

These give the patient insight into how his or her own view has been influenced by his or her family situation. According to these two models, it is important to address and discuss family members' feelings, thoughts, values, beliefs, and expectations, particularly since these have psychological meanings for other family members. Paying attention to the whole family dynamic and psychosocial interaction is a huge task, and it can be a long and heavy process not only for the patient and the family but also for the healthcare provider. A medical professional who understands Weil's Family Systems Counseling Model and Eunpu's Intersystems Counseling Model may be able to facilitate a decision-making support process for an individual by discussing family issues. If one wants to involve multiple members of the family in the session, however, facilitating the decision-making process would be much harder and would probably require specialized training in family counseling. It does not seem that "Let's talk about it together" is sufficient.

In conclusion, it is important to take into account cultural differences in the informed-consent and the medical decision-making process. For many people, especially in Japan, family issues are of paramount importance with regard to decision-makings, even if unrelated to genetics. Even when family issues matter, however, it is dangerous to apply a family-facilitated approach on the premise that the family is a single cohesive unit. A family consists of mul-

tle members who have different thoughts and feelings, with complicated and intertwined relationships between family members. It is much easier to discuss family issues with an individual, rather than to invite multiple family members into the same discussion process. Further studies should be conducted to examine how to deal with family issues, especially in a society like Japan where social and familial norms are strong. ■

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Culture and Communication: Medical Disclosure in Japan and the U.S.

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In Akabayashi and Slingsby's article, and often in discussions regarding medical ethics in Japan, "informed consent" refers primarily to the problem of delivering bad news to patients, particularly regarding a diagnosis of cancer (Akabayashi and Slingsby 2006). Many Japanese physicians, patients, and families worry that revealing a grim diagnosis harms patients by removing their capacity for hope. Japanese medical practice is rapidly moving in the direction of greater disclosure of medical information (Horikawa et al. 2000). However, this shift has not occurred without

tension. Numerous authors have addressed cultural factors particular to Japan that support the practice of concealing bad news from patients. Though not specifically linked to the issue of diagnostic disclosure, the work of Takeo Doi on characteristic patterns of Japanese interpersonal relations is especially useful. A Japanese psychiatrist trained at the Menninger Clinic, Doi's decades of research drew attention to different attitudes in Japan and the United States regarding interdependency (Doi 1973). Doi focuses on the concept of *amae*, defined as the accepted prerogative of the individual to depend on the benevolence of another. *Amae* offers a contrasting model for the doctor–patient relationship than that characterized by standard Western medical ethics. Rather than a partnership among equals, or a

¹The opinions expressed are solely those of the author and not those of the New York State Task Force on Life & the Law, nor of New York State government.

contractual relationship in which patients exert rights, patients may instead rely upon *amae*, i.e. upon physicians' benevolent, protective choices made on their behalf.

Japanese patients do not rely exclusively upon their doctors; the family is also of crucial importance. When Japanese physicians do not reveal a diagnosis to a patient, they typically do reveal the information to the patient's family, a practice referred to as "family autonomy" (Fetters 1998). Family, patient and physician are an interdependent team designed to protect and guide the care of the patient. Interestingly, this model may appeal to those Western bioethicists who are frustrated by the dyadic model of the doctor-patient relationship, and wish to offer greater acknowledgment of the family's role in medical decision-making in the U.S. (Nelson and Nelson 1995). Patients who willingly defer to their families for medical decision-making need not thereby relinquish autonomy. Rather, as Ruth Macklin argues, they express their autonomous authority in permitting selected others to choose for them (Macklin 2001).

As Akabayashi and Slingsby point out, the practice of revealing bad news to patients can be fraught with tension in the U.S. as well as in Japan. They argue that physicians should attend to individual needs and communication styles when informing patients; quite correctly, they observe that full and immediate disclosure is not the approach that best suits every patient. Indeed, one study (co-authored by Dr. Akabayashi) demonstrated that Japanese patients are both more likely to entrust decisions to family and to report more positive reactions to end-of-life care than their American and European counterparts (Voltz et al. 1998). In the present target article, however, the physician in the clinical anecdote hardly represents the sensitive case-by-case approach recommended by the authors. Rather, this physician serves as a caricature of the arrogant practitioner with one style to fit all patients. For this doctor, those who prefer frank disclosure are not motivated by the desire to deal openly with patients, but rather are merely "silly" and guided by "fashion." This physician appears never to believe in revealing medical information to patients, regardless of their personal and cultural preferences. This stereotype has its opposite in the physician who insists on brutally disclosing information despite the needs of individual patients and against the recommendations of their families.

