Ethical Decision Making and Patient Autonomy*

A Comparison of Physicians and Patients in Japan and the United States

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Background: Patient-centered decision making, which in the United States is typically considered to be appropriate, may not be universally endorsed, thereby harboring the potential to complicate the care of patients from other cultural backgrounds in potentially unrecognized ways. This study compares the attitudes toward ethical decision making and autonomy issues among academic and community physicians and patients of medical center outpatient clinics in Japan and the United States.

Methods: A questionnaire requesting judgments about seven clinical vignettes was distributed (in English or Japanese) to sample groups of Japanese physicians (n = 400) and patients (n = 65) as well as US physicians (n = 120) and patients (n = 60) that were selected randomly from academic institutions and community settings in Japan (Tokyo and the surrounding area) and the United States (the Stanford/Palo Alto, CA, area). Responses were obtained from 273 Japanese physicians (68%), 58 Japanese patients (89%), 98 US physicians (82%), and 55 US patients (92%). Physician and patient sample groups were compared on individual items, and composite scores were derived from subsets of items relevant to patient autonomy, family authority, and physician authority.

Results: A majority of both US physicians and patients, but only a minority of Japanese physicians and patients, agreed that a patient should be informed of an incurable cancer diagnosis before their family is informed and that a terminally ill patient wishing to die immediately should not be ventilated, even if both the doctor and the patient’s family want the patient ventilated (Japanese physicians and patients vs US physicians and patients, p < 0.001). A majority of respondents in both Japanese sample groups, but only a minority in both US sample groups, agreed that a patient’s family should be informed of an incurable cancer diagnosis before the patient is informed and that the family of an HIV-positive patient should be informed of this disease status despite the patient’s opposition to such disclosure (Japanese physicians and patients vs US physicians and patients, p < 0.001). Physicians in both Japan and the United States were less likely than patients in their respective countries to agree with physician assistance in the suicide of a terminally ill patient (Japanese physicians and patients vs US physicians and patients, p < 0.05). Across various clinical scenarios, all four respondent groups accorded greatest authority to the patient, less to the family, and still less to the physician when the views of these persons conflicted. Japanese physicians and patients, however, relied more on family and physician authority and placed less emphasis on patient autonomy than the US physicians and patients sampled. Younger respondents placed less emphasis on family and physician authority.

Conclusions: Family and physician opinions are accorded a larger role in clinical decision making by the Japanese physicians and patients sampled than by those in the United States, although both cultures place a greater emphasis on patient preferences than on the preferences of the family or physician. Our results are consistent with the view that cultural context shapes the relationship of the patient, the physician, and the patient’s family in medical decision making. The results emphasize the need for clinicians to be aware of these issues that may affect patient and family responses in different clinical situations, potentially affecting patient satisfaction and compliance with therapy. (CHEST 2000; 118:1172–1182)

Key words: cancer; decision making; disclosure; ethics; HIV; informed consent; Japan; mechanical ventilation; patient autonomy; physician-assisted suicide

Abbreviation: CI = confidence interval
Respect for patient autonomy has become paramount in US medical decision making in the last quarter century. Disclosure of a cancer diagnosis to the patient, for example, is a relatively recent phenomenon. Of US doctors surveyed in 1961, 88% generally did not inform their cancer patients of the diagnosis; by 1979, 98% generally did so. Physician-patient communication in the United States is now characterized by an emphasis on patient autonomy, which has become institutionalized by legally mandated informed consent procedures and the ideal of information disclosure.

A primary determinant of the nature of communication in health care is the conception that the participants have of the individual. Western bioethics now focuses more on ethical decisions that are based on individual autonomy, while the social framework of decision making has diminished in significance. This individualistic model of medical decision making, the so-called “autonomy paradigm,” has achieved dominance in the United States over the “social framework paradigm,” which plays a greater role in other countries and among some cultural groups in the United States.

