

Title	Rethinking of patient-centered medicine in Japan
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Citation	医療・生命と倫理・社会. 2019, 15, p. 1-16
Version Type	VoR
URL	<a href="https://doi.org/10.18910/73331">https://doi.org/10.18910/73331</a>
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## Rethinking of patient-centered medicine in Japan

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### 1. Doctor -patient relations in the world

Cusack (2000) argued that by European standards Ireland experiences a very high level of medical litigation. The possible reasons for this are numerous but not yet determined with any certainty. The consequences, however are quite clear negative effects on medical practice, on the psychological health of doctors and patients alike, and on the finances of the state.

There are different patterns of medical litigation throughout the world. Doctor-patient relationships in China have been deteriorating for the past 10 years. Many Chinese doctors are involved in tense and conflictual doctor-patient relationships. Most patients do not trust doctors or other medical staff and physical attacks on these professionals have become a common event.

In 'expert-to-non-expert' interactions, one of the distinguishing features is that there is no or very little shared knowledge between the subjects. This situation may become particularly challenging when the unshared knowledge is of a very technical kind, as the likeliness of misunderstandings or unsuccessful communication becomes very high.

This is particularly true of interactions between patients and physicians. In the course of such interactions, physicians are expected to inform, advise and persuade patients regarding their health problems. Especially when differences of opinion emerge that physicians need to be persuasive, but this is also when that this may become very difficult, as the patient does not share the medical expertise of the physician. At these moments, one of the most powerful means of persuasion in the hands of physicians is their professional ethos, or authority.

This paper presents partial results of an ongoing research project aimed at describing the ways in which physician utilize their professional ethos.

Also Lewis (2009) argued that patients may bring unreliable information to the physician, complicating the physician-patient relationship, or on the other hand seeking outside information seeking may complement physician information provision, reinforcing patients' responsibility for their health. The current descriptive evidence base is weak and focuses primarily on the internet's effects on physician-patient relations.

#### 1.1 The importance of patient's autonomy

Many people which people pay attention to doctor -patient relations and some people have trouble with the current state of doctor -patient relations. In article, "Lack of communication behind poor doctor-patient relation" ,The Time of India (2012). Despite obtaining written

consent from patients and their attendants before subjecting them to medical procedures, doctors often land in trouble and face litigation because of lack of communication. Also, doctor-patient relations have changed in the world. For example, Akerkar (2004) says that doctor-patient relationship - the trust has been described as the scarcest of medical commodities.

Most of the 20th century, due to the lack of information, was the era of "Doctor knows the best". However, come the information age, patients are empowered with information. The immediate fallout is the replacement of trust by skepticism and weariness. "Blind trust" is being replaced by "Informed trust". In fact the first health contact which traditionally was the family physician; is slowly being replaced by the internet in many cases. Patients search the net and consult their physician armed with information.

On this point, ACMG (2014) points out the importance of patient autonomy. What is the patient's autonomy? Sine (2008) argues that "The ethical principle placed most at risk by the "architecture of madness" is patient autonomy. Today, with few exceptions, inpatient treatment for individuals with mental and substance use disorders is provided in a locked facility. That is, patients' freedom of movement is restricted from the moment of admission until the day of discharge. Exit doors are locked and windows bolted shut; patient movement, activity, and privacy are closely monitored by staff in a modern purpose-built architectural surveillance system

Patient autonomy involves the right to refuse care, the right of association, and the right of freedom of movement. All flow from the principle of beneficence when patients are thought to be a risk to themselves or others and suitable for admission to the locked unit of a psychiatric hospital. The wholesale suspension of these patient rights is believed to be permitted because the risk of suicide and elopement is presumed for all patients. No matter what the actual clinical presentation, all patients are treated in a like manner by the prevailing architectural ethic: they are all at risk and must be protected.

Nessa (1998) argues that "within the biomedical tradition, patient autonomy implies a right to set limits for medical intervention. Patients are supposed to know their own good as autonomous moral agents, and medical intervention presupposes formal or informal consent from the patient. The notion of informed consent is a modern invention, resulting from the interaction of medical scientists and lawyers." Patient autonomy is widely acclaimed. For example, World Medical Association (WMA), in Declaration of Lisbon on the Rights of the Patient, states patient autonomy "Right to self-determination as follows.

