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Japanese doctors likelier than US counterparts to involve patients' families in decisions

Medical residents in Japan are more likely to involve patients' families in end-of-life decision making--and to favor informing family members over the patients first-- than their United States counterparts, who prefer dealing directly with the patient, according to a new study conducted by Dr. Bob Gabbay and colleagues.

Yet the Japanese medical residents are more conflicted about their approach compared with medical residents in the U.S.

The findings reflect cultural norms in the two countries, said lead researcher Baback B. Gabbay who was a fourth-year medical student at UCLA at the time the study was written. Family ties are stronger in Japan than in the U.S., where a tradition of individualism is more culturally ingrained. However, the degree of uncertainty in the responses of Japanese (medical?) residents may reflect changing cultural norms in Japan.

"Traditionally, the family in Japan usually decides what to tell the patient," Gabbay said. "It's different than in the United States, where the individual autonomy to make decisions is perceived as relatively more important."

"Negotiating End-of-Life Decision Making: A Comparison of Japanese and U.S. Residents' Approaches" is published in the July issue of Academic Medicine.

The researchers distributed surveys to 244 Japanese and 103 U.S. medical residents. Response rates were 74 percent for the Japanese residents and 71 percent among U.S. residents.

Among the findings:

- 95 percent of Japanese residents said they would inform both patient and family about a metastatic cancer diagnosis, with 99 percent of that group reporting they would notify the family first. By contrast, 53 percent of U.S. residents said they would speak only with the patient and just 2 percent said they would inform the family first.
- 72 percent of the Japanese residents said that both patient and family should be told a metastatic cancer prognosis, with 23 percent reporting they would speak about the prognosis only with the family. In the U.S., 45 percent of residents would disclose the prognosis only to the patient and just 1 percent would inform only the family.
- 78 percent of Japanese medical residents who had cared for at least one dying patient during their training said they had not disclosed a cancer diagnosis to the patient at the patients' families' request, compared with 18 percent of residents in the U.S.

Yet the Japanese residents were more apt to express doubts about their approach compared with U.S. residents. According to the researchers, only 12 percent of the Japanese doctors reported being "completely certain" that their approach was the best. By contrast, 49 percent of U.S. medical residents said they were completely certain. This finding may be explained by the fact that Japanese attitudes toward end of life care have been in a state of transition in the past two decades. Changes in family structure as a result of urbanization may be responsible for the change as well as increasing media coverage. Palliative care is also expanding in Japan. Although in 1990 there were only three specialized wards for palliative care in Japan, by 2002, there were 89 such wards.

Though the researchers did not delve into the reasons for the differences in approaches, several explanations have been hypothesized from previous studies. One cause for that divergence may stem from the types of cancers that are prevalent in each country. One of the most common cancers in Japan is gastric cancer, which has a high mortality rate. Given this poor prognosis, many Japanese health professionals have felt patients will become depressed or give up home. Another reason stems from the long tradition of family decision making in Japan. Frequently, a family caregiver is informed by the physician of a patient's cancer diagnosis, treatment plan, and prognosis before the patient is told the truth. After discussions with other family members, the family caregiver decides whether the patient should be told, and the physician usually accepts the family's decision.

The findings show that U.S. medical residents may benefit from increased awareness of culturally-based decision making processes of the various ethnic groups they will treat during their medical careers, Gabbay said. While this kind of cultural sensitivity can be taught as part of the medical school curriculum, exercises such as role playing, simulated family conferences, and increased supervision with end-of-life discussions may be helpful for both current medical students and residents. "Don't assume that just because a patient lives in the United States the patient prefers to know everything," Gabbay said. "And just because an individual is of Japanese decent, you don't want to assume that they don't want to know. A case-by-case approach is likely most beneficial. Ask the patient what their decision-making process is and go from there."

Other researchers in addition to Gabbay were Dr. Steven M. Asch, associate professor of medicine, Dr. Kenneth E. Rosenfeld, associate clinical professor, Dr. Peter P. Balingit, associate clinical professor, and Dr. Karl A Lorenz, assistant professor, all of the David Geffen School of Medicine at UCLA; Dr. Shinji Matsumura of the University of Tokyo; Dr. Shiri Etzioni, VA Greater Los Angeles; and Dr. Toshiaki Shiojiri, Asahi General Hospital in Asahi, Japan.