In placing patient autonomy at the center of ethical decisions, the medical community in the United States has proceeded as if this were universally appropriate. However, other countries have not experienced this recent paradigm shift, and physician-patient communication is consequently quite different. The reliance of the US medical community on patient-centered decision making, serving as the cornerstone of informed consent, has been referred to by Pellegrino as a “cultural artifact” in that reliance on this concept is not universal and, perhaps, somewhat anomalous. Informed consent may, therefore, complicate and potentially may interfere with the care of certain patients, particularly those from countries and cultural groups in which the family or other social unit plays a more pivotal role in treatment decisions.

Recent immigrants and patients born in this country but raised in a particular cultural milieu may perceive the current model of informed consent as less than ideal. In addition, physicians crossing national or cultural boundaries may bring with them decision-making customs not regarded as ethical or legal in their new practice environment, while US patients abroad may compromise their care by assuming US customs to be universal. We define culture here as that set of learned values, beliefs, customs, and behaviors that is shared by a group of interacting individuals. In this sense, culture and nationality are not identical constructs, and physicians and patients within a given national culture could be said to belong to different subcultures. Such values and beliefs provide, whether implicitly or explicitly, the criteria by which decisions are evaluated as good or bad, appropriate or inappropriate, and even legal or illegal.

We assessed the perceptions of physicians and patients regarding the relationships of the patient, the physician, and the patient’s family in medical decision making with the objective of directly comparing such perceptions in Japan and the United States and between physicians and patients in each country. We were motivated, in part, by the anecdotal observations and discussions among the authors regarding the decision-making practices in their respective countries. While evidence of cultural differences with respect to these issues is not lacking, this is the first study to present quantitative comparisons between groups of physicians and patients in Japan and the United States with regard to ethical decision making using a single survey instrument. Both countries are industrialized. However, Japan has a very different cultural and religious history than the United States, and reports have suggested that Japanese physicians frequently withhold diagnostic and prognostic information from patients. The Japanese experience, therefore, represented a valuable opportunity for comparison with medical decision making in the United States. We made this comparison by presenting to physicians and patients a series of “vignettes,” or clinical situations, in which the needs and desires of patients, physicians, and families were varied so as to be in agreement or at odds with each other. The responses (the extent to which respondents agreed or disagreed with various clinical decisions presented in the vignettes) are presumed to reflect underlying respondent values. And to the extent that these responses are systematically affected, across multiple vignettes, by who in the vignette holds a particular preference (patient, physician, or family member), the underlying values of the respondent regarding the relative authority of these different parties are revealed.

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Materials and Methods

Samples and Data Collection Procedures

The Japanese physician sample (n = 400) consisted of the total membership of three local medical societies in Tokyo (Fuchu, n = 120; Chofu, n = 27; and Mitaka, n = 25) and one in Okinawa (n = 30), as well as of random samples of clinical physicians from two schools of medicine, Kyorin in Tokyo (n = 150) and Ryukyus in Okinawa (n = 48). All specialties were included. Thus, the Japanese physician sample group includes both academic and nonacademics physicians from two distinctly separated regions. Questionnaires were distributed to patients attending the general medicine clinic at Kyorin University (n = 65) at different times during a 1-week period. The Japanese data were collected in the summer of 1992.

In the United States, both academic and Stanford-affiliated community physicians (n = 120) were selected randomly from the Stanford Health Services directory. All specialties were included. Stanford Health Services cares for a diverse patient population from many urban regions in California and other states in the western United States. Its affiliated physicians are diverse in cultural and ethnic backgrounds. Questionnaires were distributed to outpatients at Stanford University Hospital clinics (n = 60) during several randomly selected time intervals. US data were collected from the fall of 1992 through the summer of 1993.

Although the survey was confidential, return envelopes were coded to identify nonrespondents, to whom we sent additional surveys. This study was approved by the Stanford University Human Subjects Committee. Questionnaires were completed by 273 Japanese physicians (68%), 98 US physicians (82%), 58 Japanese patients (89% of those approached), and 55 US patients (92%).