- (a) The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions.
- (b) A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary

to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

(c) The patient has the right to refuse to participate in research or the teaching of medicine."

Also in America, in 1990 the Patient Self-Determination Act (PSDA) was established. "PSDA encourages everyone to decide now about the types and extent of medical care they want to accept or refuse if they become unable to make those decisions due to illness." (American Cancer Society, Inc. 2013).

## 1.2 Argument about patient's autonomy

However, patient autonomy is not only advantageous, but patient autonomy is also criticized as follows:" Patient autonomy is widely acknowledged as the new orthodoxy or ethic for healthcare delivery. Patient autonomy is problematic for a number of reasons. This perception of autonomy is often equated with free choice which does not reflect the more positive sense of liberty associated with autonomy. In this view self-determination and mastery have greater significance than the absence of constraints. Furthermore, autonomous choices do not involve acting solely on one's individual desires in a vacuum but encompass a critical, relational, reflexive review of one's initial wants and an appreciation of the impact of choices on others. Misinterpretation and subsequent inappropriate application of Kantian philosophy has sometimes contributed to an account of autonomy in healthcare which is less than complete and possibly misleading.

Finally, a model of autonomy based on freedom to choose, which fails to consider the notions of relationality, responsibility and care does not provide the best means for increasing human potential. (Greaney 2012)"

Marsha Garrison (2013) insists that there are 3 points about patient autonomy. i patient's understanding of medical information is adequate? ii Many patients do not want much information about his illness. iii If the patient wants adequate information, it requires much time to communicate medical information, and the information is too difficult for patient to understand. Also, there is a problem that it may not be possible for autonomy to protect the dependent, children or handicapped persons. Thus patient autonomy should be handled with care. Then, many people say that the patient should be centered in medicine.

## 2. Doctor-patient relations in Japan

Someone has said that either Japanese medicine has no patients or Japanese medicine is the highest level but Japanese medicine is not the best. In the 19 century, with the advancement of medicine, there has been also a great importance placed on the patient autonomy (Okuyama 1994). This idea, patient autonomy, is seen as one aspect of freedom of expression. This idea

says that 'the patient should decide by himself without others' control'. In particular, Medical ethics says that Patient is human, so their right of self-determination must be respected. In medical ethics, autonomy has been the most important principle, even though autonomy is not a traditional principle of medical ethics.

Nakamasa (2005) says that in general there is a tendency to define the concept of patient autonomy as one having the power to make all decision for oneself. However when it comes to a matter of law, autonomy involves restrictions regarding "personal affairs"-it is understood that it shows one has the power within his personal boundaries to make decisions about his way of life.

