale for the decision that sedation is the only method available for achieving symptom relief.
3. Aims of sedation: palliation of suffering.
4. Methods of sedation: administration of sedatives that reduce the consciousness level, with option to discontinue sedation.

5. Effects of sedation: the anticipated degree of reduction in consciousness levels; estimated effects on mental activities, communication, oral intake, and survival; and the possibility of complications.
6. Medical treatments and nursing care after sedation: that treatments and care to maximize patient comfort is continued, that patient and families' wishes are respected.
7. Expected outcomes when sedation is not performed: other choices, degree of suffering, and expected survival.

Voluntariness and continuity of the decision. The care team should confirm that the patient decision is not affected by psychological or social pressure. It is desirable to confirm that the patient decision is steady (e.g., presence of repeated explicit wishes for sedation, or long-standing wishes for symptom relief, such as "I want to die peacefully").

Exploring the patient and family wishes for sedation in advance. Patients often lack competency when sedation is required. Thus, it is desirable to provide information in advance to patient and family about potential choices for refractory suffering, including sedation, if they want such information and/or the estimated benefits of the information disclosure outweigh the estimated harms.

When patient will differs from family will. The care team should (1) help families to understand the patient's suffering and conditions by providing sufficient information and arranging an environment in which the family can attend the patient; (2) support the patient and his/her family in talking to each other and finding a solution that is acceptable to both parties; and (3) provide psychological support to families to relieve factors contributing to their conflicts, such as grief and guilt.

While the patient and his/her family continue to discuss, the care team should explore treatment options to maximally respect the patient's will and to maximize the patient's benefits. For example, if the patient wants continuous-deep sedation but the family does not agree, the care team should consider mild or intermittent sedation to minimize the patient's suffering.

If the patient becomes incompetent before agreement is reached, the care team should help the family to estimate the patient's will from the patient's values and previously expressed wishes.

When opinions differ within the family. The care team should help each family member understand the patient's suffering and condition, and coordinate family discussion to find a solution acceptable to each family member.

Part 3. Initiation of sedation (Figure 3)

Choice of sedation method. The care team should choose sedation methods with the smallest effects on the consciousness levels or physical functions, as long as the suffering is adequately palliated. Generally, intermittent or mild sedation should be attempted first, and continuous-deep sedation should be adopted when intermittent or mild sedation has been ineffective.

Continuous-deep sedation could be selected first, if (1) the suffering is intense, (2) the suffering is definitely refractory, (3) death is to occur within several hours or days, (4) the patient's wish is explicit, and (5) suffering will not be palliated by intermittent or mild sedation.

Decisions concerning artificial hydration and nutrition. Whether artificial hydration/nutrition therapy is performed should be individually decided through comprehensive evaluation of the patient's wishes and the estimated benefits/harms in light of the treatment aim (palliation of suffering). The decision about artificial hydration/nutrition therapy is independent of the decision about sedation itself.

If the patient can take nutrition orally or receive artificial hydration/nutrition therapy before sedation, it is desirable to discuss with the patient and the family before sedation whether they want to continue or discontinue artificial hydration/nutrition therapy.

If fluid retention symptoms related to artificial hydration/nutrition therapy exacerbate patient suffering, the reduction or withdrawal of artificial hydration/nutrition should be considered on the basis of patient and family wishes. If artificial hydration/nutrition therapy contributes to alleviation of patient suffering, it should be continued on the basis of the wishes of the patient and family.

Decisions concerning life-supporting treatments. It is desirable to discuss with patients and their