Survey Instrument

The survey instrument, which was developed collaboratively at Stanford University School of Medicine and Kyorin University School of Medicine, consisted of 52 statements with which respondents were asked to agree or disagree. Of these, 46 statements were based on 7 clinical vignettes. The remaining six were statements in the same format but were not associated with any particular vignette. The vignettes were designed, with input from clinical physicians and experts in ethical decision making, to assess attitudes toward autonomy issues in the following situations: (1) disclosure of a cancer diagnosis; (2) the appropriate decision maker for ventilation support; (3) informed consent in drug therapy; (4) informed consent in surgery; (5) informed consent in a clinical study; (6) physician-assisted suicide; and (7) ethical issues in HIV disease. Responses to the statements used the following 4-point Likert’s scale: 1, strongly disagree; 2, disagree; 3, agree; and 4, strongly agree. In order to avoid a consistent response bias, the orientation of the items was varied randomly. Hence, the responses of an individual who invariably accorded patient autonomy the greater role in decision making would divide his/her responses approximately equally between “strongly agree” and “strongly disagree” across those items relevant to patient autonomy. Respondents were asked to answer solely according to their beliefs, without consideration of legal constraints, and were told that there were no “correct” responses.

In the United States, we pilot-tested this self-administered instrument on 10 physicians and 10 patients, revising it for clarity and ease of comprehension. After translation into Japanese and back-translation, it was pilot-tested on 10 Japanese physicians and 10 Japanese patients. Comparable changes then were made in both the US and Japanese versions to maintain consistency. Translation and back-translation were performed by different individuals to ensure the validity of the translation. In addition, several bilingual individuals completed the questionnaire in both English and Japanese. The responses of these individuals did not differ significantly between the two languages.

Statistical Analysis

Individual Items: x² tests were performed to compare physician and patient groups between and within countries on individual items. For these comparisons, the 4-point Likert scale was dichotomized into simply “agreed” or “disagreed.” Close examination of the data indicated that the conclusions would not have differed had all four categories been used in the item-by-item analysis.

Scale Scores: Of the 52 items, 20 were constructed in such a manner that the decisions they represented could be unequivocally relevant to only one dimension, either patient autonomy (9 items), family authority (5 items), or physician authority (6 items). Numeric scores on each of these item sets were averaged to produce three simple composite scores (possible range, 1 to 4) for each respondent. A higher scale score represents stronger reliance on the targeted concept. The data analyses compared the mean scale scores of the sample subgroups.

Results

The characteristics of the respondents are shown in Table 1. All patients and all physicians except one in the Japanese sample group (a Chinese physician) described themselves as Japanese. The US physicians and patients were, respectively, 88% and 70% white, 5% and 14% Asian, and 3% and 10% African American, while 4% and 6%, respectively, did not provide this information. The patient subgroups each were divided evenly between those with and those without a college education. Both Japanese sample groups had a higher proportion of male respondents than the respective US sample groups.

Incurable Cancer

Table 2 illustrates the results for items associated with two vignettes. The first vignette (No. 4) concerns a cancer patient. At least 80% of US physicians and patients agreed that a doctor should inform the patient of a cancer diagnosis and should let them decide whether their family should be told. In Japan, few physicians (17%), but a somewhat larger proportion of patients (42%) agreed. Under the assumption that the family had been told and thought that the patient should not be told, the vast majority of US physicians and patients, but not that of Japanese respondents, thought that the patient should be told. This was not the case for Japanese respondents. High proportions of Japanese physicians (80%) and patients (65%) agreed that a doctor should inform the patient’s family of the diagnosis and should let them decide whether the patient should be told. A minority of US physicians (6%) and patients (22%) agreed.
Withholding Ventilation Support

In vignette No. 5 (Table 2) the patient needs ventilation support in order to avoid immediate death. The patient is first described as mentally competent (items 15 to 18) and, subsequently, as being mentally incapacitated (items 19, 22, and 25). Items 22 and 25 suppose an incapacitated patient who has completed an advance directive.

When the patient was described as mentally competent, approximately half of the Japanese physicians and a somewhat higher proportion of the Japanese patients agreed that such a patient should be ventilated, in accordance with the wishes of the patient’s family, despite the opposition of both doctor and patient (item 15). Only very small proportions of US respondents agreed. In contrast, where the patient’s wish to be allowed to die conflicts with that of both doctor and family (item 16), the vast majority of US physicians and patients agreed that the patient should not be ventilated, despite the opposition of both the physician and the patient’s family. However, the percentage of US respondents in agreement was significantly greater than in the corresponding Japanese subgroups.