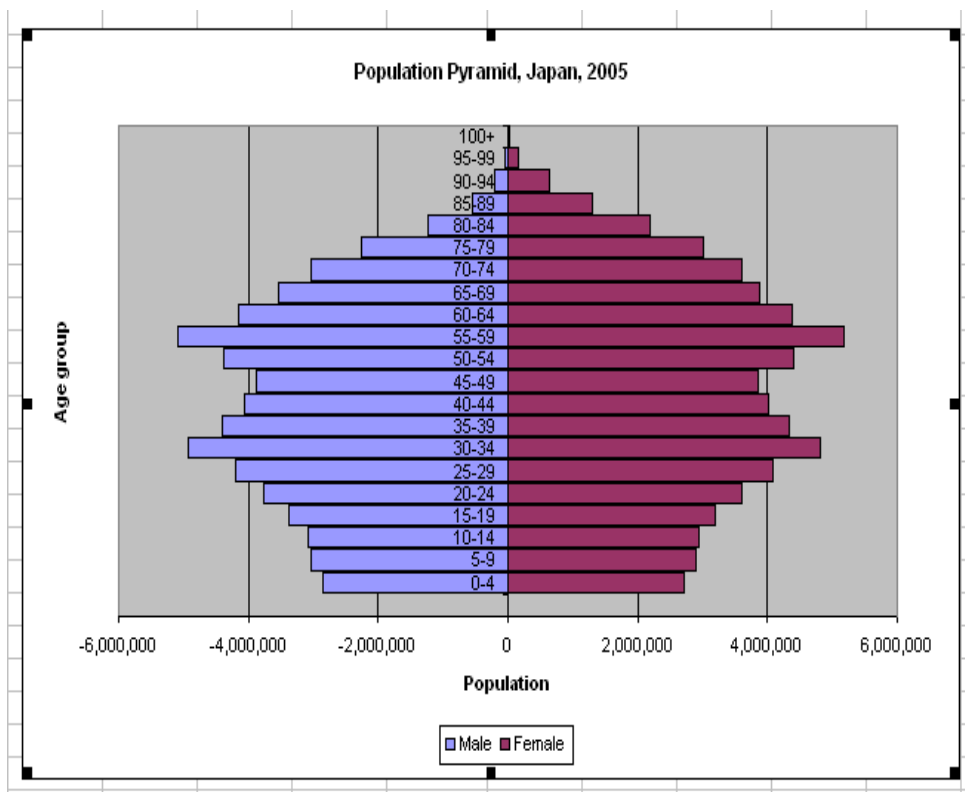
Namely, Vikki suggests that "personal autonomy is widely valued. Recognition of its vulnerability in health care contexts led to the inclusion of respect for autonomy as a key concern in biomedical ethics. The principle of respect for autonomy is usually associated with allowing or enabling patients to make their own decisions about which health care interventions they will or will not receive." Moreover, recently patient-centered medicine commands considerable attention in various fields from medicine to philosophy. The word at first sight looks good. However, the concept of the word is too unclear and ambiguous for everyone to understand what Patient-Centered Medicine is and those who insist on the importance of Patient-Centered Medicine are not patient but doctor, nurse and health workers. The concept is different between doctors and patient, so the concept is used by not patients but by doctors and not patients but for doctors. Therefore, we should know the concept of Patient-Centered Medicine and have recognition that we have autonomy.

If the population is aging and many old people can speak for themselves, nations will lose their family and they will need to decide their medical treatment by themselves or with their medical supporters. In this case autonomy is increasingly important.

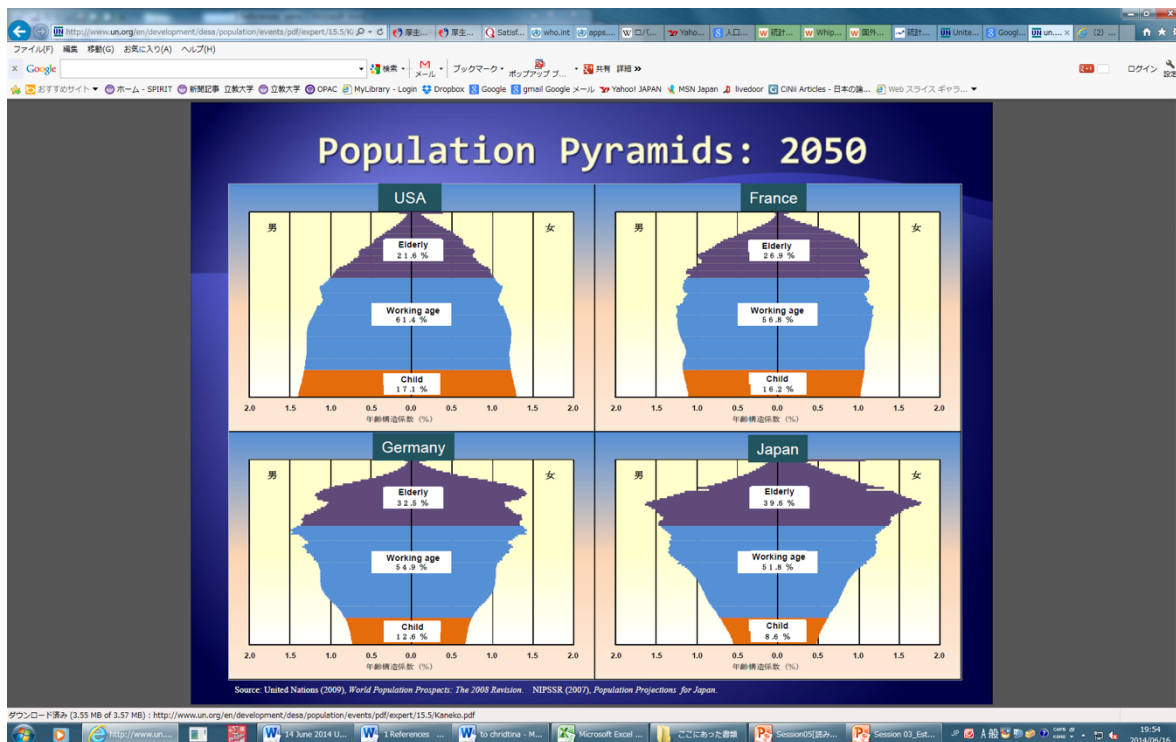
And Japan has had the highest percentage of elderly people (65%) in the world since approximately 2005, and is projected to continue to be so at least until 2050.