A welcome alternative to the doctor in the case example presented by Akabayashi and Slingsby comes from the work of Michael Fetters, an American physician who has a keen interest in Japan and frequently treats Japanese patients. In a case from his own practice, Fetters struggled with the amount and timing of disclosure for a Japanese expatriate patient with advanced cancer. Unfortunately, a careful compromise is undone by routine disclosures on the patient's hospital discharge form (Fetters 1999). Rather than

ignoring cultural factors, Fetters studies these carefully and weighs them in context with the various needs and preferences of the individual patient. Disclosure and other interventions are tailored to the individual, not to the physician's preconception. To facilitate communication, Fetters relies upon advance directives regarding disclosure, consultations with family, and change of approach when dictated by clinical circumstances.

Attention to individual preferences does not prevent clinicians or bioethicists from assessing important cultural factors as well. Rather, those who wish to deal respectfully with patients from religious, ethnic and national backgrounds different than their own would do well to learn about the patient's culture but not assume that all persons within any culture have the same preferences. Instead, doctors must continue the struggle to communicate complex and often frightening information across barriers of language and culture. Physicians who dismiss the need for communication skills and a culturally sensitive approach to making medical decisions do so at the risk of providing substandard care. Fadiman's *The Spirit Catches You and You Fall Down* recounts a medical disaster resulting from cultural misunderstandings (Fadiman 1997). Communities, patients and physicians bring to the clinical encounter complex, deeply held beliefs about illness and the ways to cure or alleviate it; these beliefs are profoundly shaped by the culture of the individual. A careful exploration of the patient's needs and preferences, including preferences regarding disclosure, forms an integral part of the effort to build a treatment plan. At times, patients may require full and frank disclosure; other patients may indeed defer to family for decision-making. The competent physician knows that effective, culturally sensitive communication is a necessary part of providing high quality care. ■

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Complications of Culture in Obtaining Informed Consent

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Akabayashi and Slingsby (2006) present critical issues in suggesting how, in obtaining informed consent, a “one size fits all” model based on an independent sense of self should yield to a more dichotomous approach; but, in fact, other complications arise as well and must be taken into account. Specifically, discussions of these issues need to reflect key aspects of, and differences among, both families and cultures.

The authors present two reasons for not disclosing a diagnosis to a patient—because either the patient would be shocked, or the patient appears to not want to know. Yet in any particular case, these justifications may not be the same. The doctor or family may choose not to tell a patient because of one, but not the other reason.

Given the complex and at times conflicted emotions that a loved one’s impending death involves, families’ fears that the news would shock or disturb the patient may or may not be accurate. A patient may *want* to be told despite the family’s more protectionist stance. Or, families may not want the patient to know because of their own reasons.

Indeed, at times, a family “not wanting the family member to know” may not be in the patient’s best interest. The family may have a variety of reasons for desiring that a diagnosis not be disclosed, depending on the type of illness. For example, here in the United States, HIV-infected mothers often do not want a perinatally-infected child to know his or her diagnosis of HIV—even as the child is entering adolescence and may become sexually active—because these mothers feel guilt over having infected the child. Hence, at times, a family’s right to withhold the truth may conflict with the patient’s right to know.

Frequently, individuals know information—including each others’ medical conditions—without explicitly being told, and possess knowledge that they are not officially sup-

posed to have (Klitzman and Bayer 2003). As a result, in order to understand the ethics of not informing Japanese or other patients of their diagnosis, it is crucial to gauge how often Japanese patients in fact are not told, but nevertheless somehow—perhaps implicitly—know their diagnosis or prognosis. Such data would be important for comprehending the role of patients’ implicit expectations or understandings concerning disclosure, which in turn can shape the ethics of such disclosure decisions. For example, it is possible that many Japanese patients who are not told their diagnosis are in fact *aware* that they are not being told.

Consequently, when the patient does not inquire about his or her diagnosis, it may not be out of ignorance, indifference, or failure to consider the potential importance of such information. Rather, the patient’s failure to ask may reflect a conscious, relatively informed decision to follow an interdependent, family-focused model of medical care, in which the patient understands that his or her family will nevertheless be told the diagnosis. Clearly, from an ethical perspective, these two scenarios differ dramatically. In one case, but not the other, the patient is at least tacitly—even if not explicitly—consenting to not being told.

A further problem with the authors’ article stems from the fact that they do not clarify how exactly physicians should make decisions about which model to use when patients are neither purely Japanese, nor purely “Western.” In our increasingly globalized world, assimilation is not a dichotomous phenomenon (e.g., of individuals being either Japanese or American), but varies across a wide spectrum, filled with admixtures of bits and parts of different cultural traditions. How should providers decide which approach to take with patients who fall along the mid-portions of this continuum—who identify with some aspects of American