Ethical Issues in HIV Testing

In response to vignette No. 7 concerning HIV testing (Table 3) in which a patient will not give permission for an HIV test to be performed (item 40), most US physicians (70%) and patients (89%) agreed that a doctor should be allowed to refuse to perform medical procedures that would place him at risk of HIV infection. In Japan, significantly fewer physicians and still fewer patients agreed. When asked to assume that, without the patient’s permission, the test has been performed and is positive (item 43), slightly more than half of Japanese physicians and about three fourths of Japanese patients agreed that the patient’s family should be informed of her disease status despite her opposition to such disclosure. In the United States, significantly fewer physicians and patients agreed.

Physician-Assisted Suicide

In a number of the vignettes (eg, No. 4 and No. 5), the views of Japanese physicians and patients agreed. Given circumstances in which the patient was mentally incapacitated and had an advance directive stating his desire to forgo ventilation in such a situation, a majority of all four subgroups agreed that the patient should not be ventilated, despite the opposition of both the physician and the patient’s family. However, the percentage of US respondents in agreement was significantly greater than in the corresponding Japanese subgroups.
ferred from the US sample groups but also diverged significantly from each other, with the patients being somewhat closer to the views of the US sample than were the Japanese physicians. Vignette No. 6 (Table 4), concerning assisted suicide, shows a somewhat different pattern in which the views of the US and Japanese physicians were relatively similar, while the views of both sets of patients were more similar to each other and were markedly different from those of their physicians. In that vignette, a terminally ill patient with stomach cancer, accompanied by severe intractable pain, requests a number of pills sufficient to commit suicide. A relatively small proportion of respondents in each subgroup, except for Japanese patients (49%) thought that the doctor should provide the pills if he had only seen the patient once and had received no input from the patient’s family. With family approval, the proportion of respondents in favor or the patient’s request was significantly higher in all subgroups except among Japanese patients, who were already the most in favor of granting the patient’s request, regardless of any other opinions.

Table 2—Proportions of Respondents in Agreement With Statements Concerning Treatment of Patients With Incurable Cancer (Vignette No. 4), and an Unspecified Incurable Disease (Vignette No. 5), Separately for Patients and Physicians From Japan and the United States

<table>
<thead>
<tr>
<th>Items</th>
<th>Agreement, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. The doctor should tell the patient, and also let the patient decide whether or not their family should be told.</td>
<td>17</td>
</tr>
<tr>
<td>11. The doctor should tell the patient’s family, and also let them decide whether or not the patient should be told.</td>
<td>80</td>
</tr>
<tr>
<td>14. Assume the family has been told and they do not want the patient told; the doctor should tell the patient anyway.</td>
<td>8</td>
</tr>
<tr>
<td>15. The patient and his doctor both agree that he should be allowed to die immediately, but his family wants him placed on the breathing machine. He should therefore be placed on the breathing machine.</td>
<td>50</td>
</tr>
<tr>
<td>16. The patient wants to be allowed to die immediately, but his doctor and family both want him placed on the machine. He should not be placed on the breathing machine even though he will die sooner.</td>
<td>44</td>
</tr>
<tr>
<td>17. The patient, his family, and his doctor all want him to be allowed to die immediately. However, he should be placed on the breathing machine anyway.</td>
<td>22</td>
</tr>
<tr>
<td>18. The doctor wants him placed on the breathing machine, but the patient and his family both want him to be allowed to die immediately. Therefore, he should not be placed on the breathing machine even though he will die sooner.</td>
<td>69</td>
</tr>
<tr>
<td>19. The patient is mentally incapacitated. The doctor wants the patient placed on the breathing machine, but the patient’s family wants him to die immediately. He should be placed on the breathing machine.</td>
<td>35</td>
</tr>
<tr>
<td>22. Assume the mentally incapacitated patient has an advance directive stating his desire to be allowed to die in such a situation. The doctor and the patient’s family both want him placed on the breathing machine. However, he should not be placed on the breathing machine even though he will die sooner.</td>
<td>55</td>
</tr>
<tr>
<td>25. The patient’s family wants him placed on the machine, but the doctor wants him to be allowed to die immediately. He should not be placed on the breathing machine even though he will die sooner.</td>
<td>35</td>
</tr>
</tbody>
</table>