The graph below, drawing from international workshop and UNSD shows that, aging population is a global issue.

[Population Pyramid in Japan]

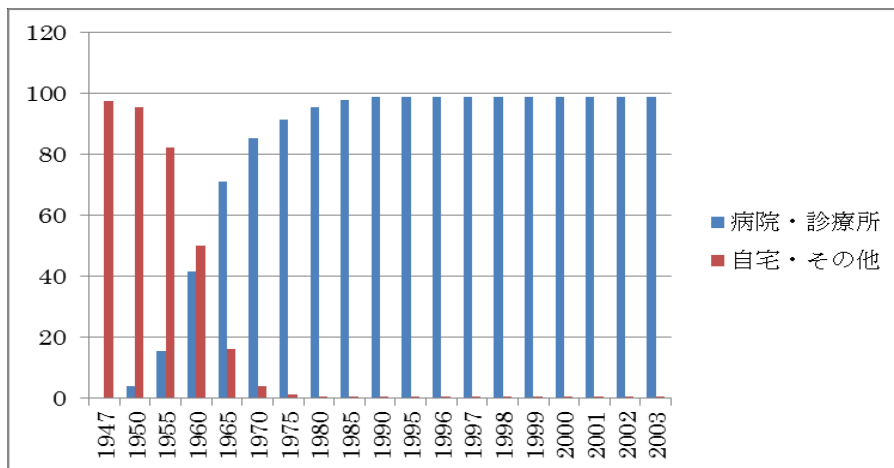


[Population Pyramids in Other Countries]

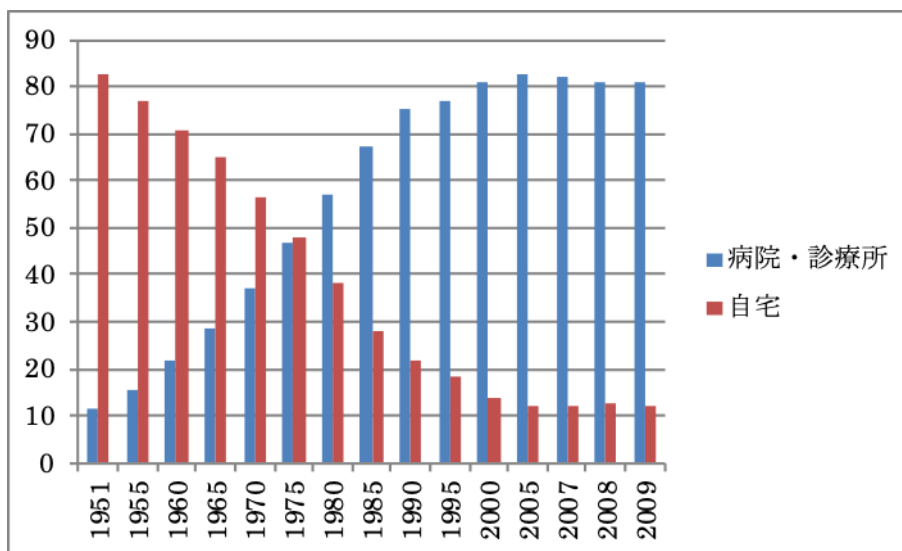


Besides, in Japan, in recent years almost all people are born and die not at home but in the hospital, so they must spend time with doctors and nurses. Therefore Japan is suitable for research about relationship between doctors and patients.