*p < 0.05 for all comparisons of Japanese physicians with US physicians and for items 10, 11, 14, 19, and 25 of Japanese physicians with Japanese patients.
†p < 0.05 for all comparisons of Japanese patients with US patients except for items 19 and 25 as not statistically significant; p < 0.05 for items 11, 15, 18, and 19 for all comparisons of US physicians with US patients.
When told that the doctor had known the patient for 20 years, significantly more respondents in all groups agreed with providing the pills. Patients in both Japan and the United States were more likely to agree with doctor assistance in the patient’s suicide than were their physicians. Patients in both sample groups, but especially the Japanese patients, were much more likely to think that the patient should be given the pills, despite family disapproval, than the physicians.

Composite Scores

To summarize and clarify some of the trends across multiple vignettes, we considered the set of 20 items that were appropriate to specifically assess whether patient autonomy, family authority, or physician authority was being given dominant weight in a respondent’s decisions. A summary or item composite was constructed, as described earlier (see “Materials and Methods” section).

Average scores on patient autonomy items (Fig. 1, left, A) for both US physicians and patients were significantly higher than those of both Japanese sample groups (no overlap of the confidence intervals [CI]). Scores on family authority items for both Japanese sample groups were higher than those for both US sample groups (Fig 1, middle, B), again with no overlap in the CIs. Physician authority scale scores were greater for the Japanese physician and patient sample groups than for the respective US sample groups (Fig 1, right, C). The 95% CIs did not overlap for the physician sample groups, although there was a slight overlap for the patient sample groups. Both Japanese and US patients gave greater weight to the preferences of the family and the physician than did their respective physician groups, again with no overlap of the relevant CIs. The weight given to patient autonomy by patients and physicians, within the same country, was very similar.

It is important to note that both the US and Japanese sample groups, physicians and patients alike, were more likely to agree with the patient when the patient’s wishes conflicted with those of the physician and/or the family. In other words, the opinions of all four of the sample groups were that the views of the physician and family should not overrule those of the patient. Additionally, all four groups were more likely to disagree with the physician when the physician’s opinion conflicted with that of the patient and/or the family. Within these general patterns, however, the Japanese sample groups gave more weight to the family’s and the physician’s views than did the US sample groups.

Discussion

The results of this study reveal that these sample groups of Japanese physicians and patients in a variety of urban care settings differ from their US counterparts in their views about a broad range of difficult medical decision-making situations, or at least from the views of academic and community physicians and patients seen in an academic medical center in the San Francisco Bay Area. While both

<table>
<thead>
<tr>
<th>Items</th>
<th>Agreement, %</th>
<th>Japanese Physicians*</th>
<th>Japanese Patients</th>
<th>US Physicians†</th>
<th>US Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>A doctor wants to have an AIDS virus test performed on blood previously drawn from a patient; the doctor tells the patient that he would perform the test at no cost.</td>
<td>32</td>
<td>70</td>
<td>16</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Assume the doctor has asked the patient’s permission to perform an AIDS test and the patient will not give permission. The doctor should be allowed to refuse to perform medical procedures that would put him at risk of infection if the patient were infected with the AIDS virus.</td>
<td>43</td>
<td>14</td>
<td>73</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Assume the doctor has performed the test without the patient’s permission and she is, in fact, infected with the AIDS virus; also assume the doctor has good reason to believe that the patient’s family is interested in finding out about her infection and that they may be able to help her deal with the problem; the patient is not married.</td>
<td>55</td>
<td>14</td>
<td>73</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05 for all comparisons of Japanese physicians with US physicians and of Japanese physicians with Japanese patients.
†p < 0.05 for all comparisons of Japanese patients with US patients and of US physicians with US patients.
sample groups give patients the dominant voice in clinical decisions, both physicians and patients in Japan give the views of family members and physicians greater weight than do the US sample groups. Patients in both countries give greater weight to the views of family and physicians than do the physicians providing care in the settings from which the patient respondents were drawn.

One prior comparison showed that, while 70% of physicians in the northern United States would inform their patients of a schizophrenia disorder diagnosis, 30% of Japanese physicians would do so. Several reports have discussed the practice regarding the disclosure of a cancer diagnosis in Japan. For example, Mizushima et al found that only 31% of Japanese physicians actually reveal a cancer diagnosis to their patients, and Tazawa et al found that only 4% of families consented to the physician notifying the patient. In Japan, studies and commentary on diagnosis disclosure and on other aspects of communication have generally been limited to the issue of cancer. However, by addressing a wider range of scenarios, we sought to provide insight into the underlying values that may affect decisions in many other clinical situations, thereby focusing on differences in views related to patient autonomy, family authority, and physician authority as possible explanatory constructs.

The most striking cross-national cultural differences were seen in the end-of-life vignettes. The response pattern suggests that the US sample groups favored patient-centered decision making, while the Japanese sample groups favored informing only the patient’s family of a cancer diagnosis, which are

| Table 4—Proportions of Respondents in Agreement With Statements About Providing Lethal Doses of Medication (Vignette No. 6), Separately for Patients and Physicians From Japan and the United States

<table>
<thead>
<tr>
<th>Items</th>
<th>Agreement, %</th>
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<tbody>
<tr>
<td>A patient is terminally ill with irreversible stomach cancer and will die within 6 weeks; she is in severe pain, which is not expected to go away; the patient tells the doctor that she wants a large number of pain-relief pills to end her suffering sooner by overdosing and killing herself.†‡</td>
<td></td>
</tr>
<tr>
<td>29. He should provide this large number of pills.§</td>
<td>8</td>
</tr>
<tr>
<td>31. Assume the doctor has talked to the patient’s family; if the family agrees that the patient should have the large number of pills she wants, the doctor should provide them.</td>
<td></td>
</tr>
<tr>
<td>32. Assume the doctor has talked to the patient’s family; if the family does not want the patient to have the large number of pills she wants, the doctor should still provide them.</td>
<td></td>
</tr>
<tr>
<td>The doctor has known the patient very well for 20 years.</td>
<td></td>
</tr>
<tr>
<td>33. He should provide this large number of pills.</td>
<td></td>
</tr>
<tr>
<td>35. Assume the doctor has talked to the patient’s family; if the family agrees that the patient should have the large number of pills she wants, the doctor should still provide them.</td>
<td></td>
</tr>
<tr>
<td>36. Assume the doctor has talked to the patient’s family; if the family does not want the patient to have the large number of pills she wants, the doctor should still provide them.</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05 for all comparisons of Japanese physicians with Japanese patients; p < 0.05 for comparison of items 33, 35, and 36 for Japanese physicians with US physicians.
†p < 0.05 for all comparisons of US physicians with US patients; p < 0.05 for comparison of items 29 and 31 for Japanese patients with US patients.
‡p < 0.05 for comparisons between items 29 and 33, 31 and 35, and 32 and 36 for all subgroups except Japanese patients (for whom none of these three comparisons are statistically significant).
§p < 0.05 for comparison of item 29 with item 31 for all sample subgroups. Comparison of item 29 with item 31 for all sample subgroups. Comparison of item 29 with 32 is not statistically significant for any sample subgroup.
||p < 0.05 for comparison of item 33 with items 35 and 36 for Japanese physicians only; other subgroup comparisons are not statistically significant.
findings that are consistent with previous research.31,32,36,39,47 The responses to these vignettes suggest that views concerning doctor-patient communication about cancer in Japan bear a similarity to views that were prevalent in the United States several decades ago.2 Our results also suggest that Japanese patients place greater emphasis on patient autonomy than do their physicians. However, the study design does not permit us to draw conclusions regarding the dynamics of change in each country or about the roots of the current differences. For example, the emphasis on patient autonomy in the United States48 may be attributable to family and community structure, or to a more developed culture of patient autonomy and associated legal directives, or both.