[Birthplace about Japan]



[Death place about Japan]



### 2.1 Patient-centered medicine

Matushige (2010) argue that many people are interested in more Patient-Centered medicine. It is rarer rather that the word a "patient center" does not come out in the argument in the medical field in recent years, so recognition that the person's himself/herself intention and standard of value should be thought as important is spreading. However, according to Asahi (2013), when it is seen from the viewpoint of who has a medical right of the final decision on

medical treatment, the concept of patient-centered medicine not emphasize about respect of a patient's autonomy. Rather, since it is thought as a partnership between a doctor and a patient, there is a problem that the locus of responsibility to the offered medical treatment is not necessarily clear. That is, even if we use this phrase, it cannot ensure the patient a position in the center of medicine. At the actual medical scene, the doctor has authority as a leader of medical practice, and most responsibility, so when there is a difference between a doctor and a patient on their opinion, it is thought that the influence which a doctor who is a specialist on medicine give a patient is great.

At the present, who is managing the condition of patient-centered medicine, and in what manner are doing so? Medicine is constituted by various persons of various positions. If the word of "patient-centered medicine" shows variance with each position, it is hard to think that the patient is respected and that the patient conducts his own medical situation. This paper aims to become the first step toward realization of better medical treatment for patients by understanding the difference which has arisen in patient-centered medicine by the difference in medical position.

## 2.2 About the validity of the sample of Japan

Robert (1991) argues that Americans think that a quality of having a good life is the ability for a person to decide everything by himself. However, Sekine (2009) argues in Japan that IC is the most practical as a Japanese medical ethic now. Now that, IC is the ethical medical act that spread widely in the medical society.

However, the creakd in Europe and America, the fact is still felt with the embarrassment. Therefore one performs an appropriate explanation to the patient in the healthcare setting and works hard "to get understanding" from a patient, and "informed formal consent of the mouth formal way" that Japanese style informed consent suitable for Japanese medical care. This is performed is the practical act that is going to build a good relationship of mutual trust between a doctor and patient. This contributes to a better compliance structure of the patient as the medical ethic that is adapted to Japanese character and society. However, interest leans on "American style informed consent" to respect the right of patients saying that the informed formal consent of the eyes that put the center of the relationship of mutual trust from the abundance of the choice in a surge and the treatment of the Japanese human rights thought is not an original figure recently. So, American IC has begun to attract much attention.

While, MARK (2001), who is an American philosopher and bioethicist who has been a key contributor to the new doctor-patient relations in medicine and medical education, argued that "we believe that the concerns about the individualistic nature of medical ethics are important. The rhetoric of informed consent still emphasizes self-determination despite the fact that good scholarship has expanded what bioethicists mean by that term.

This scholarly trend toward a less individualistic, more process-oriented notion of IC and



its resulting role for close others is salutary. However, it is not exactly clear what many of these critics of informed consent are seeking. Typically, compromises are called for because the “dominant Western bioethical concepts and principles are problematic” and “routine application of these concepts and principles may pose difficulties.”

Although cautious, some argue that informed consent can be compromised. For instance, “eviation from the usual formal standards of informed consent would be justified only by reference to patient-centered values.” And, of course, others have astutely observed that, in practice, informed consent is often compromised and truth withheld in the attempt to be culturally sensitive.

Although cultural sensitivity is important, we shall argue that any suggestion that we should step outside our ethical framework entirely in favor of the ethic of the patient’s culture is mistaken. Such suggestions should not guide clinical behavior.

We will justify this claim in two ways: by reiterating the reasons our culture holds informed consent so dear and building on this foundation, and by rebutting the epistemological assumptions of culturally relative medical ethics.

Furthermore, our skepticism regarding the use of culture in clinical decision-making might suggest that the study of culture is of no use to the clinician. We offer some preliminary speculations regarding why we believe that conclusion is overstated”.