The ventilation support vignette (No. 5) also suggests that Americans wish to preserve patient autonomy at the end of life49,50 while Japanese respondents exhibit a greater deference to family and physician authority.32,39,51 While most Japanese respondents disagreed with a patient’s right to die, given unified family-physician opposition (question 16), most respondents agreed with this right to die when it was expressed through an advance directive (question 22). Such documents are understood but are uncommon in Japan.45 Our results also may reflect the increased desire for patient autonomy that has been noted in Japan since World War II,40,44,52 which, when supported by a legal document, freed Japanese respondents to honor the patient’s request. It is also very possible that the patient’s incompetence itself influenced the responses in favor of withholding mechanical ventilation. Future research is needed to resolve this question.

In Japan, there is little tradition of communication in health care.53 In particular, to avoid the potential disharmony of autonomous decision making and to respect family authority, open discussion with the patient has not been a substantial part of communication.53–55 In agreement with Hoshino,53,54 our data suggest that Japanese adherence to these traditional principles of interaction becomes more pronounced in the case of terminal illness.

Despite the social stigma of HIV disease,56 Japanese respondents seemed to believe that HIV-positive status warrants the involvement of the family. It is likely that the incurable nature of HIV disease renders it subject to the judgment and consideration of the family. However, other explanations are possible. For example, if one assumes that the HIV was contracted through socially disapproved means, respondents might feel that the family needs to be notified to consider how to handle the situation with others to mitigate risk to family members or to avoid the shame of the family finding out later as the disease progresses.

The differences seen between the Japanese and US sample groups may be the result of several cultural characteristics. Consensus building as a model of decision making, seen in many Japanese subcultures, has likely resulted in a de-emphasis on the patient’s individual opinion in favor of decisions that reflect group (ie, family) feeling. It has been noted that Korean-American and Mexican-American ethnic groups demonstrate a family-centered model of medical decision making at the end of life.12,57

Assisted suicide has become an area of active research and controversy.58,59 Our results are most striking in that patients favored provision of the lethal dose on patient request more than did physicians in either country. In fact, half of the Japanese patients were in favor even if the physician had only seen the patient once and was unaware of the family’s perspective. When presented within the context of a long doctor-patient relationship, Japanese patient opinion did not change significantly.

Figure 1. Composite scale score measures of attitudes toward patient autonomy (left, A), family authority (middle, B), and physician authority (right, C), according to subgroup. The values shown are given as the mean and 95% CI (indicated by bars); they correspond to the degree of agreement with subsets of items assessing the three targeted concepts, on a 4-point Likert scale. JMD = Japanese physicians; USMD = American physicians; JPt = Japanese patients; USPt = American patients.
suggesting that they believe suicide to be a decision to be made by an individual patient and their family, but not by the physician, even where the physician is to provide the means. Despite this, the large proportion of respondents who are in agreement with doctor assistance suggests that patients believe there is a role for physicians when terminally ill patients decide to commit suicide, a conclusion already documented with respect to the US public.60

US respondents clearly showed greater confidence that the provision of lethal pills will be properly considered when the doctor and patient benefit from a long association. In this scenario, fewer Japanese physicians agreed with physician assistance than US physicians. Their relative lack of a communicative tradition, in combination with the long history of suicide in Japan,61,62 may tend to make Japanese physicians feel they need not play a role in their patient’s suicide. US physicians’ recognition of their patients’ beliefs,63 in conjunction with their custom of communication and knowledge of the role in euthanasia already played by health-care providers,61 may explain the US physicians’ relatively greater agreement.

The analyses of the composite scores reveal that US sample respondents, particularly physicians, give relatively more weight to patient autonomy and relatively less to family and physician authority than did Japanese respondents. This aspect of US physician culture, as revealed in this context, appears to reflect a history of patient desire for autonomy as well as legal regulations that serve to guide physician thought and behavior.4,18 It is important to note, however, that US patients expressed a greater desire to have the family and physician serve as their proxy than physicians thought appropriate. Since physician opinion is often based on beliefs regarding patient desires,64 physicians must remain aware of the potential to force unwanted autonomy on their patients. The literature discusses Japanese decision making as incorporating insufficient patient autonomy and excessive physician and family authority51,32 while suggesting that Japanese patients desire more knowledge than the physician has traditionally provided.29,30,59,65–67 In contrast, there is considerable concordance between Japanese physicians and patients with respect to their attitudes toward patient autonomy. Kai et al65 have shown that Japanese physicians often underestimate patients’ desires for candid information. Our results suggest that, although this is clearly true in the disclosure of a cancer diagnosis, it does not hold across all vignettes presented. The often-cited case of cancer, thus, may not be representative of all clinical scenarios.

Strengths and Limitations

This investigation is the first to present direct quantitative comparisons of Japanese and US physicians and patients, or of physicians and patients within either setting. It is certainly the first to use clinical vignettes in which the views of different participants in the vignettes are systematically varied so as to reveal the influence of different “actors” in the clinical situation, as opposed to using more abstract opinion questions. And it is the first study to simultaneously consider a wide range of clinical situations, rather than limiting the investigation to such issues as cancer or withdrawal of life support. While general differences between the US and Japan sample groups are clearly evident, as discussed above, the results also suggest that it is not only the national setting and which actor in the vignette holds a particular view, but also whether the respondent is a patient or a physician and the nature of the clinical situation and decision to be made that determine the responses.

We chose to obtain the views of an accessible US sample and then to contrast these views with those of physicians and patients in as comparable Japanese settings as could be arranged. We sampled physicians from two medical schools, their patients, and three (nonacademic) medical societies in different urban areas in Japan. We believe that these Japanese settings provide a reasonable basis for comparison. It is possible, of course, that a choice of different sample groups within the United States or Japan (eg, sample groups from nonurban areas) would have produced somewhat different results. Given the intra-US variation in social, ethnic, and national origin, it is possible, perhaps even likely, that the international differences could have been either increased or decreased by the selection of particular subpopulations.

These limitations on generalizability should not detract significantly from the findings, which are consistent with qualitative reports in the existing literature where relevant data are available. Further, the comparisons of the views of physicians and patients within a country or between one vignette and another within national sample groups are less likely to be affected by the issue of whether any of the four sample groups is representative of their country as a whole.

The results of this study suggest an underlying value difference that may affect patient and family response in different clinical situations, thereby affecting patient satisfaction and, potentially, compliance with therapy, which are known to be related.63,68 The results of this research may sensitize physicians to cultural differences and contribute to
more effective models of patient care. They also may be useful in sensitizing US physicians to potential communication issues with their own patients, since many cities in the United States have large numbers of recent immigrants.

It is theoretically possible that a different selection of vignettes and items would yield different results. However, there are several reasons for believing that the comparisons based on the composites, and on the individual items, are generalizable. First, we believe that these vignettes and items are reasonably representative of those that might be constructed. Second, the same pattern (ie, greater relative deference to the wishes of the patient, less to the family, and still less to the physician) is observed both within vignettes and on the item composites.

As for virtually all surveys, there is the potential for bias toward giving whatever the respondent thinks would be an acceptable response in their social reference group or to the researcher, rather than revealing what the respondents would actually do in such situations. The use of vignettes rather than more abstract statements was intended to counteract this tendency. Social desirability notwithstanding, it also is possible that respondents may have difficulty knowing how they actually would respond or feel in some of these situations, especially where they might be either the patient or a family member, and we do not suppose that their responses are necessarily equivalent to what would occur in real life.

While we take the perspective that patient satisfaction and, arguably, patient response to medical care emerge within a social context to which clinicians should be sensitive, we do not advocate medical decision making based on cultural relativism. The present study was designed to determine whether national differences exist concerning issues of patient autonomy and disclosure, of which clinicians should be aware when dealing with individual patients and their families. It does not speak to the very complex issue of whether one social context is ethically preferable to the other.

CONCLUSION

The results of this study illustrate how cultural context shapes the relationships of the patient, the physician, and the patient’s family in medical decision making. Family and physician opinion appear to play a larger role in ethical decision making for Japanese physicians and patients than for those in the United States, who place the greatest emphasis on patient autonomy. While such findings should sensitize physicians to potential communication issues and should broaden the repertoire of responses that clinicians have in talking with patients, they should not be used to stereotype patients on the basis of culture or national origin.

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Ethics in Cardiopulmonary Medicine