Also, Satoa (2014) argues that “obtaining informed consent is necessary in research involving human subjects. Despite this consensus by researchers and physicians, little effort had been spent to inform patients of this requirement in Japan. In several cases, study participants have not been provided with sufficient information, nor have they been asked to give their informed consent. A few reasons have been cited for this shortcoming.

First, until 1998, there was no legal requirement for informed consent in Japan until the Ministry of Health and Welfare (MHW) implemented Good Clinical Practice (GCP) regulations requiring informed consent in new drug trials.

Second, physicians routinely withheld information from patients, particularly diagnoses of cancer and information regarding treatment. As a result, cancer research participants were left uninformed of their diagnosis and involvement in research treatments. Consent forms were occasionally provided to patients before the GCP regulations were implemented, but the documents were exceedingly complex and difficult to read. A government-funded program was implemented to develop guidelines for appropriate research conduct in clinical trials of oral fluoroscopy medical compounds used widely for breast cancer patients.

Since we thought that obtaining informed consent in writing was critical to conduct a sound clinical trial and the GCP would be enacted a few years later, we developed a consent form that fully discloses the key elements of research and treatment, including study purpose, procedures, potential risks and discomforts, benefits, rationale for chemotherapy, and patient rights. Despite our development of this form, contributing investigator

oncologists were reluctant to use it because they were concerned that full disclosure would overwhelm patients and diminish their willingness to participate.

Some also expressed concern that the information was too difficult for patients to understand. A number of studies have reported that informed consent documents have become increasingly unreadable, lengthy, and uninformative. Although the development of modified or simplified documents has been successful in improving patient satisfaction and decreasing patient anxiety, these documents have had little impact on improving patient comprehension. Such inadequacies stem from a failure to develop consent documents that correspond to patient levels of education and informational needs.”

As stated above, the patient's self-decision should not become the thing peculiar to the country suitable for the national traits in consideration of national traits, and it is an important, regardless of whether internal or abroad to find a conclusion that is comprehensive about this point.

Moreover, recently Patient-Centered Medicine commands considerable attention in various fields from medicine to philosophy. The paper by Asahi (2013) clearly indicated that the word at first sight looks good. However, the concept of the word is too unclear and ambiguous for everyone to understand what Patient-Centered Medicine is and that those who insist on the importance of Patient-Centered Medicine are not the patients but doctors, nurses and health-care workers. The concept is different between doctors and patients, so the concept is used by not patient but by doctors and not for patients but for doctors. Thus, we should come to know the concept of Patient-Centered Medicine and have recognition that we have the autonomy.

If you research the Japanese Society of Health and Medical Sociology site, you will find Japanese Society of Health and Medical Sociology has existed since 1974 and today 659 people belong to this group, which is the largest in Japan. This group publishes three times a year. This group has published 5 treatises about patient's autonomy in 1 journal in 1998, but since that time up until 2013 this group has published 1 treatise about patient's autonomy in 1 journal. Although in 2008, this group has published 1 treatise about IC in 1 journal and in 2011 this group published 4 treatises about Communication in 1 journal and in 2013, this group has published 5 treatises about Team medicine in 1 journal the number, about patient's autonomy is 0.

According to the above we can conclude that there is much greater Patient-Centered Medicine or team medicine than Patient's autonomy. However, Asahi (2013) argue that :First , in patient-centered medicine , the word " patient-centered " has no common concept and is too unclear and ambiguous . The problem is that the word means not only the need to listen to the patient but also the need to respect the patient's values .Also, the problem is whether or not the relationship is able to return to a partnership.

Second, those who insists on the importance of patient-centered medicine are not patients but

doctors, nurses and health-care workers and there are some differences regarding patient-centered medicine between patients and doctors. This is what seems, although they insist is patient-centered medicine, that is actually egoistic medicine.

### 3. Research Question/Hypotheses

- (a) How are patient-centered medicine and non patient-centered medicine different?
- (b) How is such care tracked?
- (c) How might such care be standardized so there can be quality checks?

Doctors, nurses and patients make efforts to understand each other and try to realize patient-centered medicine. Nevertheless they have complaints with doctor-patient relations. Is the communication poor?

This paper tries to address (a)-(c) and the reason they have complaints with doctor-patient relations.

### 4. Methodology

This paper uses questionnaire analysis and interview with patients and doctors.

#### 4.1. I Questionnaire

This sheet has 29 questions and they are classified into 4 categories. First category is what is important for doctor-patient communication. Second is which case you feel hard in doctor-patient communication. Third is how do you or your doctor practice what you think important in doctor-patient communication. Final is about yourself, age, gender and so on.

#### 4.1. II Interview

This paper interviewed only one patient, and in this paper, there is cooperation from 4 doctors and 2 patients who are acquaintance or my friends' acquaintance. This is too small sample to disclose theory.

However, without going through any organization. In this point, in a sense this date is fair.

Qualitative methods give us ways to understand rather than to predict a situation and to improve a life rather than to control peoples' actions (Merriam 2004). In qualitative methods, there are many interpretations of one occurrence or incident and there is a presupposition that the meaning of experience is built by the interaction with the sociocultural context with people. To understand, we observe a certain phenomenon as it is, conduct an interview with the persons concerned, and analyze the literature and the persons image relevant to a certain activity. This process is inductive and positive.

Some people suggest that my research question should do quantitative research. For example, create a question sheet about the patients or doctors' attitude and consciousness on

patient-centered medicine. Maybe it is an important way, however in quantitative research when my paper operate and organize the subjects attitude and consciousness, my research would isolate their situation from their own story and lose the sense of them living life.

Also, in many cases two interviewees communicate though story which can result in completely different results, even when talking about the same occurrence. So, individual story is a very subjective reality which is composed of each individual's values and motives. Interview researches subjective reality and credibility, and interview does not seek universal truth. Credibility is coherence, which means the story has no inconsistency between the story having been told at a certain time and the story having been told at an another time. Of course, interview does not do away with inconsistency and tries to understand the reason why the inconsistency has arisen.

## 4.2 Sample

Doctor	Age	Gender	Medical Field	Doctor Career(year)
DoctorA(DA)	54	male	Gastrointestinal/Digestive surgery	29
DoctorB(DB)	72	male	Physician	46
DoctorC(DC)	44	male	Physician	19
DoctorD(DD)	55	male	Pediatrics	29

Patient	Age	Gender	Medical History(years)
PatientA(PA)	27	female	5
PatientB(PB)	38	female	4

PB answered questionnaire and PA answered interview. This survey was conducted from May 2014 to December 2014.

## 5. Discussion

### 5.1 Questionnaire

About first category, doctors' answers are almost the same. Different answer is only 12.5%. About second and third doctors' answers are not the same. This is attributable to variety of their work environment.

However in first category PB's answer is very different from doctors' answer. And PB's doctor practices what PB does not think is important.

### 5.2 Interview

PA has experience in tow hospital. Has illness is dystonia which is one of malignant disease, and a generic name about involuntary, sustained muscular contraction due to the central nervous system disorder.

In comparison to tow hospitals, she said that tow is too different.

About first hospital, she said

“My doctors helped me very hard.” “Every day my doctor visited my bed and asks my condition.” “My doctors and nurses explain my condition and medical term” “Outsider diagnosis, when we met by chance, they cheer up me so I can believe them”.

About second hospital, she said

“In this hospital, they do not come when I do not call. And if they come they leave soon because of busyness.” “My doctor does not explain my prescription then I do not know now what I take.” “When we are talking about my operation, they use medical term without explaining medical terms.” “Now I can not believe them, and I want to back to the first hospital.”

## 6. Resolution

In this survey, what is important in doctor-patient communication is different from doctors and patient. From this date and previous research, doctors have original value or belief.

And from interview date, environment is too different according to hospital. This is natural but we should give care to possibility that they have no choice their hospital.

This survey cannot be generalized, but this possibility is important.

Probably, importance in doctor-patient communication is different from doctors and patient and also, there is such difference in doctors.

For all of us, medicine is indispensable resource. It is ok there is no demand but some doctors supply medicine to their patient?

Now many countries try to realize patient-centered medicine. But the most importance is that concept is general. If doctors and patients or doctors and doctors continue to tackle this problem, there is a possibility that our medical situation becomes more critical state.

Finally this resolution is not over the level of the personal opinion. So I hope this work will spur continuing research effort in this area.

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